University Hospitals Dorset
NHS Foundation Trust

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

BOARD OF DIRECTORS – PART 1 MEETING

Wednesday 27 September 2023

13:15 – 15:15

Poole Hospital Boardroom and

Via Microsoft Teams

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

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

BOARD OF DIRECTORS – PART 1 HELD IN PUBLIC

The next meeting of the University Hospitals Dorset NHS Foundation Trust Board of Directors Part 1 will be held at 13:15 on Wednesday 27 September 2023 in the Boardroom at Poole Hospital and via Microsoft Teams.

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

Rob Whiteman
Chairman

AGENDA – PART 1 PUBLIC MEETING

13:15 on Wednesday 27 September 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 26 July 2023	**Paper**	**Approval**	**Chair**
	4.2	Matters Arising - Action List	**Paper**	**Review**	**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 – 6 July 2023	**Paper**	**Information**	**CEO**
13:55	**6**	**STRATEGY, RISK AND PERFORMANCE**			
	6.1	Integrated Quality, Performance, Workforce, Finance and Informatics Report *Questions to the Executive Team by exception*	**Paper**	**Assurance**	**Execs**
	6.2	Elective Recovery – *"Protecting and Expanding Elective Capacity"* – NHS England letter	**Paper**	**Information**	**COO**
	6.3	Risk Register: new risks 12 and above	**Paper**	**Approval**	**CNO**

	6.4	CQC Update	**Paper**	**Review**	**CNO**
14:20	**7**	**CULTURE**			
	7.1	Freedom to Speak Up Guardian Report	**Paper**	**Assurance**	**FTSU Guardian**
	7.2	Workforce Race Equality Standards Report and Action Plan	**Paper**	**Assurance**	**CPO**
	7.3	Workforce Disability Equality Standards Report and Action Plan	**Paper**	**Assurance**	**CPO**
	7.4	Equality, Diversity and Inclusion Annual Report	**Paper**	**Assurance**	**CPO**
	7.5	Guardian of Safe Working Hours Report	**Paper**	**Assurance**	**CMO**
14:40	**8**	**COMMITTEE CHAIRS' REPORTS**			
	8.1	Quality Committee – Chair's Reports – August and September 2023 • Annual Safeguarding Report	**Paper**	**Assurance**	**Committee Chair**
	8.2	People and Culture Committee – Chair's Report – August 2023 • Quality Assurance for Responsible Officers and Revalidation • Maternity Staffing Report • Annual Security Report	**Paper**	**Assurance**	**Committee Chair**
	8.3	Finance and Performance Committee – Chair's Reports – August and September 2023 • Premises Assurance Model – *for approval*	**Paper**	**Assurance**	**Committee Chair**
	8.4	Charitable Funds Committee – Chair's Report – August 2023	**Paper**	**Assurance**	**Committee Chair**
15:00	**9.**	**ITEMS FOR APPROVAL**			
	9.1	Senior Independent Director Appointment	**Paper**	**Approval**	**Chair**
	9.2	Terms of Reference: • Amendments to Committee Terms of Reference • Honours Group	**Paper**	**Approval**	**Chair**
	9.3	Board Governance Cycle	**Paper**	**Approval**	**Chair**
	9.4	Board and Committee Meetings 2024	**Paper**	**Approval**	**Chair**
	9.5	Anti Bribery and Corruption Policy	**Paper**	**Approval**	**CFO**

	10	Any Other Business	**Verbal**	**Discussion**	**Chair**
15:05	**11**	Questions from the Council of Governors and Public arising from the agenda. Governors and Members of the public are requested to submit questions relating to the agenda by no later than Sunday 23 July 2023 to company.secretary-team@uhd.nhs.uk			
	12	**Date and Time of Next Board of Directors Part 1 Meeting:** Board of Directors Part 1 Meeting on Wednesday 29 November 2023 at 13:15.			
	13	**Resolution Regarding Press, Public and Others:** To agree, as permitted by the National Health Service Act 2006 (as amended), the Trust's Constitution and the Standing Orders of the Board of Directors, that representatives of the press, members of the public and others not invited to attend to the next part of the meeting be excluded due to the confidential nature of the business to be transacted.			
15:15	**14**	**Close**	**Verbal**		**Chair**

* Late paper

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

Items for Next Board Part 1 Agenda

Standing Reports

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

Quarterly Reports

- Mortality Report
- Guardian of Safe Hours Report

Bi-annual/Annual Reports

- Annual Winter Plan
- Standing Financial Instructions
- 7 Day Services Board Assurance Framework

AGENDA – PART 2 PRIVATE MEETING

15:30 on Wednesday 27 September 2023

Time	Item		Method	Purpose	Lead
15:30	**15**	Welcome, Introductions, Apologies & Quorum	**Verbal**		**Chair**
	16	Declarations of Interest	**Verbal**		**Chair**
15:35	**17**	**MINUTES AND ACTIONS**			
	17.1	For Accuracy and to Agree: Part 2 Minutes of meeting held on 26 July 2023	**Paper**	**Approval**	**Chair**
	17.2	Matters Arising – Action List – *none outstanding*	**Verbal**	**Review**	**Chair**
15:40	**18**	**UPDATES**			
	18.1	Chief Executive Officer's Update • New Hospitals Programme	**Verbal**	**Information**	**CEO**
	18.2	Escalations from Committee Chairs (not already covered in Part 1)	**Verbal**	**Information**	**Committee Chairs**
	18.3	Financial Risks and Mitigations	**Paper**	**Review**	**CFO**
	18.4	Medium Term Financial Plan	**Paper**	**Approval**	**CFO**
	18.5	Electronic Patient Record	**Paper**	**Review**	**CIO**
15:55	**19**	**QUALITY AND PEOPLE**			
	19.1	Serious Incident Report	**Paper**	**Review**	**CMO**
16:00	**20**	**ITEMS FOR APPROVAL**			
	20.1	Fire Stopping Across UHD Estates	**Paper**	**Approval**	**CFO**
	20.2	Mortuary Stroke Ward 7R	**Paper**	**Approval**	**CFO**
	20.3	CT Scanners	**Paper**	**Approval**	**CSTO**
	20.4	UHD Charity: • Annual Report and Accounts o Annual Report and Accounts o Representation letter o ISA 260 report	**Paper**	**Approval**	**CFO**

	21	Any Other Business	**Verbal**		**Chair**
	22	Reflections on the Board Meeting	**Verbal**		**Chair**
	23	**Date and Time of Next Standing Board of Directors Part 2 Meeting:** Board of Directors Part 2 Meeting on Wednesday 29 November 2023 at 15:30.			
16:30	**24**	**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

Annual Report

- Local Clinical Excellence Award

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 Part 1 meeting of the Board of Directors held on Wednesday 26 July 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
	Judy Gillow	Non-Executive Director
	Philip Green	Non-Executive Director
	Siobhan Harrington	Chief Executive
	John Lelliott	Non-Executive Director
	Mark Mould	Chief Operating Officer
	Stephen Mount	Non-Executive Director
	Pete Papworth	Chief Finance Officer
	Sharath Ranjan	Non-Executive Director
	Richard Renaut	Chief Strategy & Transformation Officer
	Cliff Shearman	Non-Executive Director
	Paula Shobbrook	Chief Nursing Officer
	Caroline Tapster	Non-Executive Director
	Peter Wilson	Chief Medical Officer
In attendance:	Karen Bowers	Matron, Hospital at Home *(for the Patient Story)*
	Robert Bufton	Public Governor
	Sharon Collett	Public Governor
	Sue Comrie	Appointed Governor, Volunteer Services
	Kathyrn Crowther	Clinical Nurse Specialist for IPC
	Gillian Cumming	Consultant *(for the Patient Story)*
	Yasmin Dossabhoy	Associate Director of Corporate Governance
	James Donald	Associate Director of Communications
	Rob Flux	Staff Governor
	Sarah Hedges	Clinical Leader, Older People's Services *(for the Patient Story)*
	Matt Hodson	Deputy Chief Nursing Officer
	Marjorie Houghton	Public Governor
	Sarah Locke	Deputy Company Secretary
	Deborah Matthews	Director of Organisational Development
	Helena McKeown	Observer (Shadow Non-Executive Director)
	Keith Mitchell	Public Governor
	Sue Mortlock	Observer
	Patricia Scott	Public Governor
	Jeremy Scrivens	Public Governor
	Gemma Short	Midwife
	Diane Smelt	Public Governor
	Susanne Surman-Lee	Public Governor
	Joe Talora	Health Service Journal
	Kani Trehorn	Staff Governor
	John Vinney	Associate Non-Executive Director

Claire Whitaker	Observer (Shadow Non-Executive Director)
Michele Whitehurst	Deputy Lead Governor
Sandy Wilson	Public Governor

Public attendees: 3 members of the public attended.

BoD 163/23	**Welcome, Introductions, Apologies & Quorum** Rob Whiteman welcomed everyone to the meeting. No apologies from members of the Board had been received. The meeting was declared quorate.
BoD 164/23	**Declarations of Interest** No existing interests in matters to be considered were declared. In addition, no further interests were declared.
BoD 165/23	**Patient Story** Paula Shobbrook introduced the Patient Story, with a video being presented focusing upon the Older People's Service - Hospitals at Home. This was a unique patient centred approach providing support in the community. The service enabled patients to come out of hospital earlier than originally planned into their home setting with them being monitored in that environment. One of the benefits of this was the social aspects as well as to prevent deconditioning. Two patients were featured in the video who spoke extremely highly of the service. The staff featured in the video spoke of the benefits to patient care, the team, collaboration and innovation. Ongoing lessons were being learned including relating to referrals on to other services and increased collaboration with other services for wrap around care. Another patient, June, attended the meeting, also commending the service. She expressed that having been in hospital, she was not prepared to come home and be fully independent. The service provided a basis for transition to being independent at home. Thanking June and the team, Siobhan Harrington commented upon virtual wards increasingly becoming the operating model with partners across Dorset. She enquired of Dr Gillian Cumming, Karen Bowers and Sarah Hedges what key points the Board needed to know to help the team extend and expand the offering. In response to this, Karen Bowers highlighted that Older People's Services and Child Health had been leading the way with the workstreams. Other workstreams were coming forward including respiratory, cardiology and microbiology pathways. Stakeholder engagement was needed, including consultant involvement with patient identification and business intelligence support. The relevant patients were not medically ready for discharge when they returned to their own homes, but this was being managed safely. Work was underway with the integrated care board (ICB). Virtual wards were a proven model across the country, with some having been in place for seven to eight years. The Trust's experience was that both patients and virtual wards teams were benefiting from it. However, there were a number of challenges that needed to be overcome. Referring to a Primary Care Network meeting she had attended earlier in the day, Siobhan Harrington commented on the positive feedback that had been provided by primary care on the team's work. Dr Gillian Cumming added that it was an exciting opportunity to provide care for patients in the right place. She also commented upon how much it was

	appreciated by patients and the teams. There was more information that could be gained about the patients when at home through monitoring. Being at home was more comfortable for patients and she was confident that the same level of care could be provided but in a different way to support discharges and avoid admissions. Also extending her thanks to the team and to the patients, Caroline Tapster enquired what stakeholders and partners could do to support the team. In answer to this, Karen Bowers outlined that while much of the virtual wards was based on home visits, this had workforce implications. Locality mapping had been conducted and there was an element of green sustainability. Consideration had been given to workforce solutions and areas where other services could assist, and she cited examples of these. Referencing her own experience as a new parent, Claire Whitaker enquired how the expectations and anxiety of patients was managed as the level of care eased. Dr Gillian Cumming outlined the dovetailing with other existing services – whether GP care, community matrons or other clinically relevant support. The team would help patients with their onward journey from a care perspective. The Board NOTED the Patient Story.
BoD166/23	**Update from Council of Governors** Providing an update from the Council of Governors, Sharon Collett, Lead Governor, focused upon current membership and engagement. This included how the Council of Governors had been listening and responding to the Trust's current membership and the challenge of engaging with and capturing voices that were harder to reach and less frequently heard. • During the past few months, Governors had been in a wide range of localities to inform, listen to and respond to members. In addition, Governors had supported hospital events such as pregnancy support talks, visiting the Beales Centre, the BEACH building topping out ceremony, the Trust's awards evening and the opening of the new theatre block. • Much needed focus had been given in the west of Dorset, with events held in Corfe Castle and Swanage. The Swanage event had provided more opportunity to develop system working, with updates on all Dorset hospitals, connecting with partners such as South West Ambulance Service, and various other health organisations. Unsurprisingly, most of the interest had been with changes to the location of services and urgent treatment centres (UTC). Using online surveys at both events had enabled Governors to "take the public temperature" and review the feedback immediately. Progress had been made in understanding UTCs: 70% of those surveyed had known what a UTC was. 90% knew that Bournemouth hospital would become the main emergency site, with Poole becoming the main elective site. Although 45% responded as feeling positive about the changes, this was a higher percentage than previously. • Governors embraced the Trust values and continuous improvement was at the heart of a recent Board and Council of Governors Development Session when discussions about Trust membership had taken place. Supporting data highlighted that over 78% of the Trust's members were in the 50+ age bracket and over 89% of members were white British. This was not reflective of the Trust's workforce, where a BAME demographic of 21.5% was celebrated.

	• Governors were conscious that some hard to reach groups could be most in need of information and access to services, particularly residents who were economically and socially disenfranchised and also those residents who had learning challenges or disabilities. One of the Council of Governors' responses to this was organising a forthcoming event to engage with younger people at Bournemouth University. This would be particularly aimed at health and social care students, with a keynote speaker, Mr Ramchandani, consultant in oral and maxillofacial surgery. System partners would also be encouraged to support this event, and Governors were linking with other organisations including Healthwatch and Dorset Healthcare. • Engagement with the Trust's Youth Development Officer and BCP representatives to discuss the Youth Council and the Trust's participation was taking place. • Governors had identified the need to consider making the benefits of membership more relevant for younger people, including those who were Trust volunteers. She extended particular thanks to Sandy Wilson and Marjorie Houghton, Chair and Deputy Chair, respectively of the Trust's Membership and Engagement Group for their commitment, passion and leadership. In addition, the Trust's Communications Team were recognised for their valued support. On behalf of the Board, Rob Whiteman thanked the Council of Governors for all their work. He added that the Trust would have a new Non-Executive Director Engagement Champion, Claire Whitaker, who would work with the Council of Governors. The Board NOTED the update from the Council of Governors.
BoD 167/23	**For Accuracy and to Agree: Minutes of the Board of Directors Part 1 Meeting held on 24 May 2023** The minutes of the Part 1 meeting of the Board of Directors held on 24 May 2023 were APPROVED as an accurate record.
BoD 168/23	**Matters Arising – Action List** It was NOTED that there were no outstanding actions.
BoD 169/23	**Trust Chair's Update** Rob Whiteman provided the Trust Chair's Update highlighting: • Since the last Part 1 meeting of the Board, the NHS Workforce Plan had been presented. At a future meeting of the Board, consideration would be given to how the expectations of such plan would be met by the Trust would be discussed. • The fiscal position for the NHS remained challenging. He thanked the Executive team for continuing to provide high quality care against a resource envelope that had pressures within it. • The opening of the barn theatres. It was pleasing to have the first patient cut the ribbon. • He had been pleased to visit several of the Trust's services, to attend meetings of the integrated care partnership and some national meetings. He and Non-Executive Director colleagues had continued to chair consultant panels; as well as seeing the talent being developed within the Trust, it was good opportunity to see new talent being brought into the organisation. • The Trust valued the global community of talent who had come to work at the Trust and whose art, culture and music had been celebrated at

	the Cultural Awareness Day. He considered this a wonderful opportunity to demonstrate thanks to the ethnic minority staff working at the Trust. The Board NOTED the Trust Chair's Update.
BoD 169/23	**Chief Executive Officer's Report** Siobhan Harrington presented the Chief Executive's Report highlighting: • Demand had been high across the Trust, impacted by the longest round of industrial action by doctors within the NHS. She thanked and had been struck by how staff had managed the circumstances, with the organisation having retained its focus on patient safety. The industrial action did have an impact upon momentum, individuals and teams. The Trust was managing the circumstances well. However shortly before the meeting, there had been notification of the next round of junior doctor industrial action at the beginning of August 2023 and further consultant industrial action at the end of August 2023. She expressed on behalf of the Board, that there was a keenness to see a resolution of the issues. • Since the Trust had last met, the 75th birthday of the NHS had taken place and Dr Matt Thomas and colleagues had attended the ceremony at Westminster Abbey. She was incredibly proud of what the NHS had achieved and of what had been achieved within the organisation, while relentless to make it even better. • Earlier in the day, she had attended a national call on winter planning. A letter would be received by providers and social care the following day about this. The Trust would be working with partners to plan for the winter. • Walking around the organisation, the Trust's simple and clear objectives for the year could be seen. When discussing these with staff, people had expressed them resonating with their daily jobs. • The performance report highlighted some very positive progress. A new IT system had been implemented across two emergency departments within a period of a few weeks. • She had spoken with certain nearby trusts, who were also experiencing a challenging financial position. The Trust would continue to focus upon looking after every public pound. • Patient First was continuing. The Executive team had reviewed a project filter and considered how to prioritise and upon which to focus the Trust's improvement energy. • Inviting Paula Shobbrook to comment on the Care Quality Commission inspection, Paula Shobbrook outlined that there had been changes in the inspection regime, focusing upon areas that were the highest risk from patient safety. Following careful review, the CQC had decided to stand down the well led inspection of the Trust that had been expected to take place on 8 and 9 August 2023. The Trust was not expecting the CQC to re-visit the Trust until after the new year. Siobhan Harrington added that Dorset would be one of two that would go through a pilot of a system inspection. • The cultural celebrations and the launch of the See ME First campaign had been a time of joy to celebrate cultures, differences and similarities. It was important for the Board to set direction and a passion for being anti-racist at the Trust. She invited the Board to support the statement within her report and to be outspoken and public about being an anti-racist organisation. The conversations within the organisation were the start of a journey which would be difficult, but it

was important that the Board was clear about its expectations and that these were lived.

- An update was included in her report in relation to staff travel. The cost of parking was an issue that was not taken lightly. Further information could be provided to the Board. There had been many staff side conversations and it had been discussed with the Trust's Management Group. Car parking charges had not been increased for some time; the increases were to re-invest money into significantly reduced bus travel costs.
  Inviting Richard Renaut to comment upon this, he added that approximately half of staff arrived at work other than by means of single use car. The Trust's lowest paid staff were particularly higher bus users. Working with Morebus, the Trust was exploring whether a 50% discount on a monthly bus pass for universal use – including outside of work - could be secured.
- Referring to the NHS Dorset Joint Forward Plan 2023-2028, she mentioned that a reflection of what it meant for the Trust would be brought back to the Board.

Positive that a commitment to being an anti-racist organisation was building, Sharath Ranjan commented that while the cultural celebrations were very good, what really mattered was what happened back in the workplace and also how individuals were treated as patients. A positive start had been made and it would be important to look at the Trust's systems, processes and indicators against the commitment. Referencing the complaints paper being presented later in the meeting, he raised whether those were broken down into ethnicities and age groups and what the outcomes were. He cited this as an example of understanding how any disproportionality may play out.

Also supporting the anti-racist statement and the need to live it and send a positive message to the organisation, Judy Gillow enquired whether Non-Executive Directors would receive See ME First badges. It would be important for Non-Executive Directors to promote the campaign when out in the organisation. Siobhan Harrington confirmed that to receive a badge, a pledge needed to be made outlining what members would do to promote the campaign.

Referencing the national workforce strategy, Richard Renaut suggested that the development of a medical school in the area should form part of future strategic work. Helena McKeown added that it would be beneficial to consider the new apprenticeship scheme for doctors, as well as university status for medical schools. Peter Wilson and Siobhan Harrington had a good conversation with Bournemouth University about how the partnership could continue to be developed and these discussions would be ongoing.

Pankaj Davé reflected that the statement was more broad than anti-racism and was an inclusion statement, encapsulating race, religion, sexual orientation and disability. It was about both and was about behaviours and policies to speak about it when it was unacceptable and not to accept behaviours that were not appropriate.

Rob Whiteman commented that although the Board acknowledged and understood that car parking was an operational issue, the decision to increase charges were not taken at the Board but by the Executive team. He considered that it was reasonable for the Board to ask that the Executive team be mindful of the cost of living issues and that if the increased charges put any staff in hardship, then how would this be known as it was a concern. In addition, there had previously been feedback at the Board through Freedom

	to Speak Up that staff had complained that they paid for car parking but could not always secure a space which caused some anxiety He therefore asked that the Board be provided with assurance that the Executive team would be conscious of implications for individuals' personal circumstances and that something would try to be done about people being able to park when paying for their parking. Richard Renaut responded that the Executive team were extremely conscious of the impact and reiterated that the Trust's lowest paid staff were least likely to be undertaking single occupancy car journeys. The discounts being explored with Morebus would provide staff with a £29 per month saving. He referenced the free evening and weekend parking available. There was a rise in daytime parking in line with the national pay award, but the cost remained low when benchmarked against other trusts. 95% of staff who requested a permit received one, but space did need to be considered; there were 200 empty spaces daily at the Poole Stadium, so staff were being encouraged to park here, with this taking the same time as parking in the multi-storey. This had the added benefit of retaining spaces in the multi-storey for patients. Siobhan Harrington added that there was a process which allowed for an individual view to be taken where appropriate. Claire Whitaker enquired about the training that might be given for Board members and Governors around being anti-racist. Siobhan Harrington confirmed that more support and training would be provided as part of a wider plan. She suggested that this could be presented to the People and Culture Committee in the first instance. The Board NOTED the Chief Executive Officer's Report and unanimously ENDORSED the anti-racism statement.
BoD 170/23	**Board Assurance Framework – Breakthrough Objectives and Strategic Initiatives** Siobhan Harrington introduced the Board Assurance Framework, which was presented by Richard Renaut. Commenting upon some of the gaps in controls, Cliff Shearman queried how some of those would be remedied, for example, the measurement of patient harm. He also asked how, in particular, BAF Risks 8 and 9 would be measured. Richard Renaut confirmed that the areas of assurance would continue to be worked upon. In relation to the BAF Risks mentioned, there were detailed plans underpinning these risks. For integration specifically, an integration dashboard would begin to feature in the IPR over the coming months. The recent theatres move had been used as a pilot as the first service to have undergone the assurance process, with considerable learning about the evidence relating to readiness for the move. Caroline Tapster requested that BAF Risk 4 also be reviewed in the context of health inequalities in order to identify vulnerable or disadvantaged groups. This was endorsed by Stephen Mount and he urged that the primary concerns of the public be borne in mind, such as reducing the backlog, and therefore it was important to ensure that the correct set of priorities were in place. Recognising that the work on the BAF was a journey, Stephen Mount added that there was an opportunity to review which were the key controls going forward. There was a risk of over-relying upon too many controls rather than relying upon those controls that were key. Commending the excellent work that had been undertaken, Philip Green added the importance of filtering the controls and also including the mitigations. Raising a general comment in relation to BAF Risk 5 and 6, Judy Gillow requested that these risks be fully completed. It would be important to have

	the complete picture prior to the Patient Safety Incident & Response Framework (PSIRF) coming into effect in September 2023. In relation to BAF Risk 4, Paula Shobbrook outlined that the work was focusing upon from where the complaints were arising, the impact and being responsive to them. Siobhan Harrington commented upon the need for a consistent view of the risk appetite and the assessment of risk. It was important to also consider anything from the risk register that could impact upon the organisation more strategically. Peter Gill added that he was developing a BAF risk related to the progress on the replacement of the Electronic Patient Record. Stephen Mount echoed the comment in relation to risk appetite, observing that there needed to be greater focus on issues which breached the risk appetite in order to avoid overburdening the Board and Committees. John Lelliott emphasised the importance of facilitating innovation, which would support delivery of the objectives. The Board NOTED the Board Assurance Framework.
BoD 171/23	**Risk Register Report** Paula Shobbrook presented the Risk Register, highlighting new risk 1876. She noted that obstetric staffing was under careful review, with some recruitment having taken place that morning. In terms of maternity triage, 98% of women were seen by a midwife within 15 minutes which was one of the best performances nationally. Invited to comment on the Trust's highest rated risks, Mark Mould summarised: • Three risks above 12 related to urgent care and two related to elective care. • Risk 1074 had been reviewed and would subsequently be reduced and Risk 1393 had been reduced from 16 to 12 as a result of additional treatment activity. The associated BAF risk would currently remain at 20, however there would be consideration given to reducing this the following month. • Some improvement had been seen in urgent care, but occupancy remained high and flow was still a challenge. Ambulance handover delays had reduced by 50%; continued improvement was needed to be able to reduce this risk. Additionally, there had been a significant improvement in the number of medically ready for discharge (MRFD) patients. The associated BAF risk currently remained at 20. Commenting on the positive news on the reduction of patients who were MRFD, Pankaj Davé asked what had driven the improvement. Mark Mould indicated that the initial shift had been the purchase of care out of hospital. However, that capacity had now been filled outside of the Trust. The next step was developing the workforce externally to move that capacity. Richard Renaut raised that the critical path was rated 20 but was on track for the September 2023 Board meeting to approve the New Hospitals Programme Full Business Case (FBC) and remain within the £263m budget. The Trust had received the Treasury criteria. Consequently, the risk of securing the funds would begin to reduce. Rob Whiteman commented positively on the format of the report but suggested that it may be helpful to consider including the age of each risk. The Board APPROVED the Risk Register Report.

BoD 172/23	**Integrated Quality, Performance, Workforce, Finance and Informatics Report (IPR)** Performance Mark Mould presented the performance section of the report, adding: • In relation to fractured neck of femur (#NOF), the Surgical Care Group would be undertaking a piece of modelling work to better understand the impact of variation in demand on capacity. Quality Paula Shobbrook presented the quality section of the report, adding: • Falls had been an area of focus, particularly falls assessments, overseen by the Falls Group. An increase in the number of complex patients was noted, as well as falls in patients with no criteria to reside. • The Trust would be appointing an Associate Professor of Clinical Practice, in conjunction with Bournemouth University. • The complaints teams were on target to reduce the number of complaints over 55-days to fewer than 10 by October 2023. • The maternity call bell supplier had completed some remedial work. There had been no further escalations since this work was completed. • An internal team had completed a review of stillbirths and having discussed this with the ICB there were no concerns. However, Somerset had been asked to review this in September 2023 to provide additional external assurance. People Karen Allman presented the people section of the report, adding: • The Trust had featured in the latest NHS Providers bulletin about race equality, sharing best practice on supporting internationally educated staff. Finance Pete Papworth presented the finance section of the report adding: • There was a new agency ceiling in place to ensure that agency spend did not exceed 3.7% of total pay expenditure. However, at the end of quarter one this was 4.6%, exacerbated by industrial action. This may cause some challenges with the single oversight framework assessment. • There had been a significant reduction in tier four off-framework agency from a peak of £1.7m in December 2022 to £200k in June 2023. • The Trust had slightly overdelivered on cost improvement programmes (CIP) in quarter one. • There had been some national changes to the elective recovery fund guidance. In recognition of the challenges of industrial action the threshold for elective activity would be reduced by 2% and 84% of the elective recovery fund allocation would be fixed, making the maximum risk exposure £3.1m for the Trust and £5.5 for the system. Informatics Peter Gill presented the informatics section of the report, inviting the Board to extend its thanks to those staff who led the implementation of the Agyle system. Cliff Shearman, who had been visiting the Bournemouth Emergency Department on the day of implementation, had been impressed by those leading the process.

	Whilst acknowledging the positive progress made in relation to #NOF performance, Cliff Shearman questioned whether a different approach needed to be adopted as progress appeared to have plateaued and recognising the link with surgical site infections. Mark Mould agreed that a change in approach was required and reiterated the ongoing modelling work. This would mean some significant investment into theatres capacity, despite the Trust's challenging financial position. Rob Whiteman suggested a Board Development Session be held for a deep dive into theatre capacity, to which Siobhan Harrington agreed, noting that additional theatre staff would be joining the Trust in the Autumn. **ACTION:** To discuss the inclusion of a deep dive into theatres capacity into the Board Development programme. **Rob Whiteman / Yasmin Dossabhoy** Caroline Tapster enquired as to whether patients were falls assessed on discharge. Additionally, Rob Whiteman requested a timescale for review of falls assessments and comment on moderate falls. Paula Shobbrook confirmed that patients were assessed on discharge. The Falls Group reviewed all serious falls and key themes, aligning to PSIRF, which would help oversight of the improvement actions. Patients did deteriorate whilst in hospital which was a concern, particularly for physiotherapists, and there was an impact on flow in relation to no criteria to reside. This formed the focus of strategic work within the ICB; however this was long-term. Noting that virtual attendances were declining, Judy Gillow asked whether the reason for this was understood. Mark Mould agreed to take this away and provide a response. **ACTION:** To provide a response in relation to the decline in the number of virtual attendances. **Mark Mould** On the four-hour standard and recognising the short-term impact of the implementation of Agyle, Sharath Ranjan asked what improvements were expected to be seen from this. Mark Mould referenced the five-week deterioration in performance observed by Dorset County Hospital NHS FT on their implementation of Agyle. Prior to implementation there had been improvement, but the current challenges were around the four-hour standard, streaming at the front door and medical staffing gaps. There was an improvement trajectory of 1-2% per month. The Board NOTED the Integrated /Performance Report.
BoD 173/23	**Improvement Strategy** Deborah Matthews presented the Improvement Strategy, with Siobhan Harrington commenting on the emphasis on leadership behaviours and culture within the strategy. Pankaj Davé questioned how space would be created for staff to allow them to engage meaningfully with the programme. Paula Shobbrook commented on one of the workstreams called "project filter", led by Pete Papworth, which looked at the operational processes and challenged whether these added benefit and aligned to the strategic objectives. Judy Gillow queried whether fundamentals of care should be captured more overtly within the strategy. She had observed aspects of basic care such as

	handwashing, bare below the elbow which should be embedded needing focus. Adding to this, Stephen Mount emphasised the importance of encouraging personal accountability and empowering staff to positively call out areas of non-compliance. Cliff Shearman agreed, adding that it was critical to make this part of the everyday job. Commending the Improvement Strategy and Patient First as an anchor programme, Rob Whiteman summarised that the basics were as important to improvement as the larger-scale transformation programme. Responding to this, Paula Shobbrook commented that Patient First provided a framework to work to through the organisation to, in time, achieve Outstanding. The Trust was engaging staff and holding colleagues to account with compassion. She was confident that the process would bring consistent improvements to the Trust. The Board APPROVED the Improvement Strategy.
BoD 174/23	**Finance and Performance Committee – Chair's Reports June and July 2023** Philip Green presented the Finance & Performance Committee Chair's Reports for June and July 2023. Many of the areas to raise had been covered during the course of the meeting but he added: • A regular report on estates compliance was received, particularly covering the challenges at Poole Hospital. While these were difficult issues, there was assurance of a plan in place to resolve these. • The Committee had supported an update to the Trust's Green Plan, with energy and transport the areas of focus for 2023-24. • The Committee was expecting to receive the Private Patients Strategy in September 2023. The Board NOTED the Finance and Performance Committee - Chair's Reports June and July 2023.
BoD 175/23	**Quality Committee – Chair's Reports June and July 2023** Cliff Shearman presented the Quality Committee Chair's Reports for June and July 2023. He added that there had been no issues raised during the meeting related to quality of which the Committee had not been aware. The Board NOTED the Quality Committee - Chair's Reports June and July 2023. The Board APPROVED: • Annual Statement of Commitment for Safeguarding • Annual Infection Prevention & Control (IPC) Board Assurance Statement • Mixed Sex Accommodation Declaration • Annual Complaints Report Paula Shobbrook thanked the IPC and complaints teams for their work, particularly Matthew Hodson and Kathyrn Crowther who were in attendance.
BoD 176/23	**Population Health and System Committee – Chair's Report June 2023** Caroline Tapster presented the Population Health & System Committee Chair's Report for June 2023, highlighting: • In addition to a review of the Trust's activity, the Committee received a presentation from the ICB's Chief Medical Officer to support activity being aligned.

	• The Committee reviewed the Royal Free London NHS FT's population health annual report. It was felt that the "Flourish@TheFree" programme would be of particular interest to the Board, which had identified that staff on lower bands were more likely to experience poorer health outcomes. The Board NOTED the Population Health and System Committee – Chair's Report June 2023.
BoD 177/23	**Annual Review of Committee Effectiveness** The Board NOTED the Annual Review of Committee Effectiveness.
BoD 178/23	**Questions from the Council of Governors and Public** Jeremy Scrivens, Public Governor, had submitted the following question to the Board in advance of the meeting. *Following an article in the Times this Sunday I would be pleased to know whether there is any asbestos or unstable reinforced autoclaved aerated concrete (RAAC) in any of the hospitals or properties owned or leased by UHD. Please confirm that surveys have been carried out to ascertain whether there is any. If there is, please advise the programme for replacement* Richard Renaut confirmed that there was no RAAC on any of the Trust's sites. Like most buildings in the country there were low levels of asbestos and where work was carried out there was a robust process in place for assessing and specialist removal. Risk assessment meant that there was no risk to patients, staff or visitors from any asbestos that was in-situ. Diane Smelt, Public Governor, had submitted the following question to the Board in advance of the meeting. *Agenda item 9.2 sets out the Annual Board Assurance Statement in relation to Infection Prevention and Control . On page 183 of that report reference is made to the fact that across UHD there are two different cleaning services. The Royal Bournemouth Hospital site has their own in-house team and Poole is serviced by an external Contractor, the Contract for which has been extended according to the report, but it doesn't say when to.* *The report also highlights on page 184 the number of terminal cleans that are carried out at the Poole site but I can see no mention of the number of such cleans at Royal Bournemouth Hospital .* *I understand that the domestic cleaning staff at Royal Bournemouth Hospital are very concerned that the cleaning contract for Bournemouth is to be outsourced, which will mean that many of our loyal and long serving staff will be disadvantaged, if this were to happen. Many staff are therefore looking for alternative employment which is having an effect on the service provided at Bournemouth and the morale of the staff.* *It is also understood that the cleaning staff at Royal Bournemouth Hospital provide a faster terminal cleaning service than the private contractor at Poole, but the report is silent on this as no figures are shown for Bournemouth Hospital, which is unfortunate.* *The number of terminal cleans in March 2023 at Poole was 509 which could have a profound effect on the number of beds available at any one time. I would therefore ask the Board to give an assurance that the terminal clean figures for both Royal Bournemouth Hospital and Poole Hospital are looked at and compared, to ascertain if there is any disparity in the service provide across UHD, and to give an indication as to whether or not the bed capacity is affected as a result of the longer clean times. Also, could an indication be given when a decision will be made about the future of the cleaning services*

	at UHD, and will all staff be consulted on the proposals for the future of the service. Mark Mould explained the current contract arrangements. The executive team had agreed three things: • That both contracts have oversight from a single leadership team. • The Poole external contract had been extended for one year in order to provide additional time to consider options for the service. • There would need to be a single offer, rather than the current hybrid arrangement. A paper was being produced outlining the options, which would be reviewed, and a recommendation made. In response to a question from Sue Comrie in relation to infection prevention and control at the point of entry to the hospital sites, Paula Shobbrook reiterated the commitment to IPC signed off by the Board during the meeting. She added that mask wearing was no longer mandatory. Robert Bufton enquired about the effectiveness of the Hospital Ambulance Liaison Officer role and whether the Trust should employ its own. Mark Mould explained that they were the first port of call when there were pressures across the organisation and supported directing ambulances between sites. The role was increasingly used during the winter period. He added that the South West Ambulance Service had received the funding for these roles and the Trust would continue to work in effective partnership with them.
BoD 179/23	**Any Other Business** Rob Whiteman noted: • The Council of Governors would be presented with a proposal for Cliff Shearman to become the Trust's Vice-Chair from 1 October 2023. • It would also be consulted in relation to the proposed appointment of Judy Gillow as Senior Independent Director, again from 1 October 2023. Sharath Ranjan and Judy Gillow, as Non-Executive Directors, were approved as members of the Appointments & Remuneration Committee. The Board APPROVED the use of electronic voting (specifically internet voting, and not telephone or text voting) in the 2023 Council of Governors elections, in addition to the use of vote counting software. There being no further business, and following the passing of the resolution below, the meeting was closed.
BoD 180/23	**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 27 September 2023 at 13:15.

Board Part 1 Action List - September 2023						
Meeting Date	**Minute No.**	**Matter Arising / Action**	**Lead**	**Due Date**	**Progress**	**Status**
26/07/2023	BoD 172/23	**Board Seminar - Theatres Capacity:** Discuss inclusion of a deep dive into theatres capacity.	RW/YD	September 2023	Included for scheduling as part of Board Seminar programme.	Complete
26/07/2023	BoD 172/23	**Virtual attendances:** To provide a response in relation to the decline in the number of of virtual attendances.	MM	September 2023	**September 2023:** Verbal update to be provided at the September 2023 meeting.	In Progress

CHIEF EXECUTIVE'S REPORT
SEPTEMBER 2023

As we emerge from the latest industrial action and from what has continued to be a busy summer period, I continue to send my thanks and appreciation to every staff member and volunteer at UHD who help us maintain a focus on patient safety and caring for our staff through this challenging time.

This has also been a difficult few weeks working in the NHS when public confidence has been impacted by the experiences in Countess of Chester Hospital. It is horrific to hear that a nurse has been convicted of murdering babies in a neonatal unit. We come to work in the NHS to care for people and this series of events will impact on us all for some time to come and quite rightly. It will mean that we continue to focus on improving our safety culture across the NHS and here at UHD. Across the NHS we welcome the independent inquiry to help ensure we learn every possible lesson from this tragic and shocking case.

Activity continued to be high in August 2023 with 34,692 patients seen in our outpatient departments and an additional 7,238 virtually. We carried out 1,379 day-case procedures, supported the birth of more than 309 babies, attended 13,907 patients in our emergency departments, cared for 227 people at the end of their lives and started 212 on their radiotherapy journey; whilst caring for all the patients in our inpatient beds.

1. NATIONAL UPDATES

1.1 Major Conditions Strategy

The model of care which sustained the NHS for the past 75 years is being reconsidered to meet the needs of our population in the future. People are living longer, but for many people that life is experienced with many years in poor health.

The NHS England Major Conditions Strategy begins with one question: how should our approach to health and care delivery evolve to improve outcomes and better meet the needs of our population, which is becoming older and living with more than one health condition?

The strategy focuses on 6 groups of conditions: cancers, cardiovascular disease (which includes stroke and diabetes), musculoskeletal disorders, mental ill-health, dementia, and chronic respiratory disease.

There are several strands to the strategy and we look forward to working with our local ICS colleagues to develop the local approach and build into our work to develop our UHD clinical strategy.

1.2 NHS England Letter on Countess of Chester and Lucy Letby Trial

On 18 August 2023 NHS England issued a letter addressing the verdict in the trial of Lucy Letby. Whilst recognising the betrayal of trust and the families forever impacted by the actions of Lucy Letby, they welcomed the independent inquiry which had been announced by the Department of Health and Social Care. A commitment has been made to ensure everything possible is done to prevent anything like this happening again. Additional oversight and actions have already begun to strengthen patient safety monitoring through a number of ongoing and new schemes. Within the Trust additional focus has been given to reviewing our approaches and discussing with the

senior management our current arrangements to assure ourselves that we are doing all we can to prevent anything like this happening at UHD.

1.3 Winter Plan Letter

NHS England published their national approach to 2023/24 winter planning on 27 July 2023. The guidance identified four areas of focus which are:

- Continue to deliver on the Urgent and Emergency Care recover plan by ensuring high-impact interventions are in place;
- Completing operational and surge planning;
- Ensuring effective system working across all parts of the system;
- Supporting our workforce.

We are committed to supporting this work with our ICS colleagues and recognise the challenges already being faced.

1.4 NHS Cancer Standards

On 17 August 2023 changes to cancer waiting times standards were published which will come into effect from 1 October 2023. The standards remove the two-week wait standard in favour of a focus on the Faster Diagnosis Standard and the rationalisation of those standards into three core measures of the NHS:

- The 28-day Faster Diagnosis Standard (75%);
- One headline 62-day referral to treatment standard (85%);
- One headline 31-day referral to treatment standard (96%).

Work is already underway to assess current activity against the new standards through shadow reporting. We are updating our training resources for staff. How we communicate these new standards throughout the Trust is being planned as is communication with primary care to ensure patients expectations are proactively managed.

1.5 Fit and Proper Persons Test Framework

NHS England has released a new Fit and Proper Person Test Framework for board members aligned to the 2019 Kark review which was commissioned by the government in July 2018. The framework is effective from 30 September 2023 and its purpose is “to strengthen/reinforce individual accountability and transparency for board members, thereby enhancing the quality of leadership within the NHS”.

We are currently reviewing the framework and our own policies and procedures to ensure we meet the underlying legal requirements noted within the new framework.

2. QUALITY

2.1 Joint Advisory Group on GI Endoscopy – Accreditation

Poole Hospital have met the accreditation standards in GI Endoscopy following the assessment which took place in May 2023. JAG have congratulated the team on its excellent endoscopy service. They had noted that the organisation and endoscopy

leadership team was highly motivated to progress the endoscopy service whilst ensuring that the patient stays at the centre of its focus. They had also commented on the excellent achievement in transnasal endoscopy, clinical leadership acting on key performance indicators, local upskilling courses, excellent flow, patient tracking list and waiting list management.

2.2 Patient Safety Incident Response Framework (PSIRF)

UHD is planning and working towards implementation of the new NHS Patient Safety Incident Response Framework (PSIRF). PSIRF represents a significant shift in how the NHS plans for and responds to patient safety incidents. This replaces the Serious Incident Framework and all NHS trusts and Integrated Care Boards have been preparing to set out their PSIRF Plans this Autumn and identify the framework for implementation in their organisations. We are working to align this with the UHD Patient First strategy. It supports a safety culture that encourages open learning, innovation and quality improvement. Early adopters of PSIRF are reporting improved safety cultures, identification of more effective risk reduction strategies and early signs of harm reduction, due to their revised approach. We are also planning for transition to the national Learn from Patient Safety Events (LFPSE) system for incident reporting.

2.3 World Patient Safety Day on 17 September 2023

The Trust joined other NHS organisations to celebrate the World Health Organisation (WHO) World Patient Safety Day on the 17 September 2023. The theme this year is engaging patients for patient safety and is closely linked to the NHS England Framework for involving patients in patient safety and PSIRF.

2.4 Electronic Patient Record (EPR)

Locally we are in discussions around the provision of a new Electronic Patient Record (EPR) system. The current EPR system is to be retired by the supplier on 31 March 2027 resulting in a tight timescale to implement a new EPR. Within Dorset we are ensuring that we have a process in place that meets the needs of system partners at this time.

3. PERFORMANCE

NHSE have written to the Trust confirming that for quarter 1 the Trust remains in segment 3 of the oversight framework. This relates to elective 78-week waits and our maternity CQC rating.

The Trust continued its migration to our new Patient Administration System (Agyle) for ED in July at the Bournemouth site, which as anticipated following its introduction at Poole and learning from elsewhere, impacted on performance and reporting as the system was bedded into clinical practice. As a trust we reported 60.1% achievement against the 4-hour standard against a plan to achieve 65%. Gaps in the medical workforce as the teams recruited to the agreed staffing templates and an increase in overall attendances to our Emergency Departments in July of approximately 44 per day also had an impact. The enhanced clinical system is supporting more efficient patient management within the department, as well as a broader understanding of our breach analysis.

In July 2023, elective recovery demonstrated movement away from the trajectories for long waiters, with industrial action and workforce gaps being two significant

contributory factors. Nevertheless, our efficiency markers for theatre utilisation were improved and both theatre and outpatient services have successfully recruited to vacancies over the last couple of months to improve the vacancy position. There will be a period of induction for new starters.

Cancer performance has also been challenged as we manage both the impacts of industrial action and a rising referral rate in several key tumour pathways. We have received feedback from the Wessex Cancer Alliance however that comparatively to our peers in Wessex and nationally the Trust has managed well to maintain performance above 70% for Faster Diagnosis standard and 60% for cancer 62-day. We continue to implement recovery plans to improve further.

We also received the results of the 2022 National Patient Experience Survey (NCPES); our overall rating was 9.1 out of 10 for the care experienced by our patients in the 2022 survey. This compares favourably to a national average of 8.8 out of 10.

4. FINANCE

Further rounds of Industrial Action have exacerbated the Trusts challenging financial position. At the end of August 2023 the Trust is reporting an adverse variance of £6.5m driven by the cost of Industrial Action, energy inflation above budgeted levels, a requirement to open additional ward capacity, and a reduction in income due to lower than planned elective activity. A full re-forecast is currently underway and will be supported by a comprehensive financial recovery plan.

Medium Term Financial Plan

Considerable progress has been made in developing a medium-term financial plan for Dorset which seeks to mitigate the recurrent underlying deficit and return the ICS to recurrent financial balance over a number of years. A final plan will be brought to the September Boards of all NHS organisations for consideration and approval. The System Recovery Group will oversee the development of improvement plans to meet the productivity and efficiency requirements within this, focusing on sustainable quality improvements that also drive recurrent financial benefits.

5. PATIENT FIRST

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

In July 2023 the Board of Directors approved our three-year Patient First Strategy, describing how we are developing a culture of continuous improvement at UHD, to support the delivery of our refreshed strategy and strategic priorities.

Phase 2: Strategy Development will be completed this month, including a review of current meetings across UHD. We believe strengthening our approach to effective meetings management has the potential to give time back to our busy staff to support improvement activities within their teams and departments.

At the end of September 2023 we will start Phase 3: Strategy Deployment. This will involve a full cascade of UHD's strategic priorities through our Care Groups and

Corporate Directorates. This ‘golden thread’ will ensure everyone is pulling in the same direction, as part of #TeamUHD.

In September 2023 we commenced the first cohorts of our new Patient First for Leaders programme to ensure all our senior leadership team and their direct reports (circa 220 staff) have the right improvement tools and coaching skills to support our frontline teams. Enrolment onto the modules continues to be extremely encouraging.

This month we will also finalise our roadmap for team training for all our wards and departments to develop standard systems for managing improvement across the organisation. We are planning to start Wave 1 in October 2023.

In the meantime, we continue our regular round of face-to-face briefings with staff, to encourage informal conversations about Patient First and confirm how teams can get involved in problem solving and continuous improvement. We will be discussing the detail of our plans with the Board at a seminar in October.

6. CARE QUALITY COMMISSION INSPECTIONS

The expected CQC Well-led inspection was cancelled by the CQC. The final written reports for our recent CQC inspections have been received.

Our focus is now on preparations for the Dorset system-led CQC inspection, which is the first system inspection nationally.

7. WORKFORCE

7.1 Covid and flu vaccinations

Plans have been accelerated to deliver Covid and flu vaccinations to all UHD staff following the government's announcement on Thursday 31 August 2023. We are planning to start the autumn vaccination program with 2 weekend vaccination clinics. 15 and 16 September on the Bournemouth site and 23 and 24 September on the Poole site. Alongside this there will be daily mobile vaccination trolleys initially visiting all clinical areas. We are encouraging all to be fully immunised against winter viruses to protect themselves, their family and all patients.

7.2 National pay disputes

National pay disputes remain for the Medical and Dental staff group. Junior Doctor members of the British Medical Association (BMA) took strike action from 11 August until 15 August 2023. On average 71% of Junior Doctors rostered to work, took strike action during this period. Additionally, Consultants took strike action from 24 August until 25 August 2023 and of those rostered to work, an average of 37% took strike action.

The BMA have announced six further strike dates for Junior Doctors from 20 September until 22 September and 2 October until 4 October 2023. Consultants will strike for five dates, some of which overlap the Junior Doctors strike from 19 September until 20 September and 2 October until 4 October 2023.

7.3 UHD Chief People Officer appointment

The recruitment process was held on 21 and 22 September 2023.

7.4 UHD Bank staff

The UHD Temporary Staffing team will be holding bank worker engagement events starting in September across all 3 Trust sites. The CommuniTea sessions are aimed at bringing together a platform for workers to come together- as an integral approach to support continuous improvements. Following the launch of the NHS Bank survey in 2022, we are hopeful to promote and increase participation in the next survey.

A bank recruitment event is planned for September to engage with healthcare support workers in offering upskilling opportunities to support the growing need for mental health support within our wards.

7.5 Staff Monthly Excellence Awards

The following staff were awarded gold pins for excellence in July and August. A certificate of thanks is also presented following nominations by staff, patients and volunteers:

- Pawel Czerwonka, Estates
- Ward 11 Team
- Daniel Fry, Ward C3

8. OUR BUILDINGS

Formal Approval of the UHD Outline Business Case

Formal approval of the UHD Outline Business Case has been received. The £262.7m New Hospitals Programme, complements the DCH and DHC programmes, and the existing building works at Poole and Bournemouth Hospitals. These will deliver significant benefits for our local population. The support of local stakeholders including MPs, has been of significant benefit. The Full Business case will be submitted this Autumn, targeting approval by the Spring with building works starting in summer 2024.

9. INTEGRATED CARE BOARD (ICB)

I attended the ICB meeting which took place on 6 July 2023. The approved minutes of the meeting are included in the reading room.

Minutes of the meeting of the Part 1 Public ICB (ICB) Board of NHS Dorset
Thursday 6 July 2023 at 10am
Board Room at Vespasian House, Barrack Road, Dorchester, DT1 1TS
and via MS Team

Members Present:		
	Jenni Douglas-Todd (JDT)	ICB Chair
	Rhiannon Beaumont-Wood (RBW)	ICB Non-Executive Member
	John Beswick (JB) (virtual) (part)	ICB Non-Executive Member
	Matthew Bryant (MB)	Joint Chief Executive Dorset County Hospital and Dorset HealthCare NHS Foundation Trusts and ICB Board NHS Provider Trust Partner Member
	Jonathon Carr-Brown (JCB) (virtual)	ICB Non-Executive Member
	Siobhan Harrington (SH)	Chief Executive University Hospitals Dorset NHS Foundation Trust and ICB NHS Provider Trust Partner Member
	Leesa Harwood (LH)	Interim Non-Executive Member
	Paul Johnson (PJ) (virtual)	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
Invited Participants Present:		
	Neil Bacon (NB)	ICB Chief Strategy and Transformation Officer
	Louise Bate (LBa) (virtual)	Manager, Dorset Healthwatch
	Cecilia Bufton (CB) (virtual)	Integrated Care Partnership Chair
	Dawn Harvey (DH)	ICB Chief People Officer
	Jon Sloper (JS)	Chief Executive, Help and Kindness
	Stephen Slough (SS)	ICB Chief Digital Information Officer
	Dean Spencer (DSp) (virtual) (part)	ICB Chief Operating Officer
	Manish Tayal (MT)	Associate Non-Executive Member
In attendance:		
	Liz Beardsall (LBe) (minutes)	ICB Head of Corporate Governance
	Kate Calvert (KC) (for David Freeman)	ICB Deputy Chief Commissioning Officer
	Jane Ellis (JE)	ICB Chief of Staff
	Jonathan James (JJ) (for Andrew Rosser)	Deputy Chief Finance Officer, South Western Ambulance Service Foundation Trust
	Emma Lee (EL) (for Karen Loftus)	Partnerships Manager, Community Action Network
	Ben Sharland (BS) (for Forbes Watson)	GP Alliance Deputy Chair
	Dan Steadman (for item ICBB23/112) (DSt)	Chief Operating Officer, Agincare Group
	Natalie Violet (for items ICBB23/119 and 120) (NV) (virtual)	ICB Head of Planning and Oversight

Public:		
	1 member of the public and 1 member of ICB staff observing were present in the room.	
Apologies:		
	Sam Crowe (SC)	Director of Public Health Dorset (participant)
	Graham Farrant (GF)	Chief Executive, Bournemouth, Christchurch and Poole Council (participant)
	Spencer Flower (SF)	Leader Dorset Council and ICB Local Authority Partner Member (West) (member)
	David Freeman (DF)	ICB Chief Commissioning Officer (participant)
	Karen Loftus (KL)	Chief Executive, Community Action Network (participant)
	Matt Prosser (MP)	Chief Executive, Dorset Council (participant)
	Andrew Rosser (AR)	Chief Finance Officer, South Western Ambulance Service Foundation Trust (participant)
	Forbes Watson (FW)	GP Alliance Chair, Primary Care Partner Member (member)
	Dan Worsley (DW)	ICB Non-Executive Member (member)

ICBB23/108 Welcome, apologies and quorum

The Chair declared the meeting open and quorate. There were apologies from: Sam Crowe, Graham Farrant, Spencer Flower, David Freeman, Karen Loftus, Matt Prosser, Andrew Rosser, Forbes Watson and Dan Worsley.

The Chair welcomed Rhiannon Beaumount-Wood, ICB Non-Executive Member, to her first formal ICB Board meeting.

ICBB23/109 Conflicts of Interest

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

ICBB23/110 Minutes of the Part One Meeting held on 4 May 2023

The minutes of the Part One meeting held on 4 May 2023 were agreed as a true and accurate record.

Resolved: the minutes of the meeting held on 4 May 2023 were approved.

ICBB23/111 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.

ICBB23/112 Staff Story: Housing

The ICB Chief People Officer introduced the Staff Story video which highlighted affordable accommodation as a key to attracting and retaining the health and social care workforce in Dorset. The story focused on the story of Joju Thomas and the work of Agincare in supporting their staff with housing requirements. The Board was joined by Dan Steadman, Chief Operating Officer from Agincare, who also featured in the film.

Joju Thomas told his story of moving from India to England to work as a nurse, and the challenge he faced around housing and understanding local culture. He used this experience to build a framework for Agincare to support staff arriving from overseas. Agincare now guarantee supported accommodation for six months from arrival for their staff. Dan Steadman encouraged the Dorset system to break down the barriers to supporting people with key worker housing, for both relocating UK staff and staff arriving from overseas.

The Chair reiterated that the Board was engaged with the issue of housing and a housing round-table was being led by Matt Prosser, Dorset Council.

The Board discussed the cultural and pastoral aspects of supporting staff from overseas, noting that the system's positive work in this area had previously been discussed by the ICB Board.

The Board agreed it would like to respond with a collective message to the Dorset Council Housing Strategy consultation, and in future wished to move to codesigning housing strategies with local authority partners.

The need to understand affordability and volume was discussed. It was noted that work had already been undertaken on what was affordable in relation to housing and the percentage of the health and care workforce who were struggling with housing costs was also know. However it was not understood how many houses this would relate to, and this would form part of the work of the housing round-table.

The Chief Executive offered to bring a briefing paper back to the Board regarding housing including details of the Dorset Council Housing Strategy Consultation.

ACTION: PM

The Chair thanked the team, and especially Joju Thomas and Dan Steadman, for the Staff Story.

ICBB23/113 Chief Executive Officer's Report

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

- The Government response to the Hewitt Review
- NHS England (NHSE) has formally stood down the COVID-19 incident
- Publication of the Government mandate to the NHS
- Planned industrial action by junior doctors and consultants in July
- Publication of the NHS Long Term Workforce Plan
- Publication of the NHS Dorset Joint Forward Plan
- An update on the work regarding Place development
- Official opening of the Weymouth Research Unit
- The formation of a coalition at Bournemouth, Christchurch and Poole Council
- CQC inspections at Dorset County Hospital and University Hospitals Dorset
- Updates from partners, which were welcomed by the Board.

With regard to the NHS 75th Birthday, the CEO recognised the unique position of the NHS and the fantastic work it had done and continued to do, and the role that partners played in allowing the NHS to flourish. The future now needed a different approach: responding to those who are unwell but also focusing on prevention and heath promotion. The Board

reflected that sadly much of the media coverage of the NHS's birthday had not focused on the positive work of the NHS.

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

Items for Decision

There were no items for decision

Items for Noting/Assurance/Discussion

ICBB23/114 Committee Escalation Reports

The Board Committee Chairs presented the Committee Escalation Reports from the June meetings. All issues discussed were included in the previously circulated reports and key issues included:

- Clinical Commissioning Committee – recommended the Self Management Contract and 999 Lead Commissioning Agreement (to be discussed in the Part Two Board meeting), and scrutinised the diabetes workplan
- Finance and Performance Committee – approved the urgent ambulance service contract extension and undertook a deep dive into Personal Healthcare Commissioning, as this was an area of significant challenge
- People and Culture Committee – approved the NHS Dorset People Plan and approved a change to the committee membership to better reflect the work of the committee
- Primary Care Commissioning Committee – reviewed the process for requests for changes to Primary Care Networks, noted the excellent work around the pharmacy, optometry and dental services delegation, and discussed the Creating Sustainable General Practice in Dorset report from the GP Alliance
- Quality and Safety Committee – received the Quality Report, approved the Dorset LeDeR (Learning Disabilities Mortality Review) Annual Report 2022/23 for publication, and received the Dorset Local Maternity and Neonatal System (LMNS) Quality Report
- Risk and Audit Committee – approved the Annual Report and Accounts (19 June), and, at the meeting of 22 June, considered the plans for revision of the Board Assurance Framework, and discussed the proposed new finance ledger. The Committee Chair thanked Manish Tayal for his work on the committee.

Resolved: the Board noted the Committee Escalation Reports.

ICBB23/115 Quality Report

The ICB Chief Nursing Officer introduced the previously circulated Quality Report which had been previously scrutinised by the Quality Committee. Highlights included:

- Pathway to Home, noting the positive outcome measures and patient experiences
- Targeted visits undertaken to mental health wards and upcoming Multi Agency Discharge Events
- Positive safeguarding visit from NHSE England (letter included as an appendix)
- Annual Patient Safety Audit and the Patient Safety Incident Response Framework (PSIRF)
- The work of the Shared Learning Panel
- Quality Assurance visit to Community Health and Eye Care (CHEC).

The Board discussed the mechanisms for receiving assurance that the system was on plan, complaints and proactive feedback collection in primary care, and the need for baseline data and average mean data from previous years for comparison where this was available.

The deterioration in performance in relation to dementia diagnosis was noted. The Dementia Working Group (DWG) action plan was being monitored by the Clinical and Professional Reference Group (CPRG), who believed the plan to be robust. The ICB CEO and Joint CEO Dorset County Hospital and Dorset HealthCare agreed to continue the discussion outside the meeting, and the ICB Chief Medical Officer would update the Board after the CPRG received an update from the DWG in the autumn.

ACTION: PM/MB
ACTION: PJ

Resolved: the Board noted the Quality Report.

ICBB23/116 Finance Report

The ICB Chief Finance Officer introduced the previously circulated Finance Report covering the financial position of the ICB and ICS NHS providers as at May 2023 (month 2). The report now included information on voluntary and community sector (VCS) finances.

The system was reporting a year to date deficit of £4.3m against breakeven plans submitted to NHS England. Key financial pressures related to the impact of industrial action, inflation and agency spend. It was noted that work was underway to review the operational groups to better understand where assurance and responsibility for delivery sat.

The Board discussed the potential impact of industrial action on the financial position and noted that no national support had yet been offered in relation to this. Energy costs were discussed and it was noted that each organisation would be working on its own energy expenditure.

Resolved: the Board noted the Finance Report.

ICBB23/117 Portland Barge Update

The ICB Chief Medical Officer (CMO) introduced the previously circulated update on progress towards supporting the healthcare needs of the asylum seekers to be housed on a barge at Portland Port.

Since the paper was circulated, the initial funding offer had been increased and the team were working on how to maximise this funding to provide the fullest primary care offer to the barge residents. The go-live date was still planned for July, building to full capacity by the autumn. The ICB CMO was undertaking a series of media interviews in the afternoon, regarding mitigating the impact of the barge on the local population. The ICB CMO thanked the team for managing this complex work.

The joint priorities remained ensuring provision of services to Portland residents whilst safeguarding the residents of the barge as much as possible. The positive multi-agency work regarding this issue was noted. The Board discussed the need for access to specialised translation services and the plans that were in place regarding this.

The Chair thanked the ICB team and partners for their work.

Resolved: the Board noted the Portland Barge Update.

ICBB23/118 Performance Report

The ICB Chief Operating Officer introduced the previously circulated Performance Report, which provided a summary of performance at end of 2022/23, an overview of current performance against national operational targets for 2023/24 and an update on the developmental work underway for performance reporting in 2023/24.

The current key challenges were flow through the urgent and emergency care pathway resulting in an increase in patients with No Criteria to Reside (NCTR), the upcoming risk of industrial action, the potential for an increase in 78 week waiters, diagnostic challenges in audiology and echocardiograms, out of area placements for mental health, and perinatal mental health services.

The positive performance for cancer, four hour Emergency Department (ED) standard and ambulance response times was noted. It was noted that the figure for ED performance should be 69.5% rather than 54.8% as stated in the report (2.17) for University Hospitals Dorset (UHD). UHD were also in the process of having a new ED IT system installed, which was an added complexity currently.

The Joint CEO Dorset County Hospital and Dorset HealthCare reported that his key concerns regarding mental health service provision were out of area placements, children and young people, and dementia diagnosis. There had been a commitment to achieve the perinatal mental health standard in quarter two and it was anticipated this would be met. It was requested that a section on mental health be added into the Performance Report commentary.

ACTION: DSp

It was noted that population screening data was currently included in the primary care reporting, which would be included in the Quality Report in future.

Resolved: the Board noted the Performance Report.

ICBB23/119 Operational Planning 2023/24 Closedown

The ICB Chief Operating Officer introduced the previously circulated Operational Planning 2023/24 Closedown, which included the letter from NHS England, which was a positive response to the plan.

It was noted that the plan had been produced on the assumption, in line with guidance from NHS England, that there would be no industrial action.

The Chair thanked the team for their work on the production of the Operational Plan.

Resolved: the Board noted the Operational Planning 2023/24 Closedown.

ICBB23/120 ICB Annual Assessment

The ICB Chief Operating Officer introduced the previously circulated ICB Annual Assessment final report which had been circulated along with the data from the feedback interview conducted by Healthwatch Dorset.

The findings of the interviews were largely positive especially around leadership, and the ICB's focus on health inequalities and integration. Three areas for Board development had been identified: reducing NHS focus, understanding the ICB's new responsibilities and maximising use of resources.

The Board discussed the transition from a GP led membership organisation to an ICB, noting that this had largely gone well, but there was work to be done on developing the

relationship between the ICB and the GP Alliance and supporting GPs' understanding of the ICB's role.

The Board noted the summary outlined in the report and agreed the proposed areas of development for inclusion in the Board Development programme for 2023/24.

ACTION: LB

Resolved: the Board noted the summary outlined in the report and agreed the proposed areas of development for inclusion in the Board Development programme for 2023/24.

Items for Consent

The following items were taken without discussion.

ICBB23/121 Learning Disabilities Mortality Review Annual Report

Resolved: the Board noted the Learning Disabilities Mortality Review Annual Report.

ICBB23/122 Personal Health Commissioning Annual Report

Resolved: the Board noted the Personal Health Commissioning Annual Report.

ICBB23/123 Special Educational Needs and Disabilities (SEND) Annual Report

Resolved: the Board noted the Special Educational Needs and Disabilities (SEND) Annual Report.

ICBB23/124 Questions from the Public

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

> In Weymouth and Portland we once had four hospitals with wards full of beds. Now we have one with beds. We had eight GP surgeries, now we have six. Two of them hanging on by a thread with not enough doctors. Portland MIU is repeatedly closed. The board could ask that the Home Office fully fund an urgent restoration of the local NHS before sending the barge. To fully reopen Portland Hospital beds. To permanently reopen the MIU. To fail in these risks harming community cohesion. This will need to be agency staff at premium rates to begin with. Will the integrated care board take urgent action to restore all the cuts to Weymouth and Portland NHS provision before the arrival of the barge?

The Chair provided the following response:

> The Integrated Care Board is currently working with system partners and the Home Office in relation to how we can best support asylum seekers who will come to Portland. From a health perspective, our primary focus is to ensure that we can provide care for this vulnerable group of people in such a way that mitigates the impact on local services, which we know are stretched.
>
> Additionally, before the barge was announced, we have initiated the 'Portland Together' project, following a meeting with the local community earlier this year, where some of the challenges you mention were also raised. This project is at the initial discovery phase, which includes conversations with local residents and those who work on the island to identify what really matters to them, information gathering and sharing as we better understand the services provided and identifying any opportunities for change that we can immediately take action on.

This project will enable us to plan together with local communities across the whole of Dorset on how we can improve the health and well-being of our population.

ICBB23/125 Any Other Business

Review of the meeting:

- Papers were sharper and the number of pages had reduced
- There was a good level of questioning and challenge, noting that this questioning was a reflection of the Board's greater understanding of the issues under discussion
- Noting it was a year since the transition to the ICB, the Board was now talking in a more holistic way and was focusing more on strategic issues
- There remained a need to ensure that Board conversations reflected the system infrastructure
- There was a need to ensure local authority colleagues were in attendance, noting that it had been unavoidable that they were absent today
- There was a need to develop a greater focus on prevention in Board meetings, with consideration being given to how the Board agendas could be driven by the Board Assurance Framework and the four core ICS purposes.

ACTION: LB

The Chair noted that it was Manish Tayal's final meeting after a full year in post, as he was moving abroad. The Chair thanked Manish for being part of the ICB's initial journey and praised him for his skills in blending cultures and exemplifying the values of the NHS. His commitment, constructive challenge and passion for engagement with wider voices would be missed.

ICBB23/126 Key Messages from the Meeting

The Chair summarised the key messages from the meeting as:

- The Board reiterated its commitment to focusing on housing as a key determinant of health with the ambition of codesigning future housing strategies with local authority partners
- The positive messages relating to the NHS 75th Birthday, the role of partners in supporting the NHS to flourish and the move to a prevention and healthy communities focus
- The risks and challenges posed by planned industrial action by junior doctors and consultants in July
- The positive annual assessment feedback, especially relating to the ICB's leadership and focus on integration and tackling health inequalities.

ICBB23/127 Date and Time of Next Meeting

The next meeting of the ICB Board would be held on Thursday 7 September 2023 at 10am, in the Boardroom, Vespasian House, Barrack Road, Dorchester, Dorset DT1 1TS.

ICBB23/128 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 2 MEETING

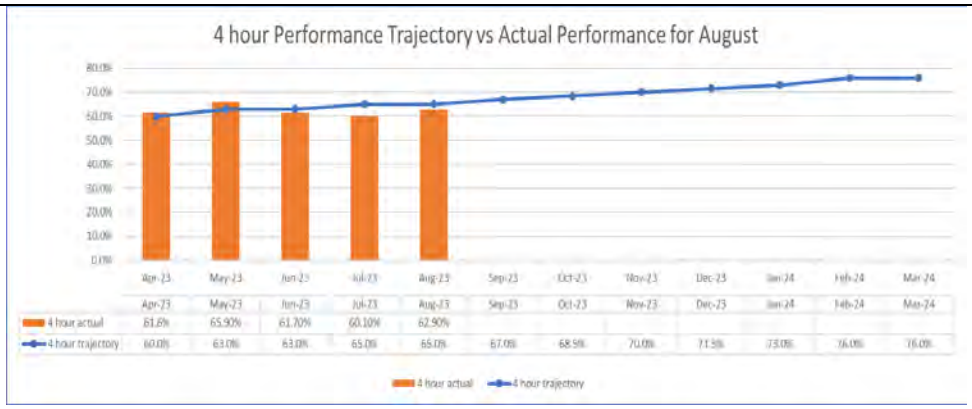
Meeting Date: 27 September 2023

Agenda item: 6.1

Subject:	Integrated Performance Report (Safety, quality, experience, workforce and operational performance)
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:	UHD Chief Officers

Strategic themes that this item supports/impacts:	Systems working and partnership ☒ Our people ☒ Patient experience ☒ Quality: outcomes and safety ☒ Sustainable services ☒ Patient First programme ☒ One Team: patient ready for reconfiguration ☒
BAF/Corporate Risk Register: (if applicable)	BAF Risks 1-7 Trust Integrated Performance report August 2023 - Appendix A
Purpose of paper:	Assurance
Executive Summary:	There was an increase in overall attendances to our Emergency Departments (ED) in August 2023 to 14257 in month. Performance improved to 62.9% achievement against the 4-hour standard against a plan to achieve 65%. The migration of the Patient Administration System (Agyle) for ED is now complete for both sites. Gaps in the medical workforce continue to impact performance, particularly out of hours and at weekends, with recruitment to the agreed staffing templates ongoing. August 2023 has seen a sustained focused improvement in the recording and management of patients with 'No Criteria to Reside' (NCtR). UHD has met with the Dorset Integrated Care Board (ICB) executives and provided assurance relating to data capture and reporting. The Trust remains an outlier in the south west in terms of the highest number of NCtR as a % of beds available. August 2023 saw a temporary reduction in escalation beds being opened, however this has increased in late August and into September 2023. This continues to carry associated risk and unplanned costs related to maintaining an extended bed base. Elective and cancer recovery demonstrate movement away from trajectory for 65 week waits and Cancer Faster Diagnosis. The cumulative impact of cancelled, rescheduled or unbooked capacity due to industrial action since April 2023 is having a significant impact on the Trust's ability to meet its long waiter reduction plans. Significantly higher demand for skin suspected cancer referrals and workforce gaps in breast radiology have also impacted cancer performance. Rapid recovery plans are supporting an improvement across elective care as we move through September 2023.

	The cost of the recent ongoing industrial action, energy cost inflation and unfunded escalation capacity drive the challenging financial position, with a year-to-date adverse variance of £6.5 million. Consistent with national reporting guidance; elective income has now been adjusted to reflect the actual Payment by Results income earned for elective activity delivered during April and May 2023, with further adjustments required in future months to reflect outturn activity during June, July and August once national guidance has been confirmed. Mitigating actions continue to be identified and progressed to recover this position.
Background:	The integrated performance report (IPR) includes a set of indicators covering the main aspects of the Trust's performance relating to safety, quality, experience, workforce and operational performance. It is a detailed report that gives a range of forums the ability if needed to deep dive into a particular area of interest for additional information and scrutiny. As part of our commitment against the CQC Well-Led Framework we continue to develop the format and content of the IPR by: • Extending best practice use of Statistical Process Control (SPC) Charts. • Greater focus on key indicators as part of our Patient First roll-out programme. • Providing SPC training to operational leads who compile the narrative against the data included within the report. • Linking the structure of the report to the delivery of our strategic objectives.
Urgent & Emergency Care (1 Advise)	**Strategic goal: To meet the patient national constitutional standards for Planned and Emergency care supporting reducing inequalities in outcome and access and improving productivity and value.** ***Advise (1): The Trust commenced national reporting against the 4-Hour Organisational safety standard in July 2023. In August 2023 performance was 62.9% against a plan of 65%*** • The Trust is planning for further ongoing British Medical Association industrial action in September and October 2023 with August having proved to be a particularly challenging month with industrial action and the bank holiday. • The organisation continues to sustain performance above 60% and is starting to recover following the implementation of Agyle in June and July 2023 delivering 62.9%. • Whilst attendances rose in August 2023, ED saw a sustained improvement in both Decision to admission times (DTAs) and total meantime in the department. • In terms of ambulance handover, whilst marginal improvement across UHD and Dorset wide was seen, this is a positive improvement compared to the regional South Western Ambulance Service Foundation Trust position. The IPR provides detailed performance against the national Urgent & Emergency Care standards.

	 The weekly enhanced support meetings set up as part of the 'Enabling Trust Accountability Framework' remain in place led by the Chief Medical Officer, Chief Operating Officer and Chief Nursing Officer to work with the Emergency Department and the wider urgent and emergency care team. This is with the aim of enabling focused support of the Trust's recovery against our internal trajectory. There is also a planned review of the hospital flow programme in its entirely to support transformation and delivery across the organisation as a cycle of continuous improvement.
Occupancy, Flow & Discharge (1 Advise)	**Strategic goal: To meet the patient national constitutional standards for Planned and Emergency care supporting reducing inequalities in outcome and access and improving productivity and value.** ***Advise (1):* No Criteria to Reside position – UHD remains the most challenged organisation for No Criteria to Reside (NCtR) in the South West** • Both sites continued to maintain escalation beds open in August 2023 although there was some reduction mid month. Occupancy remains at an average of 93.5% across UHD. The Trust has de-escalated to declare OPEL level 3 (Operational Pressures Escalation Levels) for the majority of August 2023. While we continue to use planned escalation beds the Trust continues to have unfunded escalation beds to maintain flow. • UHD has been consistently showing as an outlier in the south west with a higher percentage of bed base occupied by patients with NCtR, for August this remained at c23-26%. UHD met with the ICB executive leads in August 2023 to provide assurance relating to data processes and reporting. • The ICB ambition to achieve a 30% reduction in Q1 of NCtR was not achieved by any provider in Dorset, and the 50% reduction by the end of Q2 remains extremely challenging and would require a reduction of 100 patients. • The ICB system's (all partners) ambition is that at least 95% of supported discharges are under a discharge to assess (D2A) approach, however this has not been fully achieved. • With the ICB we are identifying gaps in the commissioned provision of D2A capacity and continue to see patients in acute hospital beds waiting for D2A capacity, as well as those needing more complex care.
Surge, Escalation and Ops Planning (1 Assure)	**Strategic goal: To meet the patient national constitutional standards for Planned and Emergency care supporting reducing inequalities in outcome and access and improving productivity and value.** Assure (1): We have now adopted a centralised bed management approach with dedicated oversight of flow across both acute sites and have moved to embed this system with expected improvements in oversight, co-ordination and reduced transfer time. Revised processes relating to pushed admissions from

	ED and assessment units are embedding, with acute issues being managed by the Clinical Site Teams. We are developing winter plans both locally and in the wider Integrated Care System, recognising the forthcoming challenges coupled with ongoing industrial action affecting our hospital processes overall.
Referral to Treatment (RTT) (2 Advise)	**Strategic goal: To meet the patient national constitutional standards for Planned and Emergency care supporting reducing inequalities in outcome and access and improving productivity and value.** **Advise (1): Both 78 week and 65 week referral to treatment (RTT) wait breaches increased in August 2023 and maintained a variance to plan. A reduction in the total RTT waiting list and improvement in RTT performance however has been delivered.** • The cumulative impact of cancelled, rescheduled or unbooked capacity due to industrial action since April 2023 is having a significant impact on the Trust's ability to meet its longwaiter reduction plans. • 65-week breaches increased to 1,296 with an increase also in the variance to plan (variance +462), nevertheless the Trust achieved a reduction in the overall cohort of patients at risk of breaching 65 weeks by March 2024, which reduced by 4,932 in the month of August 2023 and now stands at 12,676. This is a 69% reduction in the cohort since 1 April 2023. • 43 over 78 week waits were reported at the end of August 2023. This was an increase compared to July, but an improvement on the month end forecast (53). The Trust is working to an ambition to reduce or eliminate 78 week waits by 30 September 2023. • The Trust delivered an overall reduction in its RTT waiting list in August 2023 and met the operational plan trajectory, which is reflected in improved RTT performance. • Industrial action planned for September and October 2023 will continue to reduce capacity for routine elective care and present a challenge to teams seeking to reduce long waits for patients. • Improvement actions are detailed within the IPR.

Planning requirement	**July 23**	**August 23**	
Referral to treatment 18-week performance	55.40%	56.99% ▲	National Target 92%
Eliminate > 104 week waits	0	0	Plan Trajectory 0 by February 23
Eliminate >78 week waits	34	43 ▲	Plan Trajectory 0 by 31 March 2023
Eliminate >65 week waits	1,122	1,293 ▲	Plan trajectory 831 August 2023
Hold or reduce >52+ weeks	4,613	4,501 ▼	Plan Trajectory 4,032 by August 2023
Stabilise Waiting List size	75,884	73,727 ▼	Plan trajectory 75,449 July 2023

	• A significant reduction in the theatre case opportunity has been consistently delivered by the Trust for the last two months with the Trust meeting the 15% target again in August 2023. • Improvement across a range of theatre efficiency markers is also evident. • Actual theatre utilization was 9.2% below intended (booked) theatre utilization. Ongoing industrial action is hampering sustainable improvement in performance to reach the intended utilization levels due to cancellations and the effects on utilisation. • Excluding Orthopaedic lists would increase overall utilisation by 3% (5% in July), demonstrating some improvement has been made within the specialty since July. Oral and Maxillo-Facial services are also a contributor to performance and similarly showing improvement. **Key areas of focus for theatres:** • Workforce: Profiling theatre activity factoring in new starters and improved workforce position has been completed with plan to increase Orthopaedic activity in October 2023 with trajectory indicating full template by end of March 2024. • The implementation of Mypreop - virtual pre-op assessment platform in the first week of October 2023. • Piloting 'super lists,' on 23 September 2023 by way of a proof of concept for working differently. **Advise (2): The percentage of fractured NOF patients operated on within 36 hours of admission declined in August, however compared to a similar period last year, statistically performance has improved.** • Trauma admissions in August 2023 mirrored July and are consistently higher than in Q1. • Compared to the same period last year, where admissions increased at a similar rate there has been an improvement in performance year to date. • However, compared to July 2023, a decline in our target attainment against the quality standard has been reported in August. 30.7% of patients with a fractured neck of femur (NoF) were operated on within 36 hours of admission; 45% of patients were operated on within 36 hours of being fit for theatre. A clustering of admissions partway through the month impacted on performance. • Improvement actions are included in the IPR and will be discussed at a Board Seminar on Trauma being held on 27 September 2023.
Cancer Standards (1 Alert)	**Strategic goal: To meet the patient national constitutional standards for Planned and Emergency care supporting reducing inequalities in outcome and access and improving productivity and value.** **Alert (1) The forecasted decline in performance against the cancer Faster Diagnosis Standard materialised in July 2023.** • Performance against the cancer Faster Diagnosis standard in July 2023 demonstrated a decline after several months of positive improvements. This is due to an increase in referrals, the impact of industrial action, workforce gaps and capacity challenges within Skin and Breast services. • 62 day performance improved to 63% and the Trust continues to deliver against the regional expectations on reducing the over 62-day backlog in meeting its 50% fair shares allocation of the March 2024 target set regionally (302 against target 330). • 31 day performance achieved the standard in July 2023 and is expected to achieve for the rest of the year.

KPI	Target	Q1 23/24 FINAL	May 23 FINAL	June 23 FINAL	Jul 23 FINAL
Faster Diagnosis	75%	71.1%	70.2%	71.8%	60.1%
31 Day First Treatment (Tumour)	96%	96.8%	96.3%	97.9%	96.2%
Cancer Plan 62 Day Standard (Tumour)	85%	63.4%	62.7%	60.8%	63.0%
62 Day Screening Standard (Tumour)	90%	74.1%	75.0%	80.6%	65.8%

- There is continued evidence of progress against the recovery plans in place for Gynaecology, Urology and Colorectal tumour pathways, which will need to continue.
- Improvement actions are detailed within the IPR and include:
    - a rapid recovery plan for skin which includes 1,350 additional clinic slots in August/September
    - Implementation of new post-menopausal bleeding pathway clinics in Gynaecology in October.
    - Deployment of a Breast Radiology Locum from 1 September for 3 months to address a gap in capacity.
- It is likely that the Trust will see a further deterioration of FDS performance in August before recovery against the standard commencing in September.

DM01 (Diagnostics report) (1 Assure)

Strategic goal: To meet the patient national constitutional standards for Planned and Emergency care supporting reducing inequalities in outcome and access and improving productivity and value.

The DM01 standard has achieved 86.8% of all patients being seen within 6 weeks of referral, 13.2% of diagnostic patients seen >6weeks in August

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

August	Total Waiting List	< 6weeks	> 6 weeks	Performance
UHD	12,405	10,763	1,642	**13.2%**

UHD remains one of the top performing trusts for diagnostics in the south-west region and an area we are very proud of as a team. Nevertheless, there are challenges related to workforce capacity in Echocardiology, Neurophysiology and Radiology (imaging). Mitigating actions are in place to maintain a high level of performance.

Health Inequalities

Strategic goal: To meet the patient national constitutional standards for Planned and Emergency care supporting reducing inequalities in outcome and access and improving productivity and value.

Waiting list by Index of Multiple Deprivation (IMD) The median weeks waiting at the point of treatment shows no variation between the 20% most deprived and the rest of the population treated. At sub-Trust level the greatest variation in Q2 exists in general surgery (11 weeks), paediatrics (7 weeks) and OMF services (3.5 weeks).

Waiting list by ethnicity: An analysis of the median weeks waiting by ethnicity grouping identifies 1 week variation between patients within community minority groups and White British populations in Quarter 2 to date; this is consistent with the previous two quarters. At sub-Trust level variation in waiting by ethnicity is greatest in Ophthalmology and Elderly Medicine.

Waiting list by age band: There is variation between age and length of wait on the waiting list with the greatest variation between 0-19yrs and 20+ age bands. There has been a widening of the variation in the age band 0-9 years

	in Q2 to date. Paediatric waiting times in oral surgery, ENT and community paediatrics contribute to this variation. Improvement actions are in place to increase capacity and reduce waiting times in these areas.
Infection Prevention and Control: (1 Advise)	**Quality, Safety, & Patient Experience Key Points** **Strategic goals: To achieve top 20% of Trusts in the country for mortality (HSMR)** **To reduce moderate/severe harm patient safety events by 30% through the development of an outstanding learning culture** **Advise (1)** Cdiff Cases In August 2023 we have noted a reduction in in the number of C. difficile cases reported, both identified – in the community and trust associated, this continues a downward trajectory. **Advise: Hospital Associated cases trend** • Reportable cases across all organisms have seen a month-on-month reduction since. Increase in UTI continues, also increase in Hepatobilary as source are noted. • August saw two ward closures, both due to COVID-19 • A C.difficile outbreak was reported and full review to go to Infection Prevention Group. • There are a number of post infections reviews being monitored and updates with reports back through Care Groups. • The team are assessing themes as part of the Patient Safety Incident Response Framework, including management of urinary catheters, intra-venous cannulae and C. difficile relapses. • Appointment of our UHD first Infection Prevention and Control Nurse Consultant – due to start late 2023.
Clinical Practice Team ***(4 Advise)***	**Clinical Practice Team** **Advise (1) Moving and Handling - Essential Core Skills** The ability to meet the face-to-face level two training requirements for clinical staff continues. The risk register entry remains at 10 (moderate). The development of an eLearning Level 2 package is being developed. **Advise (2) Moving & Handling:** recruitment into the following posts: Associate Practitioner, Falls and Moving and Handling lead and Moving and Handling Risk Advisor were successful and due to start in September 2023. Current support is being provided from an external provider to support all new starters with practice and Level 2 face to face training. **Falls prevention & management**: The Falls and moving and handling lead is currently vacant and after successful recruitment the new postholder is due to start in September 2023. **Advise (3)** There has been an increase in the number of serious falls incidents in month with four reported; of these three were moderate and one severe fall was reported. The incidents are following the appropriate scoping and investigation process.

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

	Tissue Viability: The ability of the service to meet the increased demand remains on the risk register entry 1821 and rated as 9 (moderate), an action plan has been updated. The number of complex patients being referred to the service remains high. • The team have successfully recruited an additional band 6 for a six-month secondment to support increased activity and the post holder started in August 2023. **Advise (4)** There has been an increase in reported pressure ulcers in month with eleven new category three pressures ulcers reported which are following the appropriate investigation process and learnings identified.
Patient Experience ***(3 Advise)***	**Strategic goal: Every team is empowered to make improvements using patient (or user) feedback, in order that all patients at UHD receive quality care, which results in a positive experience for them, their families and/or carers.** **Patient Advice Liaison Service (PALS) and Complaints Team** **Overview:** • 564 PALS concerns raised. • 27 new formal complaints (remain within our control measures). • 14 Early Resolution complaints (ERC) processed. • The number of complaints that were responded to and closed in August were 44. Key themes from PALS and complaints: • Quality – clinical standards. • Safety – errors, incidents, and staff competencies. • Communication – absent or incorrect. • Respect – caring and patient rights. **Advise (1):** The reduced number of complaints open continues to reflect the change in process of the recording of all new complaints. The complaints team now advise the open complaint date as the date in which consent and conformation of investigation points has been received. This follows best practice and avoids duplication of complaints reporting. **Advise (2):** The number of open complaints over 55 days continue to be prioritised within the complaints team and care groups. Due to sickness coinciding with planned leave during August 2023 the complaints and PALS teams have been running at a significantly reduced number, returning to plan numbers in September. Plans to start a combined PALS and complaints service are in place to commence in October 2023, to reduce duplication of effort and allow flexibility to ensure a quality, timely service. **Friends and Family Test (FFT)** **Advise (3):** An error in transferring ED data for FFT text messaging service has been seen due to the change from Symphony to Agyle. This has meant no text messages have been sent for ED and thus no FFT results. Trust wide (excluding ED) our FFT results are near to 95%. **Mixed Sex Accommodation (MSA) Breaches** There were no reported MSA incidents in August 2023

Nurse Staffing: (4 Advise)	**Care Hours per Patient Day (CHPPD)** **Advise (1)** August 2023 CHPPD for registered nurses and midwives remained static at 4.9. An increase of 0.3 CHPPD is noted for HCSW. **Healthcare Support Workers (HCSW)** **Advise (2):** HCSW reported vacancies remain high; the Trust continues to meet monthly with the NHS South West Direct support team, to review actions and monitor the HCSW vacancy reduction trajectory; currently on target to achieve. **Red Flag Reporting** **Advise (3)** There were 13 red flags reported across UHD in August 2023, a reduction from 19 in July. No critical staffing incidents were reported, indicating all flags were mitigated this month. **Advise (4)** Safe Care: Ward and Matron level refresher training in patient acuity and dependency assessment continues. The result of the twice daily assessment informs the Trust of safer staffing levels and generates the CHPPD data. A Trust wide consistent approach to census data completion will further inform and support Trust wide safer staffing.
Workforce Performance:	**Strategic goal: To significantly improve staff experience, engagement and retention**
CPO Headlines:	
People Operations: (3 Advise, 1 Assure)	**Advise (1) Industrial Action** • National pay disputes remain for the staff Medical and Dental staff group. • September 2023 strike action: The British Medical Association (BMA) and British Dental Association (BDA) - Consultants will strike from 0700 on Tuesday 19 September – 0700 Thursday 21 September and the BMA and Hospital Consultants and Specialists Association (HSCA) Junior doctors and BDA dental trainees will strike from 0700 on Wednesday 20 September – 0700 Saturday 23 September. • October 2023 action: The BMA and BDA Consultants, HSCA and BMA Junior doctors, and BDA dental trainees will strike together from 0700 Monday 2 October – 0700 Thursday 5 October. • Members of the Society of Radiographers (SoR) from 0800 on Tuesday 3 October to 0800 on Wednesday 4 October will be striking across the NHS. The minimum threshold to mandate a strike at UHD was not met, and therefore this does not apply to UHD. **Advise (2) Transformational Change** • The HR Operations Team has newly appointed 2 HR Managers on a fixed term contract to support the transformational change programme however, it is still carrying 2 vacancies (50%). General recruitment and agency searches continue. **Advise (3) Employee Relations Capacity** • HR Business Partners remain unable to fulfil the full remit of their role due to the level of urgent/complex employee relations issues which has increased again this month, to more than 60 formal processes. Alternative staffing structure proposals to reconfigure and increase the establishment are being considered. **Assure (1) Staff Absence, burnout and PTSD (Risk 1493)** • Sickness absence has been decreasing but stress/ anxiety/ depression remains the top reason for absence. Data has been examined and

	compared to previous years which identifies that overall, in 2022/23 there had been less days lost due to this reason (5,766 FTE days) when compared to 2021/22.
Blended Education & Training (1 Alert, 2 Advise, 3 Assure)	**Alert (1) Registered Nursing Associate Medicines Management** • An urgent review of the Medicines Administration Policy is taking place at the next Pharmacy MMG (Medicines Management Group) and PPG (Policy and Procedures Group) to include competency level standards for Registered Nursing Associates (Band 4). **Advise (1) Compliance** • Mandatory training compliance: 89.76% Target: 90%. **Advise (2) Apprenticeships** • 4 Trainee Nursing Associate Apprentices due to commence in September 2023. Future Trainee Nurse Associates will be completed as a Dorset System and will include internal and external candidates. • 23 Registered Nurse Degree Apprentices have started at UHD this month. **Assure (1) Moving and Handling** • To support reduced MH training waiting times, the development of an E-Learning package for Level 2 is on track to launch from January 2024 (Risk 1432). • 3 additional Manual Handling training team members are joining UHD in September 2023. • Train the trainer programme is launching in November 2023, this will increase the amount of manual handling champions across UHD. **Assure (2) Healthcare Support Worker Retention** • HCSW Celebration event arranged for 23 November 2023. • Higher Development Award to support HCSW retention commencing January 2024. • HCSW Forum to support colleagues will commence January 2024. • 16 new starters commencing on HCSW Scholarship September 2023. **Assure (3)** • In partnership with Dorset Integrated Care System and NHS England 2 Legacy mentors are currently being recruited to Maternity and Theatres to support staff retention. • Multi-Professional Preceptorship Programme commenced September 2023 – 97 Preceptees, 53 RNs and 40 AHPs.
Resourcing ***(5 Advise, 1 Alert, 3 Assure)***	**Alert (1)** • Data verification is in progress- despite a high number of new starters each month, and a low number of leavers, the HCSW vacancy rate has not fallen over the past 12 months – and remains at an average of 21%, which places UHD is amongst those trusts in the south west with the highest number of HCSW vacancies. Both NHS England and the Trust are keen to establish what this anomaly is due to, as ward areas are reporting that they have few or no vacancies. **Advise (1)** • Resourcing, Business Intelligence and Workforce leads are meeting with Finance Leads to align the recording of some posts within funded establishment and Electronic Staff Record which may be affecting this data, specifically Students and Apprenticeship roles.

	Assure (1) Medical Recruitment Activity • There were 42 Medical Appointments in August 2023, 22 of which were new to the Trust. The majority were Junior Clinical Fellows recruited to fill gaps in the rota, as well as Medical Education Fellows to support Medical Students and Trainee Physicians Associates. • There were 2234 applications received for 29 advertisements run over the month. **Assure (2) General Recruitment Activity** • The number of new joiners continued to increase month on month, at 114 for August 2023, this follows the trend of the previous year. • The number of posts advertised, and appointments made also increased noticeably this month, to 304 offers made – the 2nd highest in 12 months, and 294 advertisements posted, up 32 on previous month. • The Theatres Workforce Group has been successful in establishing a pipeline of candidates to fill all but a few remaining support worker roles for the new build additional theatres. **Advise (2)** • The number of internal moves now equals the number of external hires, creating high levels of 'churn' within the organisation. **Advise (3) International Recruitment Activity** • 6 International Radiographers have now arrived in the UK, from the Philippines. Further recruitment advertising is attracting high levels of interest from candidates currently based in India. **Advise (4)** • The remaining 10 NHS England funded International Midwifery posts have now been offered employment and are expected to arrive between now and November. Reserve candidates have been identified in case needed or should additional funding be offered. **Assure (3)** • During September 2023 there are 3 HCSW Recruitment Events scheduled, two mid- week and one Saturday. • There are over 100 HCSW in the pipeline completing employment checks. The next available induction dates are beginning of October, and availability is good. **Advise (5)** • The Trust is exploring the use of a new engagement App – TALK N JOB, which was developed at University Hospitals Southampton, and is proving good value for money in attracting HCSW and other applicants when compared to other sources, such as Indeed.
Occupational Health and Wellbeing (3 Alert, 1 Advise)	**Alert (1) Management Referrals** • 211 Management referrals were triaged in August 2023. Current wait time for OHN (OH Nurse) is up to 7 weeks due to long-term absence in the team. Agency nurse support is being sourced to address the waiting times. This will be added to the risk register. **Alert (2) Pre employments** • 357 new pre-employment questionnaires triaged in August 2023. 68% of pre- placements were cleared within 5 days, with the majority of the remaining being cleared within 10 days. The aim is for all pre-placements (not requiring immunisations) to be cleared within 3 days as new staff members are fully trained. **Alert (3) Staff physiotherapy** • 42 staff self-referred to Staff physio service in August 2023. The current the wait time for routine staff Physio appointments is currently 7 weeks

	from triage and 3 weeks for urgent referrals. A part time physiotherapist has started in post and the team is sourcing agency support to the service whilst the remaining vacant days remain substantively unfilled. **Advise (1) Autumn Vaccination Program** • OH nurses will be supporting the roll out of the Autumn vaccination program throughout September 2023, steps are being taken and waiting times closely monitored to review what impact this will have on clearance times. OH are working closely with external partners and the internal Vaccination cell.
Workforce Systems (3 Assure, 2 Advise)	**Assure (1) ESR Data cleanse** • The project is 74% complete (for Agenda for Change staff only) and has increased from 49% in July. The Medical and Dental ESR data cleanse will begin on 1 October 2023. **Advise (1) Medical Rostering Project** • Issues have been raised by Cancer Care on the functionality of Health Rota, 3 Learning Event Report Notifications (LERNs) have been raised and are being reviewed to make improvements to functionality where appropriate. **Assure (2) Medical Rostering Project** • 77% of Junior Doctors and 46% of Doctors are now on an active roster. Priority is still being given to Junior Doctors. Medical and Dental Annual Leave and Rostering policies are being generated. **Assure (3) Safe Care project** • 210 band 6/7 and senior band 5s have been trained. First stage of training for Matrons was completed via the Matron Development Programme. Improvements to the system continue so it can be used in the daily staffing meetings. **Advise (2) Roster Improvement** • A Roster improvement Lead role commenced 21 August 2023. This role will concentrate solely on roster improvement.
Temporary Workforce ***(1 Alert, 2 Advise, 2 Assure)***	**Alert (1)** • There has been an increase in worker cases connected with staff allegations/irregularities. One case has highlighted a critical review of the Trust's VISA Right to Work obligations, in relation to a student on bank agreement. An urgent review is underway to assess the Trust's legal & statutory compliance requirement. This will be added to the risk register. **Advise (1) Agency Usage Risk 1492** • Whilst the overall position of using high cost off-framework agencies continues to improve, month 5 shows a 3.8% increase in off-framework nursing usage which in part is attributed to the peak summer period. • Overall agency usage down to 4.52% expenditure of the pay bill remaining above the spend cap. **Advise (2)** • Ahead of the imminent staff survey, preparations are underway for hosting the September 2023 CommuniTea engagement event for bank workers. These will be across all 3 sites and an opportunity to meet and network. **Assure (1)** • Data cleanse project continues. A new batch of terminations are with payroll to process c1300 terminations.

	Assure (2) • To date, c£62k in savings have been achieved as a result of the Band 3 MHSW (Mental Healthcare Support Worker) rate reduction initiative and the migration of supplies from Tier 2 to Tier 1 supply since rates were implemented in July 2023.
Organisational Development ***(5 Advise, 1 Assure)***	**Advise (1) Equality, Diversity and Inclusion (EDI)** • Dorset ICS Leading for Inclusion Change Agent Programme (Senior Leader 6 months Health Inequalities/Workforce programme) launched - UHD delegates assigned. • BDO internal EDI Audit review underway. • UHD Annual EDI Report and Workforce profile completed. • See ME First Ambassador campaign launched. **Advise (2) Leadership & Talent** • 5 UHD applications for the BPP Level 5 Coaching Professional Apprenticeship. • Plans to advertise and recruit to a cohort of 15 staff for our own internal ILM (Institute of Leadership and Management) 5 coaching qualification (quotes received, and decision made on provider). • Launch of Leadership Fundamentals cohort 5 and final sessions of cohorts 1 & 2 Leadership in Action Programme in early September 2023. • 43 staff participated in leadership development workshops throughout August 2023 (across 4 workshops). • Express Coaching offer launched across UHD. **Advise (3) Team Development** • UHD Team Month to be advertised in the brief - a learning month for UHD staff to support their understanding of their role in building effective teams • Continuing support to teams across UHD. • Plans to follow up with team leaders who have been supported by UHD to see how they have progressed on their team development journey and how they have put the learning into practice. **Advise (4) Health & Wellbeing (H&W)** • Wellbeing Champions & H&W Ambassadors amalgamated to become H&W Champions. F2F development afternoon planned for 11 October 2023. Recruitment drive planned for October to coincide with World mental health day. • Health Kiosks will be in situ at RBH and Poole restaurants for 1 month from 18 September. • Work on menopause policy and educational information is underway in collaboration with OH and Women's network. • Winter wellbeing guide for managers and staff planned for Winter 2023. **Assure (1)** • H&W Check in conversations launched with managers guide and self-directed learning available on revamped intranet page. • 3 Cohorts Training planned for 2023. Current MHFA (Mental Health First Aid) completing refresher training and in-house development session planned for 7 September 2023. • 81 bids approved in conjunction with Estates in response to UHD Improving Rest Areas initiative. **Advise (5) Culture & Engagement** • Preparations underway for the Staff Survey 2023. The data will be taken from ESR on 1 September 2023. This year UHD surveys will be sent by email. Significant work has been done to increase the number of correct email addresses held on ESR and to group teams with less than 10 staff in them to improve our reporting ability. The survey will go live in mid-September.

	• The People Pulse survey will be open for the month of September 2023 as the focus in on Freedom to Speak Up. We collated data last September with the same questions giving the opportunity for comparison.
Trust Finance Position	**Strategic goal: To return to recurrent financial surplus from 2026/27** **Alert: Forecast Outturn Risk** The Trust continues to manage a number of significant financial risks and whilst a range of mitigations have been identified, these are currently insufficient to fully mitigate the identified risks should these all materialise in full. A detailed re-forecast is currently being prepared alongside the development of a comprehensive financial recovery plan. A full update will be provided to the October 2023 Finance and Performance Committee and Board. **Advise: Revenue Position** At the end of August 2023, the Trust has reported a deficit of £11.7 million against a planned deficit of £5.2 million representing an adverse variance of £6.5 million. This is mainly due to energy cost inflation £1.6 million, the net cost of the Nursing, Junior Doctors and consultant strikes £2.3 million, unfunded escalation costs of £1.3 million together with premium cost pay overspends in the Care Groups. This has been offset in part by additional bank interest due to a higher cash holding and recent movement in Bank of England base rates and reduced depreciation charges due to the timing of capital expenditure. Elective Recovery Performance for April and May 2023 has been published by NHS England in relation to the variable elements of commissioner contracts and has been reflected within the August 2023 year to date position. This has resulted in a £1.5 million commissioner contract income reduction due to the activity delivered against the Trusts NHS England required trajectory. **Advise: Cost Improvement Programme** Cost Improvement Programme (CIP) savings of £8.3 million have been achieved as at 31 August 2023 against a target £8.2 million. This includes non-recurrent savings of £4.9 million. The full year savings requirement is £33.3 million which represents a significant challenge. Current savings plans total £19.5 million representing a shortfall of £13.8 million and a recurrent shortfall of £21.4 million. Mitigating this shortfall continues to be the key financial focus for the Trust with the implementation of a dedicated Project Management Officer supporting CIP identification and delivery. **Advise: Capital Programme** At 31 August 2023 the Trust has a rephased capital budget of £129.4 million, including £102.8 million of centrally funded schemes including the acute reconfiguration and the New Hospital Programme (NHP). At the end of August 2023, the Trust has committed capital expenditure of £26 million against a plan of £57.2 million representing an underspend of £31.2 million. This underspend mainly relates to STP Wave 1, phasing of IT works and the One Dorset Pathology scheme. The STP Wave 1 full year forecast remains consistent with the plan and the NHP plan reflects the latest cashflow agreement with NHS England. **Advise: Cash** As at 31 August 2023 the Trust is holding a consolidated cash balance of £91.6 million which is fully committed against the future Capital Programme. The current cash balance is higher than planned due to the successful award of capital funding for multiple schemes alongside a rephasing of the capital programme spend. The balance attracts Government Banking Services interest of 5.14% at current rates, together with a PDC benefit of 3.5%.

	Advise: Public Sector Payment Policy In relation to the Public Sector Payment Performance the Trust is currently delivering performance of 91.2% against the national standard of 95%, reflecting the positive impact of the recovery actions taken in August 2023.
Key Recommendations:	Members are asked to: • Note the content of the report
Implications associated with this item:	Council of Governors ☐ Equality and Diversity ☒ Financial ☒ Operational Performance ☒ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☒ Regulatory ☒ Strategy/Transformation ☒ System ☒
CQC Reference:	Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well Led ☒ Use of Resources ☒

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

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

University Hospitals Dorset
NHS Foundation Trust



Integrated Performance Report

Reporting month: August 2023
Meeting Month: September 2023

Contents

Performance at a Glance Indicators (1)

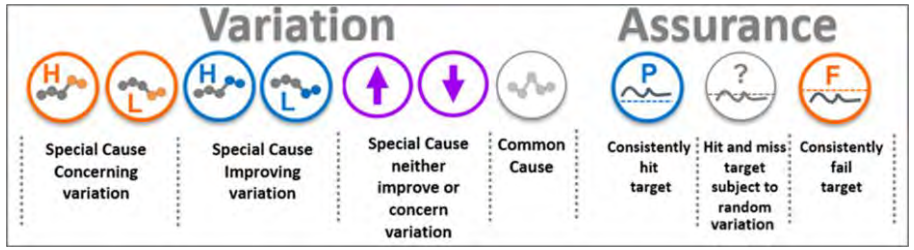
			standard	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
SAFE																
Quality	Presure Ulcers (Cat 3 & 4)			4	9	8	3	9	10	7	7	5	9	5	2	14
	Inpatient Falls (Moderate +)			7	5	3	2	5	9	3	3	5	2	7	1	5
	Medication Incidents (Moderate +)			2	1	0	2	1	0	1	0	0	0	2	1	4
	Patient Safety Incidents			1193	1096	1236	1216	1204	1166	1044	1201	1073	1190	1138	1224	1230
	Hospital Acquired Infections	MRSA		0	1	1	0	0	1	0	0	1	0	0	0	0
		MSSA		3	3	7	2	3	3	1	1	4	6	8	4	4
		C Diff		11	9	2	4	5	6	4	5	5	8	19	11	4
		E. coli		7	9	6	7	5	10	7	14	5	8	17	14	8
EFFECTIVE																
Mortality	HSMR (al Latest Mar 23	(source Dr Foster)		109.5	109.7	119.6	118.7	115.4	107.8	103.8	101.3	106.2	126.2			
	Patient Deaths	YTD		226	225	256	256	294	273	217	259	238	228	215	196	227
	Deaths within 36hrs of Admission			29	29	41	37	50	38	37	32	36	41	34	33	43
	Deaths within readmission spell			22	21	21	17	24	23	23	16	22	21	18	26	31
CARING																
	Complaints Received			83	90	98	100	75	92	84	86	73	95	91	37	41
	Complaint Response Rate (55 Days)			63.9%	56.6%	66.7%	58.7%	62.3%	52.5%	51.4%	47.4%	45.5%	45.5%	38.5%	24.1%	26.3%
	Friends & Family Test			90.4%	90.0%	89.8%	90.2%	87.8%	91.1%	92.7%	90.3%	90.9%	91.8%	91.0%	93.8%	94.4%
WELL LEAD																
Safety	Risks 12 and above on Register			35	38	37	35	37	38	41	38	38	40	43	43	43
	Risks 15 and above on Register			19	20	19	19	19	20	20	19	19	20	21	20	22
	Red Flags Raised*			128	142	107	74	84	41	43	38	21	43	25	19	13
People	Turnover			14.50%	14.70%	14.60%	14.70%	14.80%	14.94%	14.72%	13.90%	13.83%	13.66%	13.42%	12.90%	12.25%
	Vacancy Rate			8.76%	6.06%	7.85%	8.75%	7.2%	7.0%	6.4%	6.0%	6.0%	7.0%	8.1%	9.1%	
	Sickness Rate			4.7%	4.9%	5.7%	5.2%	6.4%	4.8%	4.7%	4.8%	3.9%	3.7%	3.9%	4.1%	4.1%
	Statutory and Mandatory Training			87.11%	86.75%	85.32%	85.80%	85.92%	86.31%	86.81%	86.98%	87.84%	88.45%	89.41%	89.70%	89.75%

Performance at a Glance Indicators (2)

Performance at a Glance - Key Performance Indicator Matrix

		standard	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	
RESPONSIVE																
RTT	18 week performance %	92%	57.1%	54.9%	55.5%	56.1%	55.1%	55.4%	54.3%	53.8%	52.6%	54.3%	55.1%	55.4%	57.0%	
RTT	Waiting list size	44,508	75,065	72,860	70,918	71,161	70,259	71,230	72,522	72,770	74,557	74,500	74,483	75,884	73,727	RAG based on trajectory
RTT	No. patients waiting 26+ weeks		21,326	21,172	20,227	20,765	21,024	21,726	22,109	22,248	24,223	24,230	22,499	22,301	20,703	
RTT	No. patients waiting 52+ weeks		4,010	3,559	3,468	3,634	3,472	3,565	3,861	4,100	4,380	4,813	4,574	4,613	4,501	RAG based on trajectory
RTT	No. patients waiting 65+ weeks		1,464	1,420	1,449	1,342	1,195	1,127	1,147	1,070	1,249	1,242	1,053	1,122	1,293	
RTT	No. patients waiting 78+ weeks	0	502	504	513	487	473	395	274	96	112	97	32	34	43	RAG based on trajectory
RTT	No. patients waiting 104+ weeks	0	95	76	63	37	25	10	0	0	0	0	0	0	0	RAG based on trajectory
Theatre	Theatre utilisation (capped) - main	98%	75%	75%	69%	75%	73%	71%	71%	65%	72%	73%	73%	73%	73%	
Theatre	Theatre utilisation (capped) - DC	91%	69%	70%	74%	74%	69%	69%	67%	57%	69%	74%	73%	72%	72%	
Theatre	NOFs (Within 36hrs of admission - NHFD)	85%	18%	8%	40%	52%	43%	49%	24%	67%	54%	33%	37%	37%	37%	
Outpatients	**Outpatient metrics**															
Outpatients	Overdue Follow up Appts		33,268	33,840	32,999	32,757	33,369	34,863	34,756	34,302	31,778	31,057	30,594	29,622	27,619	
Outpatients	% DNA Rate	5%	8.0%	7.4%	6.8%	6.5%	7.5%	7.5%	6.5%	7.1%	7.6%	6.5%	6.1%	6.2%	6.3%	
Outpatients	Patient cancellation rate		10.5%	11.4%	11.0%	10.5%	12.3%	10.6%	10.8%	9.2%	8.9%	11.3%	11.6%	11.0%	11.3%	
Outpatients	% non face to face (telemedicine) attendances	25%	21.8%	21.1%	20.4%	20.0%	20.2%	20.8%	21.3%	18.5%	18.6%	18.6%	17.5%	15.7%	17.3%	
DM 01	**Diagnostic Performance (DM01)**															
DM 01	% of >6 week performance	1%	22.6%	20.0%	16.4%	11.0%	13.6%	10.7%	7.4%	7.0%	8.4%	6.0%	7.7%	9.4%	9.4%	
Cancer	28 day faster diagnosis standard	75%	62.9%	64.7%	63.1%	59.6%	68.4%	65.0%	71.0%	75.4%	71.2%	70.2%	71.9%	60.1%	*54.1%*	*August cancer position predicted*
Cancer	62 day standard	85%	65.9%	71.2%	69.4%	64.3%	63.4%	63.6%	61.9%	65.4%	67.0%	62.7%	60.2%	63.0%	*46.4%*	
Emergency Dept	4 hour care standard										61.6%	65.9%	61.7%	60.1%	62.9%	
Emergency Dept	Arrival time to initial assessment	15	30.0	15.0	16.0	15.0	20.5	11.0	15.0	13.0	16.0	19.0	22.0	24.0	16.0	
Emergency Dept	Clinician seen <60 mins %		26.6%	26.0%	25.5%	24.3%	21.8%	31.6%	25.7%	26.1%	31.6%	27.6%	35.6%	20.3%	27.0%	
Emergency Dept	Patients >12hrs from DTA to admission	0	103	129	295	157	343	234	294	211	220	82	13	59	2	
Emergency Dept	Patients >12hrs in dept		779	886	1292	1074	2000	1108	1443	1238	849	637	504	871	723	
SW AST	Ambulance handovers		3743	3657	3716	3855	3545	3602	3360	3997	4020	4147	4022	4272	4454	
SW AST	Ambulance handover >60mins breaches		445	547	666	583	1568	733	859	904	707	342	382	616	560	
Patient Flow	Bed Occupancy (capcity incl escalation)	85%	93.4%	92.8%	94.2%	92.7%	93.3%	93.1%	94.1%	94.5%	93.6%	92.3%	94.4%	94.6%	93.5%	
Patient Flow	Stranded patients:															
Patient Flow	Length of stay 7 days		577	567	605	550	522	564	582	543	523	502	480	474	476	
Patient Flow	Length of stay 14 days		400	397	421	375	332	366	387	355	337	322	294	295	308	
Patient Flow	Length of stay 21 days	108	295	303	315	281	228	250	269	255	235	223	199	202	220	
Patient Flow	Non-elective admissions		5367	5472	5535	5817	5956	5693	5165	6203	5690	6288	6347	6223	6233	
Patient Flow	> 1 day non-elective admissions		3396	3475	3578	3676	3905	3673	3202	3881	3612	3826	3783	3863	3821	
Patient Flow	Same Day Emergency Care (SDEC)		1971	1996	1956	2141	2050	1979	1963	2316	2078	2458	2560	2358	2410	
Patient Flow	Conversion rate (admitted from ED)	30%	26.30%	27.60%	25.80%	29.10%	28.30%	30.90%	27.79%	28.30%	29.70%	29.90%	31.60%	28.70%	28.60%	

Statistical Process Control (SPC) – Explanation of Rankings



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

Quality Outcomes & Safety Patient Experience

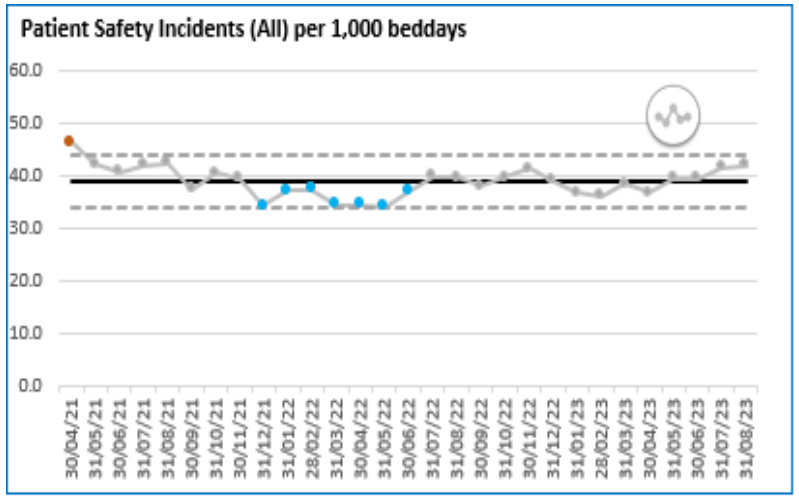
University Hospitals Dorset
NHS Foundation Trust


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

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

Committees:
Quality Committee

Quality (1) – Safe



Background/target description

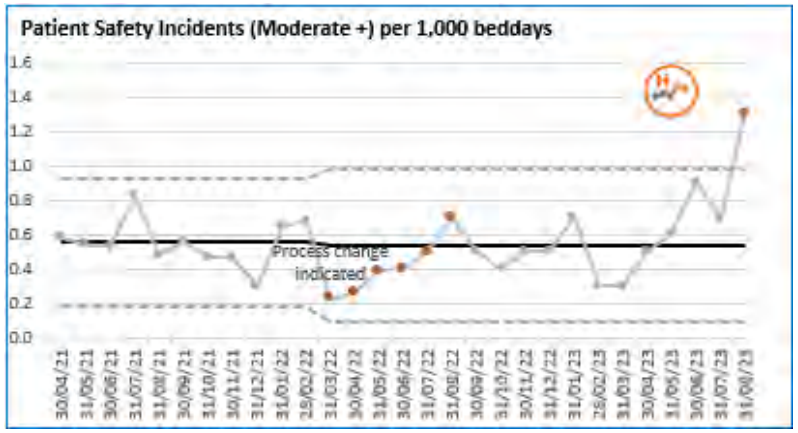
To improve patient safety.
Number of patient safety incidents per 1,000 bed days and severity
Number of serious incidents reported in the month
Number of medication incidents per 1,000 bed days

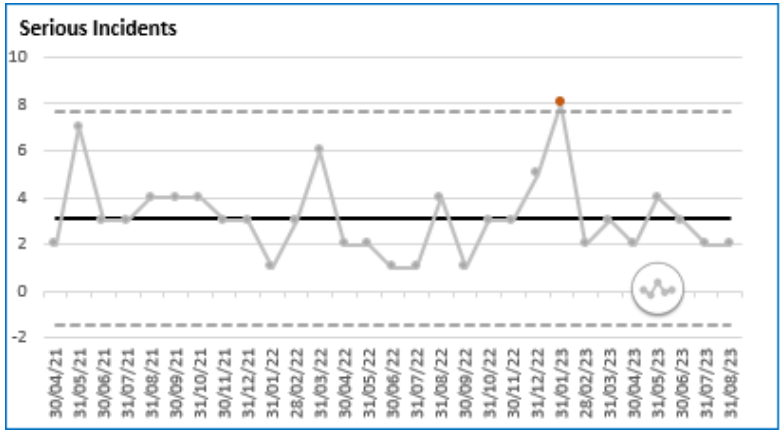
Performance

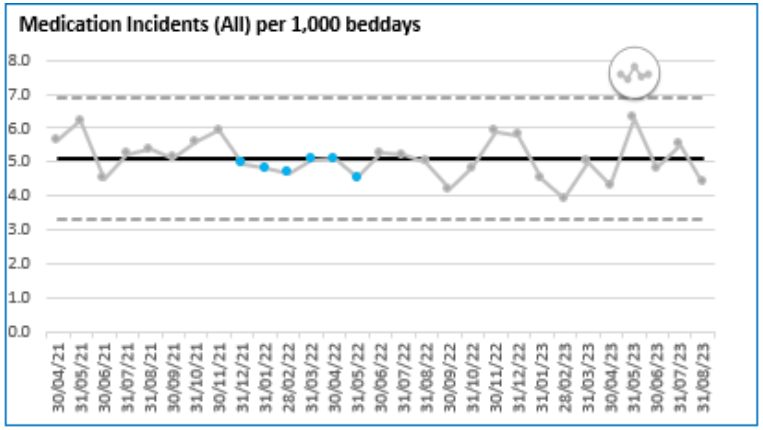
- Two externally reported incidents reported in month (August 23).
- Moderate patient safety incidents for August 23 shows peak but these are unvalidated LERNs and are liekly to drop to within expected range once validation completed
- No significant trends or changes in IPR reported metrics .

Key Areas of Focus

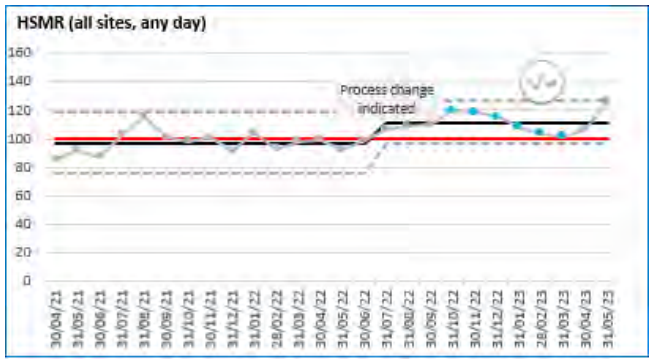
Full report on learning from completed investigations to be included in CMO report to Quality Committee and Board.

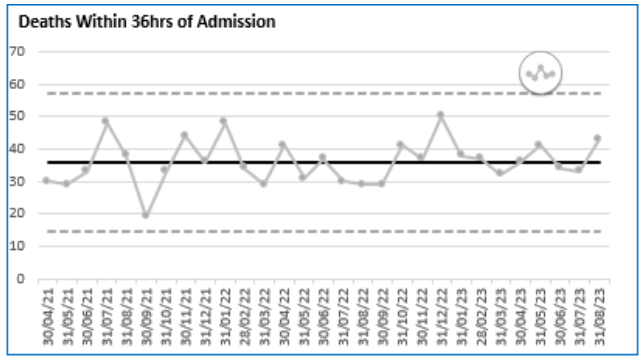


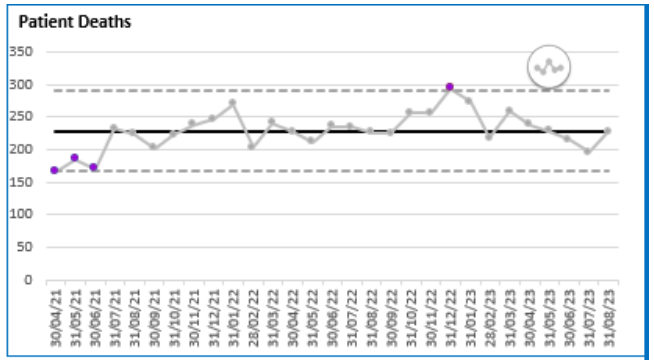


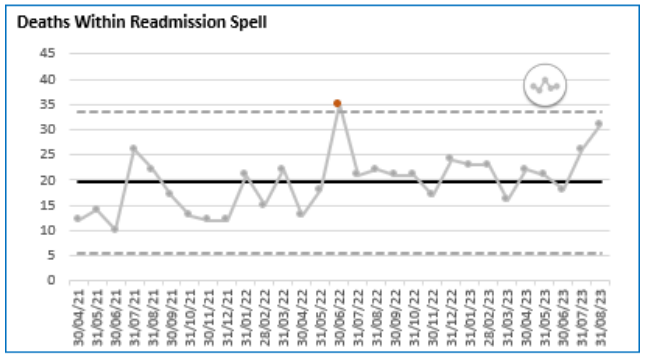


Quality (3) – Effective & Mortality









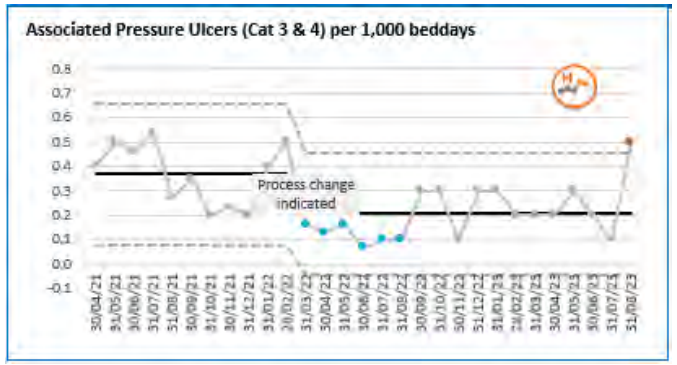
Please see the separate 'Mortality Update' which has been submitted to the Board outlining the imminent development of a new suite of mortality metrics. This new development will be the standard mortality output for all committees – Board, IPR and Quality Committee.

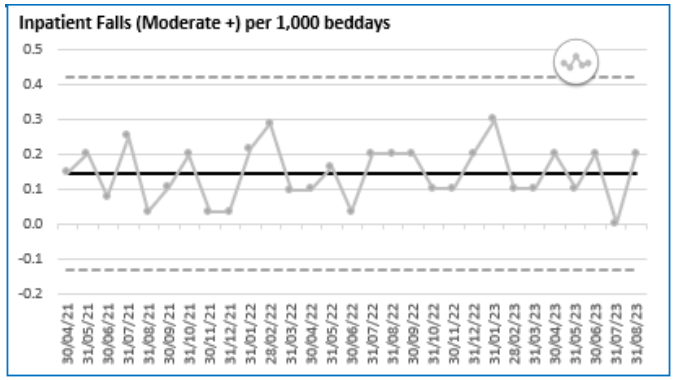
The headline mortality figure that we will report and which will align with the key metric in Patient First will be HSMR for the whole of UHD.
We will support this with an evolving suite of relevant metrics which will adapt to need and any risks.

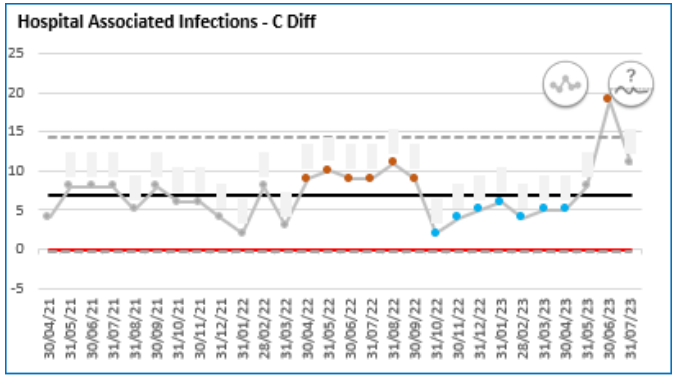
As previously reported to board, all formally reported mortality metrics are at least 5 months old and any trends are about a year old. As a trust we need to be mindful and sighted on this data and we will also use some more contemporaneous sources from the medical examiner and learning from deaths review.

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

Quality (2) – Safe







Background/target description

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

Performance

Clinical practice:

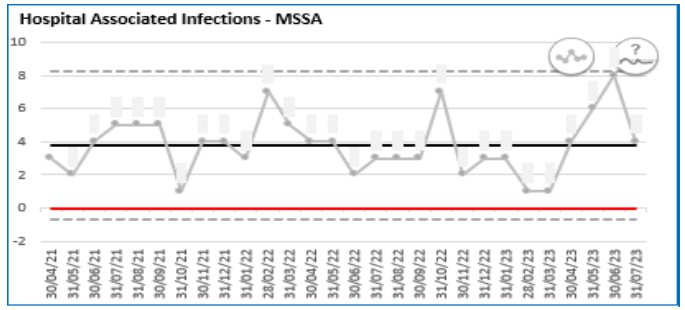
- There has been an increase in reported Pressure Ulcers in month with eleven new category three pressures ulcers reported which are following the appropriate investigation.
- There has been an increase in number of serious falls incident in month with four falls reported (one severe and three moderate). These falls are following the appropriate scoping and investigation process.

Infection Prevention and Control

- Reportable cases across all organisms have seen a month-on-month reduction since June. Increase in UTI and Hepatobilary as source are noted.
- C.difficile cases have reduced although there is a theme around increase in relapses which is being reviewed the weekly MDT.
- August saw two ward closures, both due to COVID-19
- One of the C.difficile incident was later declared an outbreak and full report to go to IPG.
- There are a number of post infections reviews being moniotred and updates with reports back through Care Groups.
- The team are assessing themes as part of the PSIR Framework, including management of urinary catheters, IV cannulae and CDI relapses

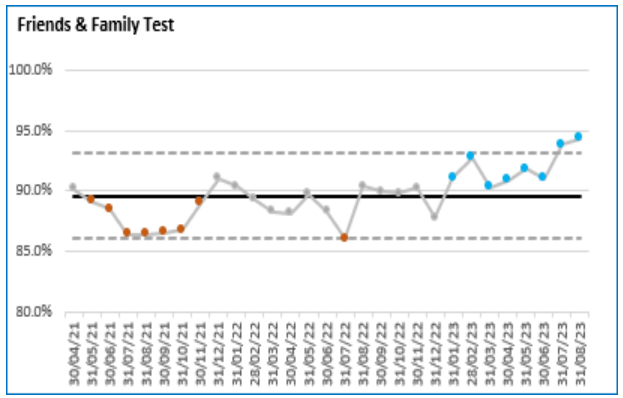
Key Areas of Focus

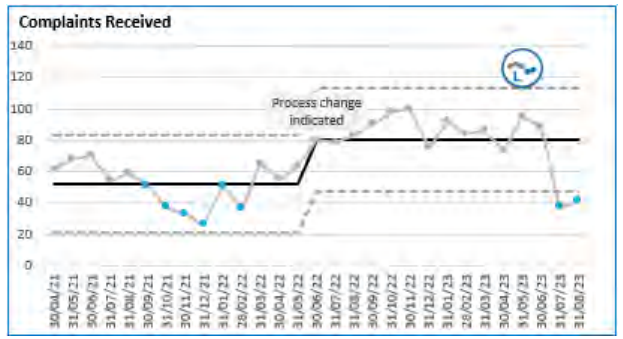
Full report on learning from completed scoping meeting and investigations to be included in CMO report to Quality Committee and Board.

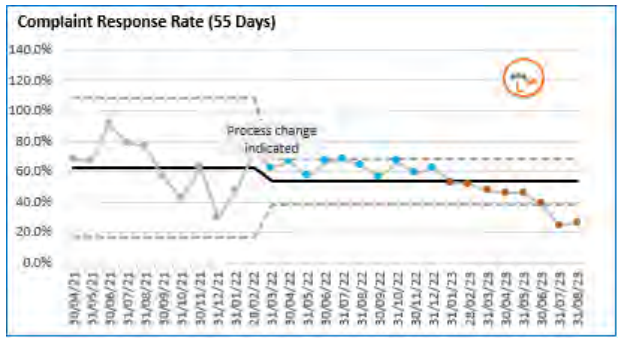


Organism	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Cdiff	11	9	2	4	5	6	4	5	5	8	19	11	4
eColi	7	9	6	7	5	10	7	14	5	8	17	14	8
MRSA	0	1	1	0	0	1	0	0	1	0	0	0	0
MSSA	3	3	7	2	3	3	1	1	4	6	8	4	4

Quality (3) – Caring







PALS and Complaints Data for August 2023:

Overview:

- 564 PALS concerns raised
- 27 new formal complaints (remain within our control measures)
- 14 Early Resolution complaints (ERC) processed.
- The number of complaints that were responded to and closed in August were 44.

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

Assure (1) : The reduced number of complaints open continues to reflect the change in process of the recording of all new complaints. The complaints team now advise the open complaint date as the date in which consent and conformation of investigation points has been received. This follows best practice and avoids duplication of complaints reporting.

Advise (2): The number of open complaints over 55 days continue to be prioritised within the complaints team and care groups.

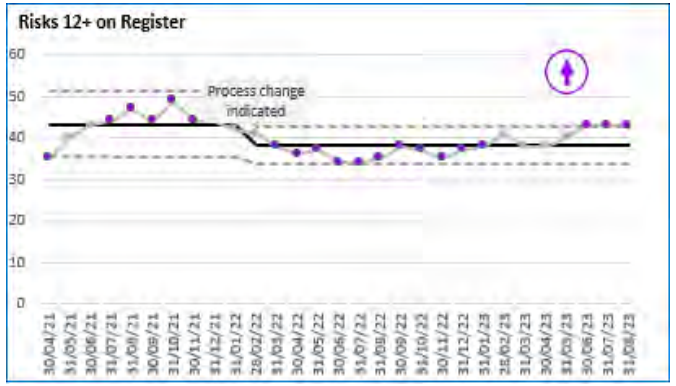
Friends and Family Test (FFT)

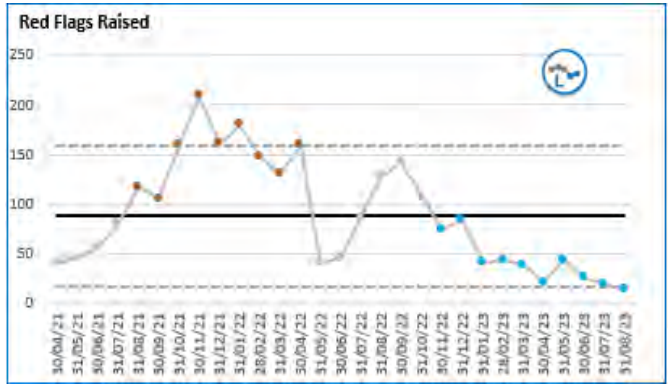
Assure (3): An error in transferring ED data for FFT text messaging service has been seen due to the change from Symphony to Agyle. This has meant no text messages have been sent for ED and thus no FFT results. Trust wide (excluding ED) our FFT results are near to 95%.

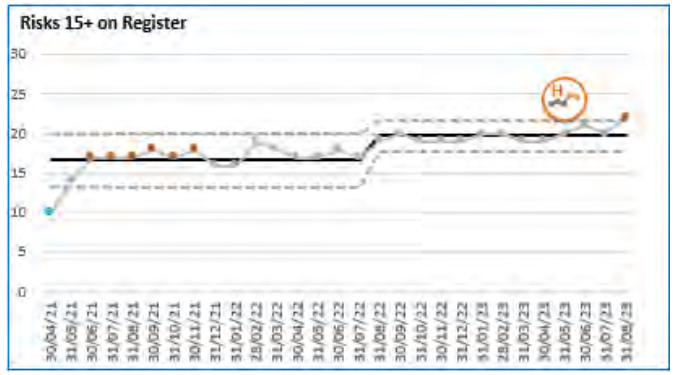
Mixed Sex Accommodation Breaches

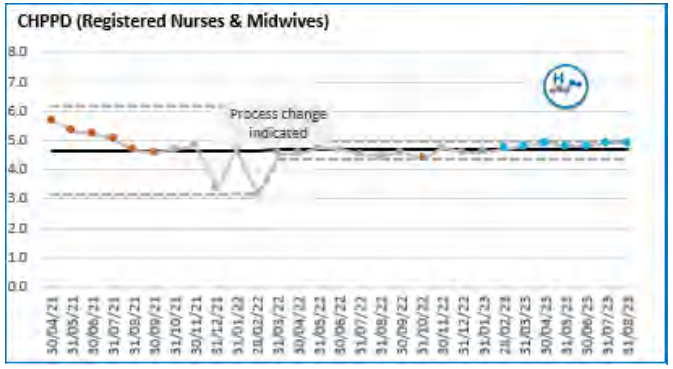
There were no reported MSA incidents in August 2023 – continued monitoring of areas continues with care group matrons.

Quality (4) – Well Led









Performance

- August CHPPD for registered nurses and midwives remained static at 4.9. Guidance for organisational level CHPPD for registered nurses and midwives advises this should be >3.
- The Red Flag data for August shows a further reduction with 13 raised this month compared to 19 in July. No critical staffing incidents were reported during this period indicating safe staffing was maintained.

Key Areas of Focus

- Separate Risk Report provided to TMG, Quality Committee and Board.
- Number of risks 12+ remains high. Risk reviewed in accordance with risk management strategy.

Summary of compliance UHD overall:

Current Risk Grading	*No: of risks under review*	*Number of Risks compliant with Risk Appetite timescales*	*% of Risks Compliant with Risk Appetite timescales*	*Month on month position*
12 and above	41	39	95%	⟷
8 to11	88	78	89%	↑ 2%
4 to 7	77	70	92%	⟷
1 to 3	3	3	100%	↑ 20%
Total	**209**	**190**	**91%**	↑ 2%

Safe Staffing (CHPPD) - Total (Day & Night Combined) August 2023

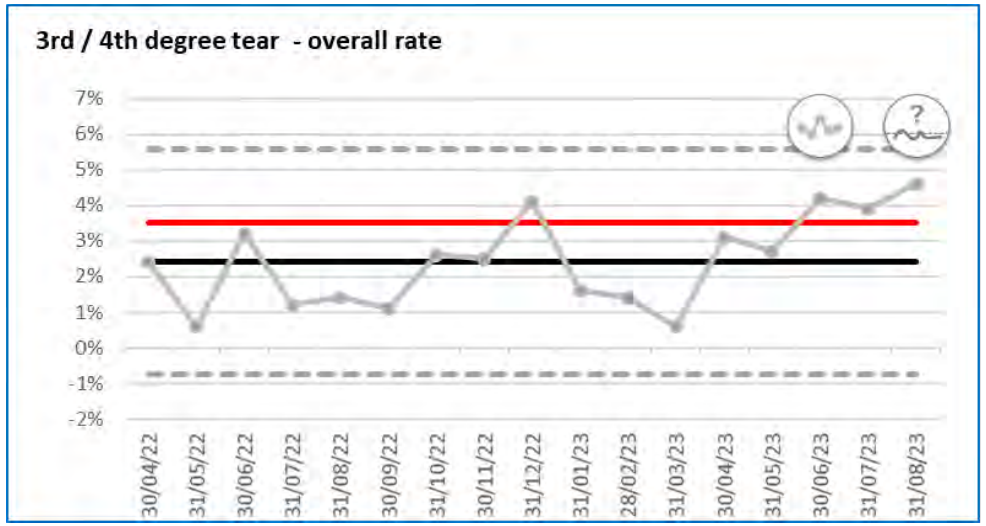
Hospital Site name	Patient Count	Registered Nurses/Midwives			
		Total monthly planned staff hours	Total monthly actual staff hours	Fill Rate %	CHPPD
Poole Hospital	15157	79211.3	76318.6	96.3%	5.0
Bournemouth & Christchurch	15493	76149.2	72637.0	95.4%	4.7
UHD Total	30650	155360.5	148955.6	95.9%	4.9

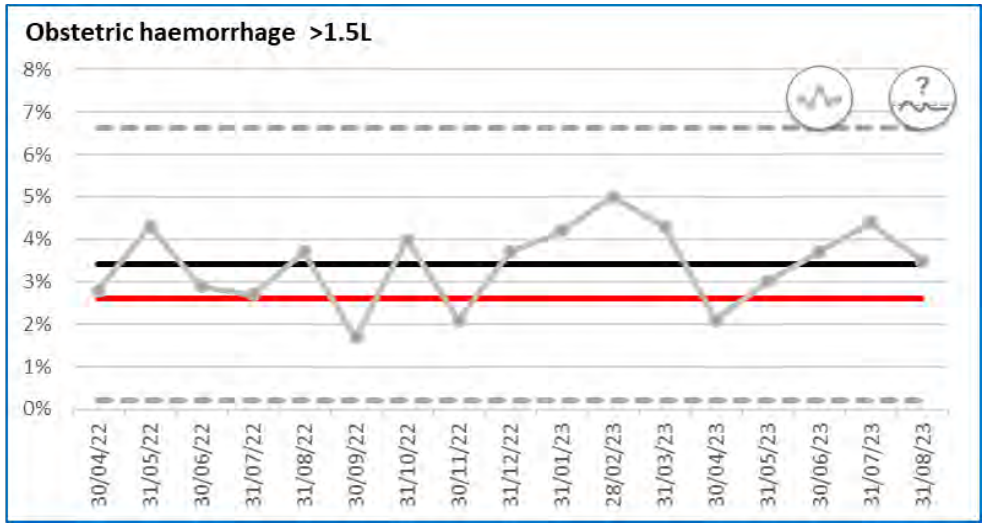
Maternity (SPC)

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

Maternity - Areas of Focus

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
3rd / 4th degree tear - overall rate	Aug 23	4.6%	3.5%			2.4%	-0.7%	5.6%
Obstetric haemorrhage >1.5L	Aug 23	3.5%	2.6%			3.4%	0.2%	6.6%





Maternity (1)

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

Maternity Perinatal Quality Surveillance Scorecard

Perinatal Quality Surveillance scorecard	Metric	Alert (national standard/ average where available)	23-Feb	23-Mar	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Perinatal	Red flags: 1:1 care in labour not provided	0	0	0	0	0	0	1	0
	3rd/4th degree tear overall rate	>3.5%	1.40%	0.60%	3.1%	2.70%	4.2%	3.9%	4.6%
	Obstetric haemorrhage >1.5L	>2.6 %	2.10%	4.30%	2.10%	3.0%%	3.7%	4.4%	3.5%
	Term admissions to NNU	National <6%, Regional <5%	3.40%	6.20%	5.9%	6.50%	5.50%	4.30%	4.50%
	Apgar < 7 at 5 minutes	<1.2 %	2.40%	1.10%	2.3%	0.0%	1.10%	0.70%	0.0%
	Stillbirth number	Actual	1	0	4	2	1	0	0
	Stillbirth number/rate (per 1,000)	> /1000	3	0	13.29	7	3	0	0
Workforce	Rostered consultant cover on Delivery Suite - hours pw	<72	72	72	72	72	72	72	72
	Dedicated anaesthetic cover on Delivery suite - per week	<58	58	58	58	58	58	58	58
	Midwife/band 3 to birth ratio (establishment)	01:23	01:21	01:21	01:21	01:21	01:21	01:21	01:21
	Midwife/band 3 to birth ratio (in post)	01:23	01:23	01:25	01:25	01:24	01:24	01:25	01:22
Feedback	Number of compliments (Smiles via Badgernet)		18	43	42	37	41	66	51
	Number of concerns (PALS)		2	0	0	0	4	3	0
	Complaints	3	0	4	2	3	2	2	0
	FFT Repsonse -returns as % of deliveries not mandated now)		12%	40%	43%	46%	87%	80%	62%
Training	UHD Mandatory training - women's health	90%	87%	86%	82%	84%	86%	88%	88%
	PROMPT/Emergency skills all staff groups	90%	94%	94%	82%	82%	84%	86%	not known
	K2/CTG training all staff groups	90%	85%	85%	91.76%	96%%	94%	96%	95%
	CTG competency assessment all staff groups	90%	not known	not known	91.76%	96%%	94%	96%%	95%
	Core competency framework compliance	90%	not known	84%	84%	87%	89%	86%	84%
	Coroner Reg 28 made directly to the Trust	nal <6%, Regiona	N	N	N	N	N	N	N
	HSIB/CQC etc. with a concern or request for action		Y (CQC)	Y (CQC)	Y (CQC)	Y(CQC)	Y(CQC)	Y(CQC)	Y(CQC)

Data and Targets

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

Performance

There are 2 areas currently flagging as red RAG rated , see slide 13 SPC charts :

- 3rd/4th degree tear overall rate : the SPC chart in slide 13 shows normal cause variation. The mean sits below the target which can be achieved but not consistently.
- Obstetric haemorrhage >1.5L : the SPC chart in slide 13 shows normal cause variation. The mean sits above the target which is achieved infrequently.

There are 2 areas currently RAG rated as amber

- Training –ongoing challenges to meet 90% compliance due to staff vacancies continues
- PALS no national benchmarking for this area, and not concerning within professional judgement accepted range.

Improvement continues in the Apgar <7 at minutes metric has been noted following staff training and improvement in Term admissions to NICU this may be due to staff awareness.

Key Areas of Focus

3rd/4th degree tear overall rate : performance for this metric has been reviewed and identified and above national rate for 3 consecutive months QI project commenced to support learning on caring for the perineum under the oasis bundle (A national programme)

Obstetric haemorrhage >1.5L : performance for this metric has been reviewed has remained elevated for 3 consecutive months. In line with the implementation of the national Patient Safety Incident Response Framework (PSIRF) a Thematic Review' will be commenced .

Term admissions to NNU : Deep dive continues and will be reported to the Trust Board

Training

Not meeting 90% compliance for PROMPT MDT training- ongoing work with the team to improve this standard.

Maternity (2)

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

CQC Maternity Ratings UHD Assessment 2019 and Oct 2022.	OVERALL	SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL LED
	Inadequate	Inadequate	GOOD	OUTSTANDING	OUTSTANDING	Inadequate
Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their Trust as a place to work or receive treatment (reported annually)						73.2%
Proportion of speciality trainees in O&G responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (reported annually)						89.3%

National position & overview

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

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

MBRRACE reportable cases:

There have been no reportable cases for MBRRACE in August

However overall PMRT cases year to date figures remain high , and above expected range .In agreement with the ICB there will be an external review with Somerset which will occur now in October due to Somersets ability to facilitate. The scope of the review will be all PMRT cases from January 1st to May 31st.Findings from this review will be shared with the Trust Board.

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

Matters for Board information and awareness

Patient Safety Incident Response Framework (PSIRF)

PSIRF is being implemented in maternity this autumn and our top 3 areas identified for thematic reviews are

1.Stillbirth

2. Term admissions to NICU

3 PPH greater than 1.5 liters.

Other incident to note from August report

Insufficient numbers of healthcare professional: due to high midwifery vacancy rate

- Causing disruption in service and delay in care.
- Training compliance standards not being met
- 17 incidences of homebirth suspension

Trust Board Reading room reports to be noted:

- Final SI reports for board report
- L105470 and L107233

Progress in achievement of Year 5 Maternity incentive scheme

MIS year 5

Year 5 standards have been released. In July, a second version has been published and we will be working to these new standards

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

At risk areas are:

Safety action 4 : Obstetric medical workforce needs to provide a robust locum induction package –resources required to support this.

Safety action 6 :Saving babies lives version 3.1 was released in July. Element 6 outlines pathways which are multi -disciplinary and will require trust wide pathway and response. Further assurances by quarterly reports are required to Trust Board and oversight by the ICB . The 1st review by the ICB is scheduled for September.

Safety action 8 :In house training, This remained a challenge in August moving to digital beat records of attendance however accurate digital data not available and the teams are working to provide this.

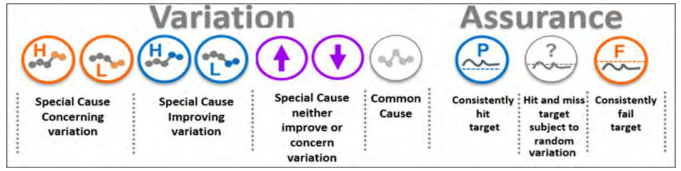
Other areas we are improving are:

Safety action 9 Additional support was provided in August by the NHSI-AQUA programme they will continue to support our safety champions and the team by providing guidance and useful resources around data, intelligence , using analysis to underpin timely evidence decision making and having better conversations for safety improvement.

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	Aug 23	0.5	-			0.2	0.0	0.5
Inpatient Falls (Moderate +) per 1,000 beddays	Aug 23	0.2	-			0.1	-0.1	0.4
Medication Incidents (Moderate +) per 1,000 beddays	Aug 23	0.1	-			0.0	-0.1	0.2
Medication Incidents (All) per 1,000 beddays	Aug 23	4.4	-			5.1	3.3	6.9
Patient Safety Incidents (All) per 1,000 beddays	Aug 23	42.0	-			38.9	33.8	44.0
Patient Safety Incidents (Moderate +) per 1,000 beddays	Aug 23	1.3	-			0.5	0.1	1.0
Serious Incidents	Aug 23	2				3	-1	8
Never Events	Aug 23	0	-			0	-1	1
Hospital Associated Infections - MRSA	Aug 23	0	0			0	-1	1
Hospital Associated Infections - MSSA	Aug 23	4	0			4	0	8
Hospital Associated Infections - C Diff	Aug 23	4				7	-1	15
Hospital Associated Infections - E Coli	Aug 23	8	0			7	-2	16
Risks 15+ on Register	Aug 23	22	-			20	18	22
HSMR (all sites, any day)	May 23	126.2	100.0			111.3	96.4	126.3
Mixed Sex Accommodation Breaches	Aug 23	0	0			4	-13	21
Complaints Received	Aug 23	41	-			80	47	113
Complaint Response Rate (55 Days)	Aug 23	26.3%				53.3%	38.0%	68.7%
Friends & Family Test	Aug 23	94.4%	-			89.6%	86.1%	93.1%
			0					
Patient Deaths	Aug 23	227	-			228	167	290
Deaths Within 36hrs of Admission	Aug 23	43	-			36	15	57
Deaths Within Readmission Spell	Aug 23	31				20	6	34
Risks 12+ on Register	Aug 23	43				38	34	43
Red Flags Raised	Aug 23	13				88	16	159
CHPPD (Registered Nurses & Midwives)	Aug 23	4.9				4.7	4.4	5.0



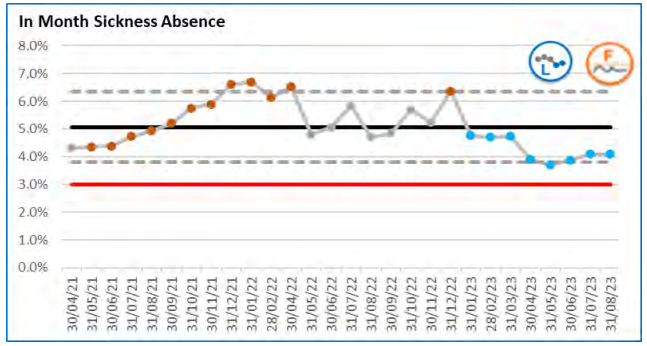
Our People

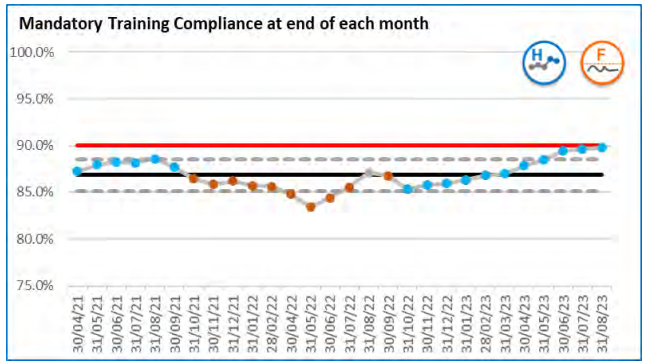
Karen Allman
Chief People Officer

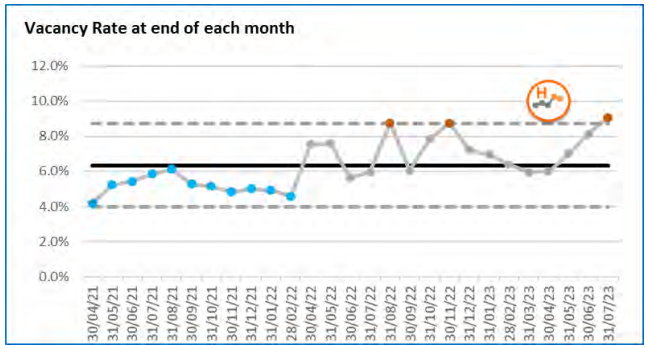
Operational Leads:
Irene Mardon - Deputy Chief People Officer

Committees:
People and Culture Committee

Well Led - Workforce (1)







Performance

- Rolling 12 month Turnover rate (excluding fixed term temp) is at 12.3%, which is a slight reduction on last month and continues the downward trend.
- In month sickness absence for August 2023 was at 4.1%, the same as previous month. Latest rolling 12 month rate (as at end of August 2023) is 4.7% which is a reduction on the previous month.
- Mandatory Training has improved slightly to 89.8% as at end of Aug 2023 but is still under the 90% across all sites.
- Latest vacancy position is 9.1% (Jul 2023). This figure incorporates the latest position for July – including any changes made in arrears. The increase is due to budget adjustments being made in arrear in ESR which has also seen June's figures rise. work is underway with finance and BI colleagues to understand the increase and review data sources.

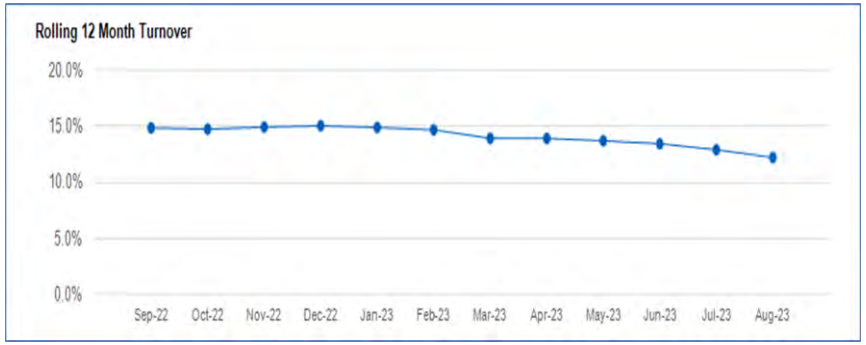
- Appraisal compliance for values based as at end of Aug is 35.4%. Medical & Dental is 58.2%.
- Trust wide agency spend should be no more than 3.7% of the overall pay bill. Currently the Trust at M4 is at 4.68%

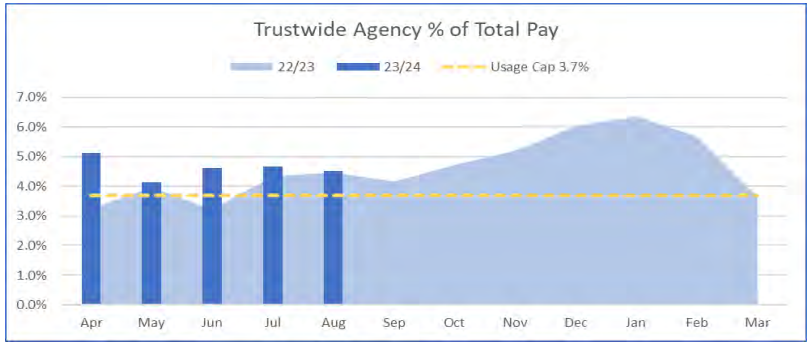
Underlying issues:

- Data continues to adjust as the ESR establishment work and data cleanse process continues.
- Agency spend has increased in the Medical Care Group M4 7.33% to 8.80% in M5, The Surgical Care Group was 4.20% in M4 and is now 4.07% in M5. Women's, Children, Cancer and Support Services Care Group was 4.41% in M4 and is now 3.19% in M5. Surgical Care Group is still above 3.7% for M5.

Key Areas of Focus

Information Governance is currently below the 95% national compliance required – currently it is 90.5%.

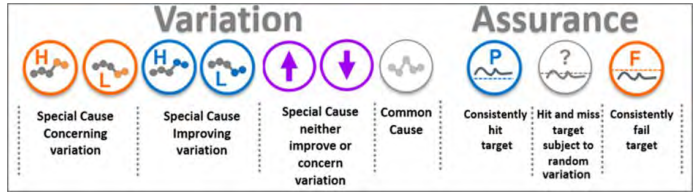




Performance at a glance
Well Led - Key Performance Indicator

UHD Workforce

KPI	Latest month	Actual	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Vacancy Rate at end of each month	Jul 23	9.1%	-			6.3%	4.0%	8.7%
In Month Sickness Absence	Aug 23	4.1%	3.0%			5.1%	3.8%	6.4%
Mandatory Training Compliance at end of each month	Aug 23	89.8%	90.0%			86.9%	85.1%	88.6%
Temporary Hours Filled by Bank	Aug 23	53.7%	-			53.8%	47.1%	60.5%
Temporary Hours Filled by Agency	Aug 23	25.8%	-			15.8%	13.2%	18.4%



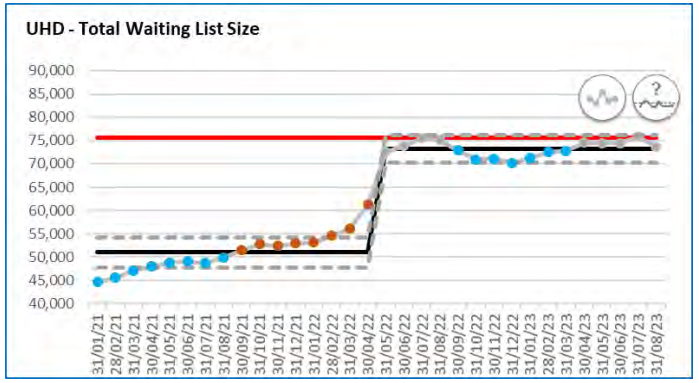
Population Health and System Working

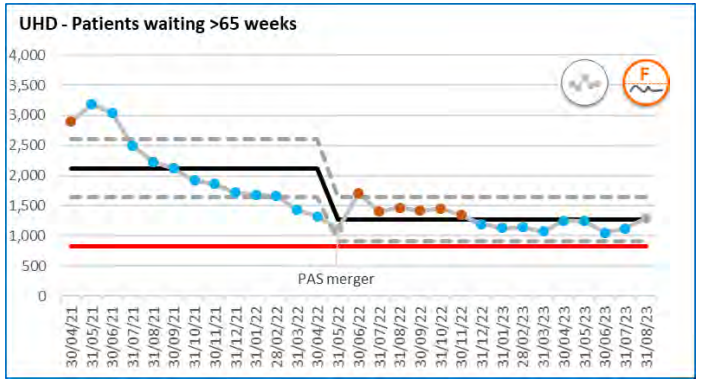
Mark Mould
Chief Operating Officer

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

Committees:
Finance and Performance Committee

Responsive – (Elective) Referral to Treatment)





	Standard	Merged Trust	% of pathways with a DTA
Referral To Treatment			
18 week performance %	92%	56.99%	
Waiting list size (and trajectory)	75,368	73,727	17%
Waiting List size % variance compared to trajectory	0%	-2.2%	
No. patients waiting 26+ weeks		20,703	23%
No. patients waiting 40+ weeks		9,969	24%
No. patients waiting 52+ weeks (and % of waiting list)	6.1%	4,501	25%
No. patients waiting 65+ weeks (and % of waiting list)	1.8%	1,293	27%
No. patients waiting 78+ weeks (and % of waiting list)	0.1%	43	63%
No. patients waiting 104+ weeks (and % of waiting list)	0.0%	0	-
% of Admitted pathways with a P code		97.35%	

Data Description and Target

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

Performance

There was a total of 25 cancelled inpatient operations, 114 daycases and 364 outpatient appointments in August due to industrial action. However, taking account un-booked activity due advanced notice of IA taking place, activity reduced by 126 inpatients, 299 daycases and 2,143 outpatient appointments in comparison to usual planned rates of activity. The requirement to reschedule all cancelled operations and procedures has a further impact still.

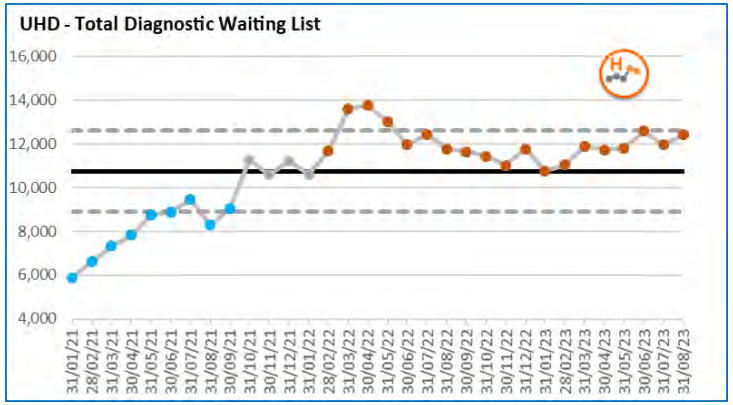
- The total waiting list (PTL) fell to 73,727 at the end of August largely due to increased RTT validation. This is 1,911 below the operational planning trajectory for August 2023 (75,638).
- The adverse impacts of industrial action (IA) on long waiting patients have been minimalised but a reduction in capacity has meant that 43 patients breaching 78 weeks remain at the end of August; an increase of 9 since July 23. Breaches are in 7 surgical specialties and the School Age Neurodevelopmental Service.
- 65 week wait variance to plan increased to +462 (plan 831) however, a sustained reduction in the cohort of patients who will breach 65-week waits if not seen or treated by March 2024 is being maintained and the variance to plan is reducing in this group.

Key Areas of Focus

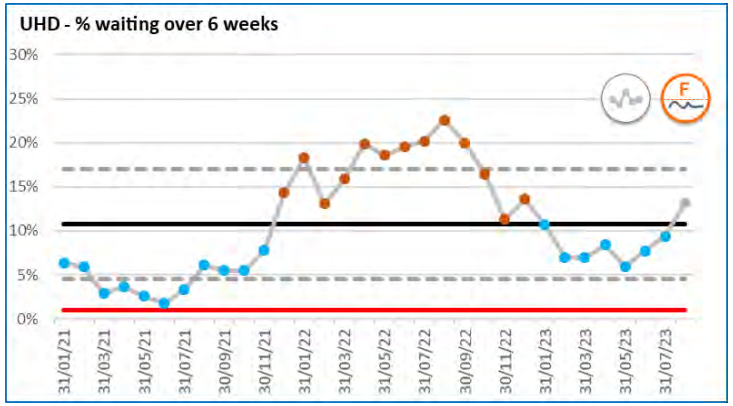
Internal actions are being taken to mitigate against the further loss of routine elective capacity in September and October 2023 due to industrial action and its impact on long waiters. Including:

- Increasing in the number of theatre sessions scheduled and prioritising this capacity for specialties who have the greatest capacity challenge for 65 week waits.
- Applying strict booking criteria for allocation of insourcing theatre lists or clinics to managing long waiters.
- Additional clinics for School Age Neurodevelopmental services will continue to be provided through an ISP in quarter 3
- Additional capacity for cancer 2-week waits is being targeted to reduce the impact of increased cancer referrals on routine elective capacity.
- Internal waiting list initiatives are being run over next 3-6 months alongside actions to increase productivity within core capacity. These include wait-in-line reviews in neurology and endocrinology, validation hubs and a review of clinic utilization.

Responsive – (Elective) Diagnostic Waits



Diagnostic Performance (DM01)				
% of >6 week performance	*(6+ Weeks / Total)*	1%	1642/12405	13.2%



Data Description and Target

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

Performance

Consistent improvement in overall diagnostics (DM01) performance had been delivered since January 2023. However, August performance was 13.2% compared to 9.4% at the end of July (mainly due to reduced waiting list initiatives in month).Further improvement is required to meet the 1% target.

Endoscopy performance has remained stable at 12.8% at the end of August (12.6% at the end of July).

Echocardiography performance has deteriorated, moving from 16.8% in July to 23.8% in August.

- Heart failure remains the challenge in achieving DM01, Additional Heart Failure clinic capacity from visiting a GP is in place from August.

Neurophysiology deteriorated from 8.1% in July to 24.0% in August.

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

Radiology performance has deteriorated since July (7.7%) to 10.4% in August.

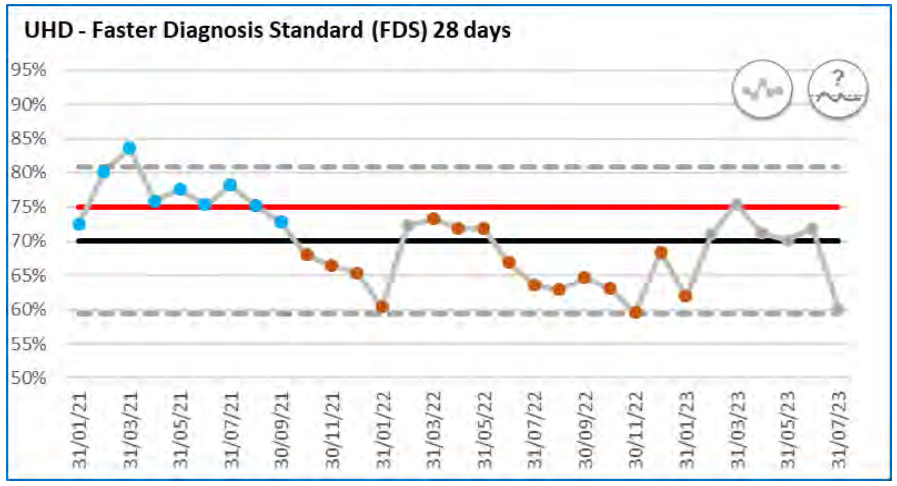
- Imaging – the target is not being achieved, predominately due to ongoing reduction in cardiologist CT / MRI sessions and also for August; reduced ultrasound performance (increased numbers of ultrasound breaching patients due to BH, unfilled waiting list initiative sessions and reduced outsourcing to AECC).

Key Areas of Focus

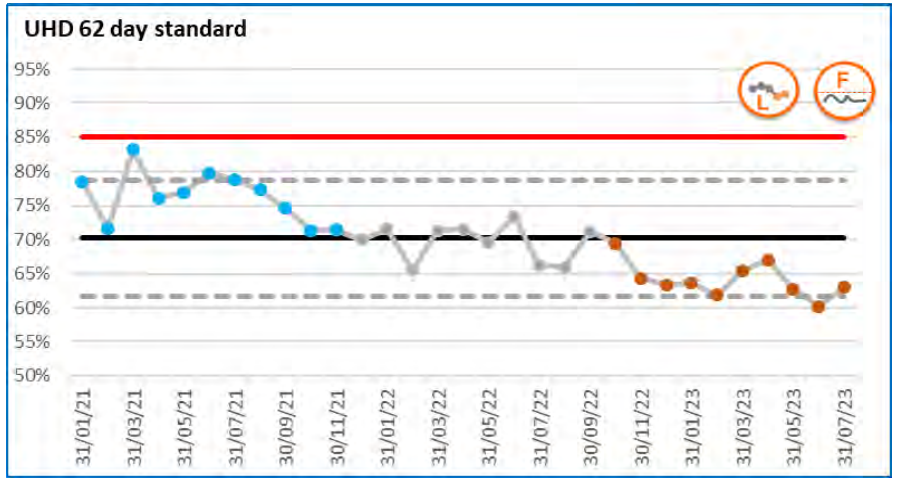
- Endoscopy: Trans nasal endoscopy is due to commence in Sep using TIU/old ACU capacity at PH. Cytosponge activity increasing. Job plans being reviewed to identify opportunity to increase endoscopy in line with JAG recommendation.
- Dr Doctor to be integrated with e-Camis for Endoscopy with ongoing management of bookings team to ensure high utilisation (currently at 88%) and low DNAs. New report has been developed to pull utilisation data.
- Delivery of a reduction in DNA using dedicated A&C support and recruitment campaigns in Echocardiology.
- Continued assistance from AECC planned in September for ultrasound and MRI recovery.
- Bring in agency Radiographers/Sonographers (via Healthshare) to start CDC CT and U/S services.
- Reviewing cardiac MRI provision for DCH patients (circa 20 slots/month).
- Mitigation of the impact of industrial action in all modalities.

Responsive (Elective)
Cancer FDS & 62 Day Standard

28 Day Faster Diagnosis Standard (Target 75%)
Finalised UHD July Performance (60.1%)



62-Day Standard (Target 85%)
Finalised UHD July Performance (63.0%)



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. 62 Day Standard = 85%
- The number of 62-day patients waiting 63 days or more on their pathway – no more than 220 by March 2024.

Finalised July Performance

- 28 Day Faster Diagnosis Standard - Performance in July was finalised at 60.1% (6 out of 14 tumour sites achieved the target). The main tumour site that affected the July position was Skin. Rapid recovery actions are in place with an expected improvement to be seen in September.

- 62-Day performance in July (63.0%) increased by 2.2% compared to the previous month. Surgical cancellations due to the industrial action increased the breaches in month.

- The total number on the UHD PTL over 62 days increased by 11 to 302 for July which remains within the 50% fair shares target allocation of the March 2024 target set regionally.

Predicted August Performance (un-finalised)

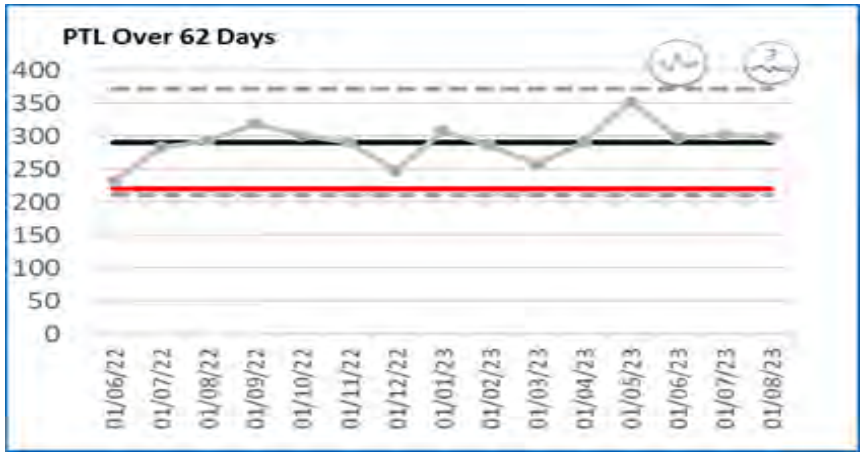
- 28 Day Faster Diagnosis Standard - August's performance is currently at 54.1% which is a decrease of 6.0% from July and below trajectory (trajectory 75.0%). This is mainly due to the ongoing impact of the known Skin challenges. An additional 1350 fast track slots have been opened to support recovery in September. Skin referrals saw a 13% increase for both June and July compared to the same period last year.

- 62 Day performance - The provisional performance for August is currently 48.3%. Performance levels are expected to increase as treatments are reported throughout the month. A high number of breaches were confirmed in August – Urology saw a 50% increase in breaches, mainly due to a high number of patients starting active surveillance / hormone treatment following a diagnosis of prostate cancer. This is not expected to impact future months.

- The total number of patients over 62 days decreased in August to 299 and remains within the target set regionally. Work is ongoing with the Care Groups to reduce the number of patients over 62 days including weekly clinical reviews of all long waiters.

Responsive (Elective)
Cancer over 62 Day Breaches

62 Day Breaches (Target July: 225)
Finalised UHD July Performance: 302



High Level Performance Indicators

Cancer Standards	Standard	Final Jul-23	Predicted Aug-23
31 day standard	96%	96.2%	97.0%
28 day faster diagnosis standard	75%	60.1%	54.1%
62 day standard	85%	63.0%	46.4%

Key Areas of Focus

The priority areas of focus for the next quarter continues to be Colorectal, Gynaecology and Urology. In addition to this, first outpatient capacity within the Skin pathway has a rapid improvement plan in place to support the Trust's performance against trajectory and to prevent any impact to the 62D Standard.

Key areas of focus include:

Dermatology:
- Delivery of waiting list initiatives in Skin to increase OPA capacity – an additional 1350 slots in August and September.
- Finalisation of the teledermatology plan within UHD, whilst supporting system wide teledermatology projects, which support demand management.

Gynaecology:
- Implementation of the Gynae PMB (Post Menopausal Bleeding) pathway transformation to reduce the demand for 2WW referrals and to ensure patients are seen in the most appropriate setting for their needs. Clinical sign off expected in Sept 23.

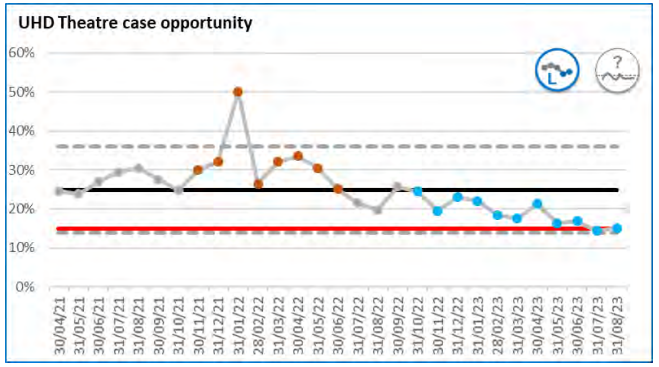
Colorectal:
- Cessation of the FIT <10 pathway at UHD. This will move to Primary Care in Q4 2023/24.

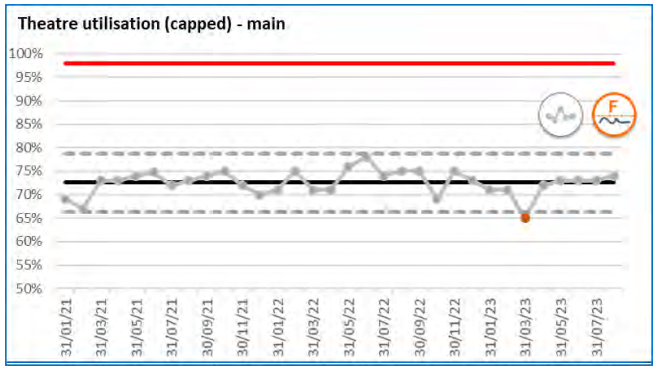
Breast:
- Recruitment of a Breast Radiology Locum for 3 months to support capacity gaps.

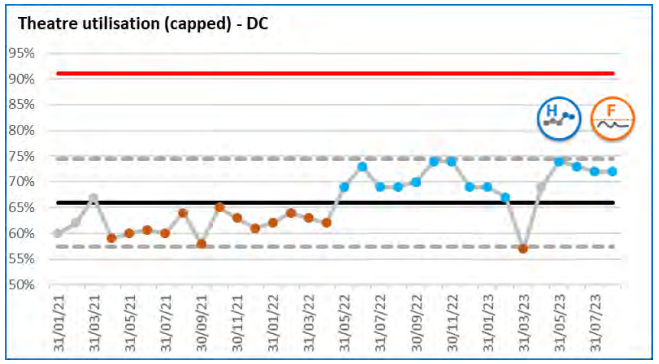
Urology:
- Continuing to progress the development of a business case to move the Urology service to a nurse led diagnostic pathway planned to go live in Quarter 3, 2023/24.

Cross tumour sites:
- Promoting excellence in the basics including continuation of weekly clinical reviews of all long waiters to meet the over 62 Day trajectory for 220 patients by March 2024.
- Ensuring standardisation across all tumour sites for clinical triaging to improve efficiencies in outpatient clinic utilisation.
- Ensuring all 2WW referrals from Primary Care meet the minimum data requirements for a suitable referral into the Trust.

Responsive (Elective)
Theatre Utilisation







Data Description and Target

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

Performance

- A significant reduction in the case opportunity has been consistently delivered. The 15% target was achieved in August .
- Aug 2023 month end snapshot of intended (booked) utilisation is 83% but actual utilisation of 73.8%, which is down on the previous month. Ongoing industrial action is hampering sustaining performance due to cancellations and impact to utilisation. Excluding Orthopaedic lists, increases utilisation by 3% demonstrating some improvement on Orthopaedic elective lists.
- Lost minutes to early finishes has increased to 44 min average as compared to 33 min reported last month with Oral Surgery lists accounting for most of the increase.
- The time spent in theatre carrying out procedures is also showing improvement with an increase to touch-time minutes and a decrease in inter-case downtime.
- Orthopaedic lists continue to struggle to achieve utilisation > 70%. OMF are starting to show a sustained improvement.
- Improvement in lost minutes to late starts has been sustained, driven by improvements across Ortho lists, with much less variation indicating a controlled process.
- Successful recruitment campaign now a key enabler to increasing the session being run. Plan to re-establish template aligning to on-boarding, skill mix and development of new starters.

Underlying issues:

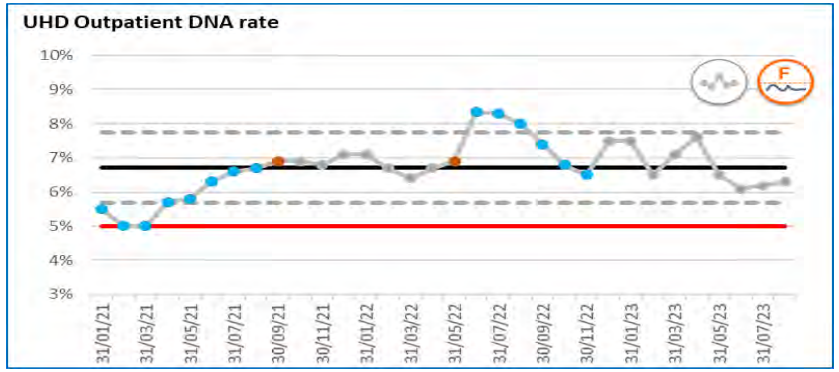
- Equipment issues including coordination of equipment has impacted orthopaedic late starts and an overall utilisation impact of c3%, noting improvement.
- Ongoing staffing shortages across theatres remains a significant barrier to providing a full template for all surgical specialities, noting improvement as above.
- Strike days are impacting across all theatre efficiency markers.

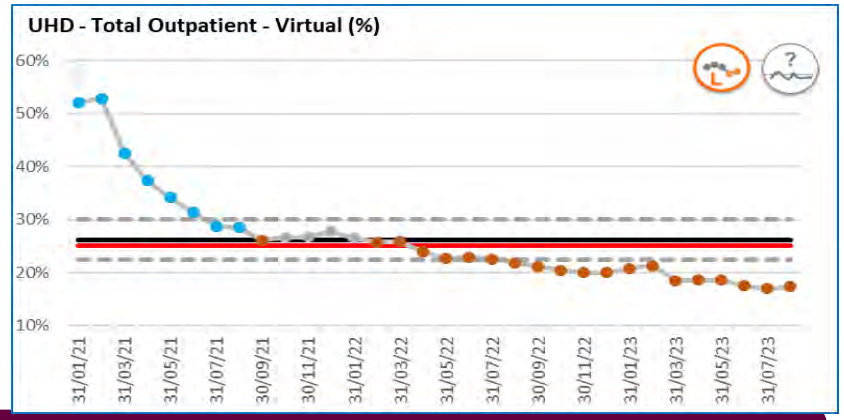
Key Areas of Focus

- Targeted work underway to focus on orthopaedic utilisation, including booking habits and integrate newly recruited 'kit coordinator role,' to improve list utilisation and reduce case opportunity.. This will increase number of patients being listed in addition to efficiency metrics.
- Profiling theatre activity factoring in new starters and improved workforce position has been completed with plan to increase Ortho activity in Oct with trajectory indicating full templet by end of March 2024 (subject to loss of staff).
- The implementation of the virtual pre-op assessment is on-track for 1st week of Oct 23.
- Piloting 'super lists,' on the 23rd Sept by way of proof of concept for working differently. .

Responsive (Elective) Outpatients

		Standard	This Year	Trust Perf
Referral Rates (MRR Return)				
GP Referral Rate year on year		-0.5%	41752	-24.2%
Total Referrals Rate year on year		-0.5%	62843	-27.7%
Outpatient metrics				
Overdue Follow Up Appointments (Cons-Led Only)				27619
New Attendances				19574
Follow-Up Attendances				29027
% DNA Rate	*(Total DNAs / New & Flup Atts)*	5%	3255 / 48601	6.3%
Hospital cancellation rate	*(Hospital Canx / Total Booked Appts)*		11709 / 71700	16.3%
Patient cancellation rate	*(Patient Canx / Total Booked Appts)*		8135 / 71700	11.3%
Reduction in face to face attendances (acute only)				
% telemed/video attendances	*(Total Non F-F / Total Atts)*	25%	8388 / 48601	17.3%





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 August increased to 6.3% and demonstrates normal variation around the mean percentage. The rollout of text appointment has commenced and there are plans to extend this across a wider range of services.

17.3% of attendances were delivered via telemedicine/video.

The number of patients overdue their target date for a follow up appointment reduced in August to 27,619 and demonstrates consistent month on month improvement. A pilot of using the 'quick question' functionality in DrDoctor to support validation of the follow up waiting list in Gynaecology was delivered in August and is now being extended to five other services in September.

Continued industrial action at UHD has had an impact on outpatient booking teams' capacity due to the volume of cancellations and rebooks required and reduced clinic capacity.

Key Areas of Focus

- Pilot using basic re-scheduling for the next phase of DrDoctor implementation, which will allow patients to request alternative appointment dates. The pilot commences in September in Gynaecology and Physiotherapy (Christchurch)
- Continued DrDoctor expansion to build on the soft launch undertaken of its 'Quick Question' and Broadcast messaging functionality within all services.
- Delivery of outpatient productivity improvements, which support a reduction in DNA rates, increased use of Patient Initiated Follow ups and increased clinic utilisation rates.
- Embedding the outpatient performance dashboard (including all Outpatient KPIs) into performance management practices at Care Group and speciality level.
- Continuing to promote telemedicine/video and the benefits for patients.

Responsive - (Elective) Screening Programmes

Breast Screening

High Level Board Performance Indicators **AUGUST** position :

BREAST SCREENING	STANDARD	ACHIEVED
Round Length within 36 months	90.00%	98%
Screening to first offered assessment appointment within 3 weeks	98.00%	99%
Screening to Normal Results within 14 days	95.00%	99%
Longest Wait Time (Months)	36	36
UPTAKE – QTR 2 (Apr – June)	70%	73%

Background/target description
To ensure the breast screening access standards are met.
Performance:
- KPI Targets have been achieved in August , noting that women are being screened at 25 – 30 months following the NHSE guidance for the post covid round smoothing process.
- Screening uptake for Quarter 2 was recorded at 73% which is an excellent improvement following the pandemic and exceeds the national target of 70%.

Underlying issues:
- Due to staffing issues across the peak holiday period the screening rate has dropped to (1700 per month) which is 60% of the required level. It is now crucial to increase and maintain screening at a much higher rate (2500 – 3000 per month) to keep the smoothing process on track. This will prevent significant breaches as we move through the round and address the expected peak in 2024 – 25.
- The new Facebook page is achieving excellent reach across the region and this is going from strength to strength.

Actions:
- A locum Radiologist is starting 5th September but Radiology cover is still under pressure due to a retirement in October.
- An IT assisted project is underway to enable a text messaging service implementation.

Bowel Screening

High Level Board Performance Indicators **AUGUST** position :

BOWEL SCREENING	STANDARD	ACHIEVED
SSP Clinic Wait Standard (14 days)	95%	100%
Diagnostic Wait Standard (14 days)	70%	100%

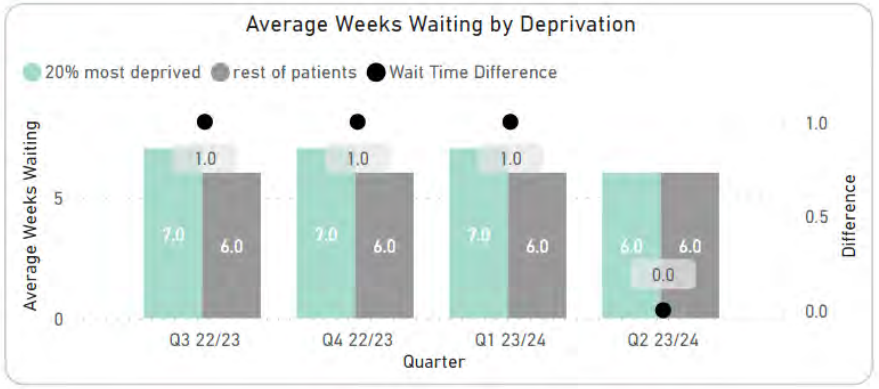
Background/target description
To ensure the bowel screening access standards are met.
Performance:
- SSP Clinic Wait Standard: This standard continues to be maintained at 100%.
- Diagnostic Wait Standard: This standard was delivered at 100% in August 2023.

Underlying issues:
- Lynch syndrome roll out has gone live for prospective and retrospective patients, meaning the programme is currently inviting an additional 4 patients per week.
- Next phase of age extension is currently delayed due to lack of accredited screener capacity at Dorset County (DCH). Escalated via the Dorset Endoscopy Network and currently confirming a date to meet with the DCH team to develop a plan. Commissioners aware and have requested age extension to go live by end of September.

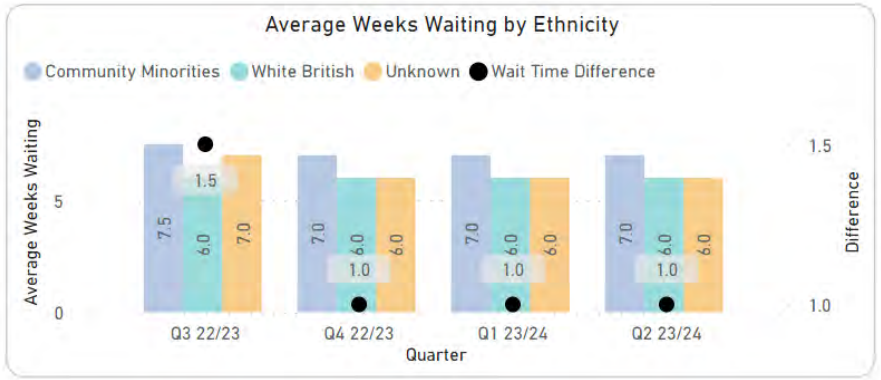
Actions:
- Develop plan with DCH to deliver required screening colonoscopy lists for patients in the west of the County
- Support three potential screeners through the accreditation process

Health Inequalities

Median Weeks waiting by Deprivation Group



Median Weeks waiting by Ethnicity Group and Age



Average Weeks Waiting by Age

Age Band	Q3 22/23	Q4 22/23	Q1 23/24	Q2 23/24
0-9	11.0	12.0	10.0	14.0
10-19	8.0	11.0	9.0	11.0
20-29	7.0	7.0	6.0	7.0
30-39	7.0	6.0	6.0	7.0
40-49	7.0	6.0	6.0	6.5
50-59	6.0	6.0	7.0	6.0
60-69	6.0	6.0	7.0	6.0
70-79	6.0	6.0	6.0	6.0
80+	6.0	6.0	5.0	6.0

Data Description and Target

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

Performance

Waiting list by Index of Multiple Deprivation (IMD) Analysing RTT activity in Quarter 2 to date, 8.4% of patients on the waiting list live in the 20% most deprived areas of Dorset. The median weeks waiting at the point of treatment shows **no variation** between the 20% most deprived and the rest of the population treated. At specialty level the greatest variation in Q2 exists in general surgery (11 weeks), paediatrics (7 weeks) and OMF services (3.5 weeks).

Waiting list by ethnicity: 10.8% of patients on the waiting list are from community minority ethnicity groupings. An analysis of the median weeks waiting by ethnicity grouping identifies **1 week variation** between patients within community minority groups and White British populations in Quarter 2 to date; this is consistent with the previous two quarters. At sub-Trust level variation in waiting by ethnicity is greatest in Ophthalmology and Elderly Medicine.

Waiting list by age band: There is variation between age and length of wait on the waiting list with the greatest variation between 0-19yrs and 20+ age bands. There has been a widening of the variation in the age band 0-9 years in Q2 to date. Paediatric waiting times in oral surgery, ENT and community paediatrics contribute to this variation. Improvement actions are in place to increase capacity and reduce waiting times in these areas.

Key Areas of Focus

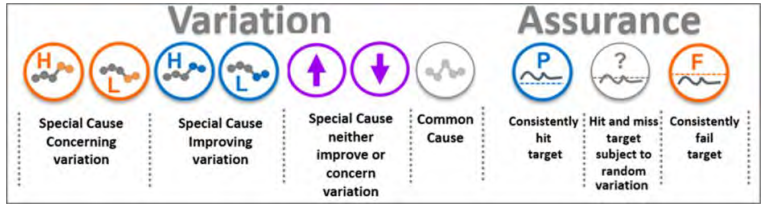
The Trust Health Inequalities group are working to:

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

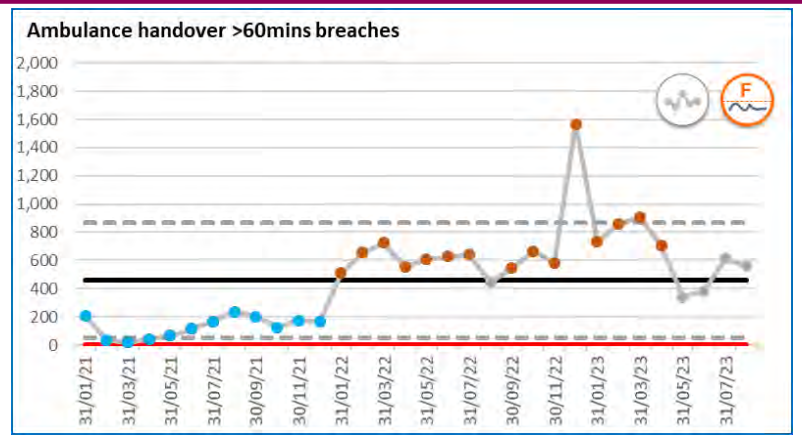
Performance at-a-glance
Responsive (Elective) - Key Performance Indicators Indicator

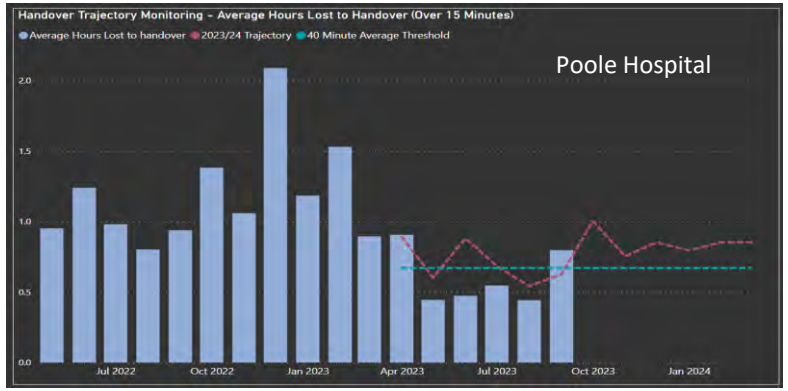
UHD Elective Care

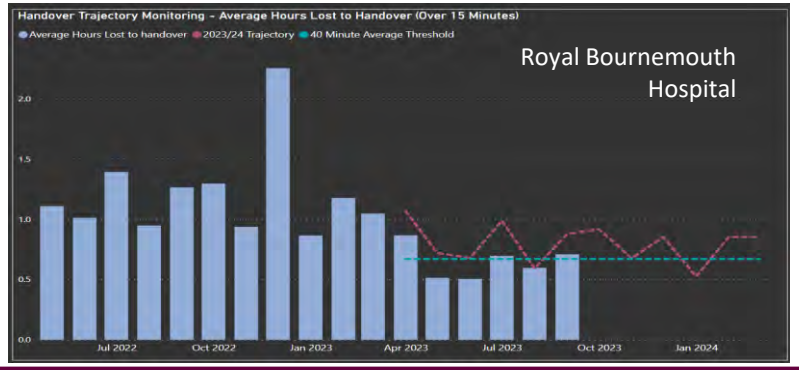
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
UHD - Total Waiting List Size	Aug 23	73727	75638			73246	70304	76189
UHD - Patients waiting >104 weeks	Aug 23	0	0			101	31	171
UHD - Patients waiting >78 weeks	Aug 23	43	-			707	435	979
UHD - Patients waiting >65 weeks	Aug 23	1293	831			1276	908	1643
UHD - Patients waiting >52 weeks	Aug 23	4501	-			3855	3054	4657
UHD - Patients waiting >52 weeks non admitted	Aug 23	3364	0			2294	1542	3046
UHD - RTT Performance against 18 week standard	Aug 23	57.0%	92.0%			58.9%	55.3%	62.4%
UHD - Total Diagnostic Waiting List	Aug 23	12405	-			10747	8900	12594
UHD - % waiting over 6 weeks	Aug 23	13.2%	1.0%			10.8%	4.5%	17.0%
UHD - Faster Diagnosis Standard (FDS) 28 days	Jul 23	60.1%	75.0%			70.1%	59.3%	80.8%
UHD 62 day standard	Jul 23	63.0%	85.0%			70.2%	61.7%	78.7%
Trauma Admissions	Aug 23	412	-			365	300	430
% of NOF patients operated on within 36 hrs of admission	Aug 23	30.7%	85.0%			29.9%	-12.0%	71.8%
UHD - Total Outpatient - Virtual (%)	Aug 23	17.3%	25.0%			26.2%	22.4%	29.9%
UHD Outpatient DNA rate	Aug 23	6.3%	5.0%			6.7%	5.7%	7.7%
Theatre utilisation (capped) - main	Aug 23	74.0%	98.0%			72.6%	66.3%	78.8%
Theatre utilisation (capped) - DC	Aug 23	72.0%	91.0%			66.0%	57.4%	74.5%
UHD Theatre case opportunity	Aug 23	15.1%	15.0%			24.9%	13.8%	36.0%



Responsive – (Emergency) Ambulance Handovers







Data Description and Target

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

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

Performance

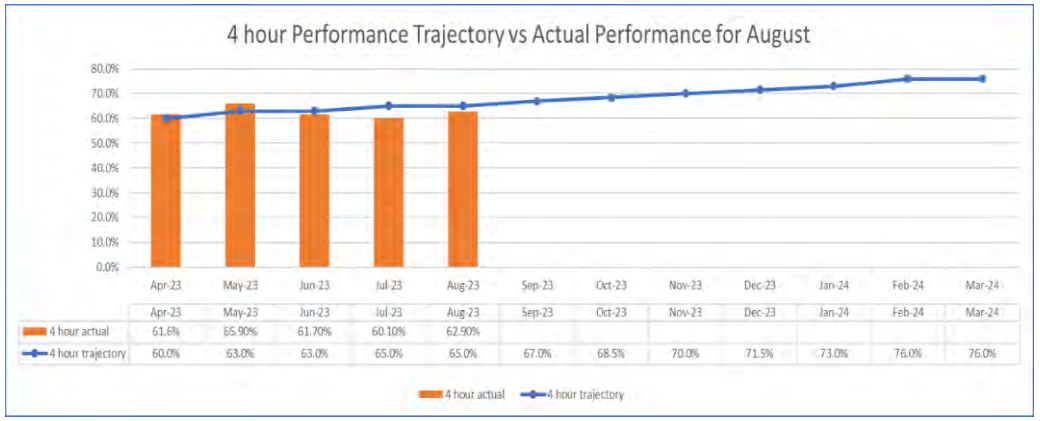
SWAST system malware attack July 18th - anticipated new year until resolved. Post that date all data is unvalidated.

- Ambulance arrivals from July to August saw another increase. Total conveyances were 4454 vs 4268 in July.
- Whilst Poole remained relatively static at 70 vs 69 in July, Bournemouth saw an increase in conveyances to 74 a day vs 68 in July which is a significant daily change and additional pressure on the site.
- Despite this, performance did recover in number of Ambulances waiting longer than 60 minutes from 616 to 560 with a majority of improvement at the Poole site.
- This is an improvement to 13% of total handovers over 60 minutes from 15%. Furthermore 67% of patients across both sites had a handover under 30 minutes.
- Reported lost hours for August remained relatively static at the RBH site, though improved at the Poole site from 720 to 553.
- This improvement compares in par with the Dorset region, however the SWAST region in its entirety saw an increase in time lost to handovers from 17,146 in July to 20,950 in August.

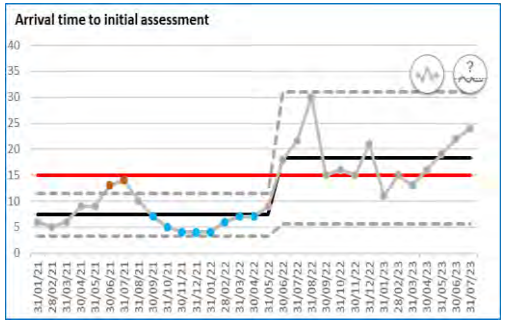
Key Areas of Focus

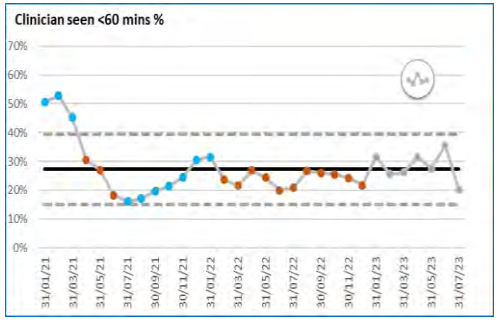
- Discrepancy in lost hours reported due to system issues with SWAST mobimed continues to be an issue.
- As a result, there is a significant increase in handover time and ‘clear’ time being the same. Awaiting implementation of Dual Pin sign off for SWAST - awaiting testing. This will give more accurate reporting.
- The Trust Hospital Flow Improvement Programme includes review of streaming pathway's including direct from ambulance handover to SDEC to minimise lost hours, and better enforce right care in the right place for patients.
- Furthermore, expedited management of co-horted patients to support handover and mitigate any impact or risk of corridor care is in place.

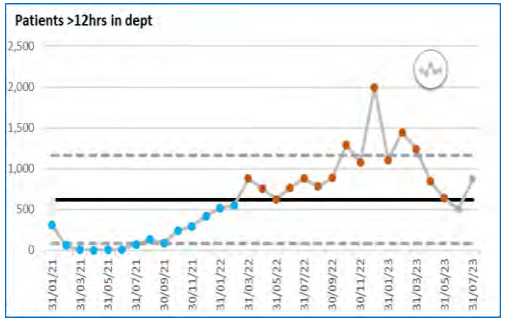
Responsive (Emergency) Care Standards

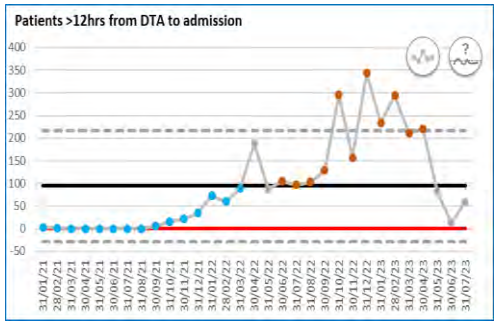


	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
4 hour actual	61.6%	65.90%	61.70%	60.10%	62.90%							
4 hour trajectory	60.0%	63.0%	63.0%	65.0%	65.0%	67.0%	68.5%	70.0%	71.5%	73.0%	76.0%	76.0%









Data Description and Target

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

Performance

Following implementation of 'Agyle' the new electronic PAS system in both emergency departments in June and July, despite a challenging month with increased attendances and conveyances across both sites and the impact of managing another junior doctor strike, performance has started to recover.

August delivered 62.9 % against a trajectory of 65% which bar May is the highest performance YTD since reporting restarted in April 23.

Total attendances increased to 14257 which is an additional 5 patients a day.

Despite this, patients spending more than 12 hours in the department decreased from 888 to 723 which is on par with the same period in 22/23.

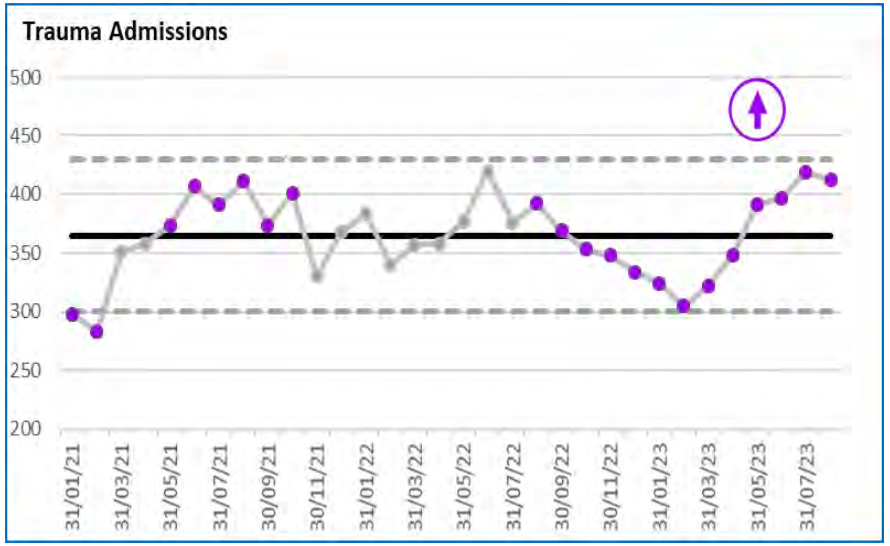
However, the Trust continues to see a sustained improvement in patients waiting more than 12 hours from decision to admit as well as mean time in the department. This has dropped again in August to 2 patients and 284 minutes, respectively.

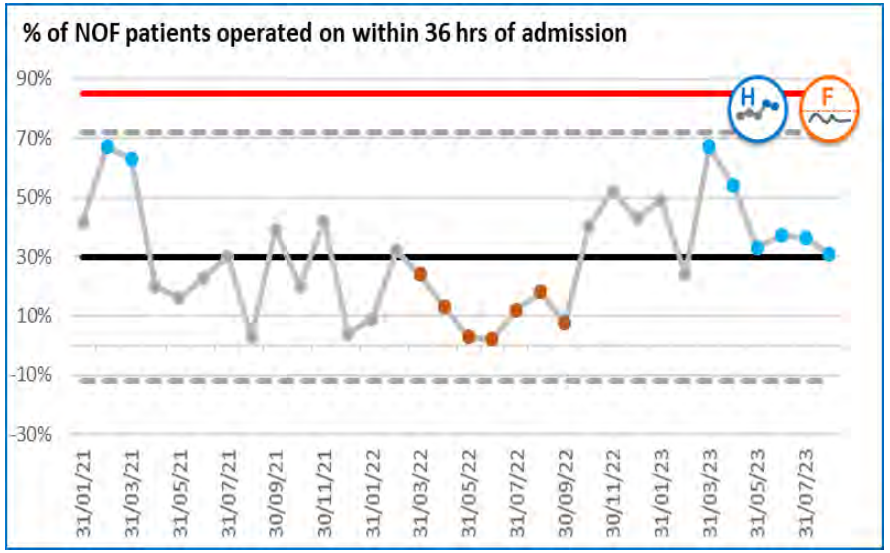
Key Areas of Focus

Full implementation of the new PAS (Agyle) system at both site is embedding. Initial feedback of Agyle as a clinical system is positive and Medical colleagues have noted an improvement during patient assessment and handover. However, it is noted that as well as utilising the system as both a clinical system, performance also needed to prioritised with design and development underway whilst the historical dashboard remains.

Towards the latter part of August the department has also shifted from implementation to review of a rapid improvement cycle. 'Seen in 60' programme to launch in September as a QI initiative to support on-going recovery of the Trust's delivery position against trajectory.

Responsive (Emergency)
Trauma Orthopaedics





Data Description and Target

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

Performance

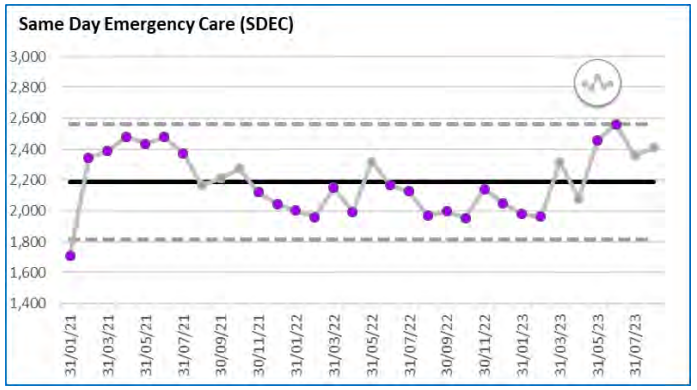
August performance for time to theatre for fractured neck of femur (# NoF) patients: 45% achieving surgery within 36 hours of being fit for surgery and 30.7% with surgery within 36 hours from admission.

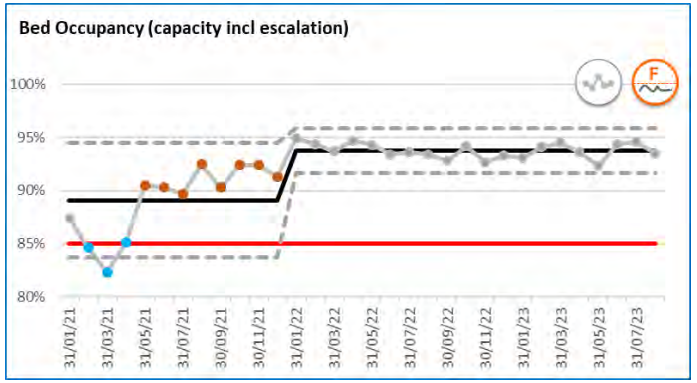
- Overall trauma admissions sustained at high levels with 412 in August including 81 with a fractured neck of femur (NoF).
- Clustering of admissions caused pressure on theatre capacity with 16 admitted in a 3-day period between 21st – 22nd August and 17 in a 4-day period between 26th - 29th
- 18 Shaft of femur (SoF) fractures admitted in August with 16 requiring surgery, 6 required revision hips, 4 patients with a # NOF required a THR
- 13 patients required 2 trips to theatre, of which 5 required complex surgery .
- The barn theatres are working well. Ongoing work to review case mix and paediatric capacity.

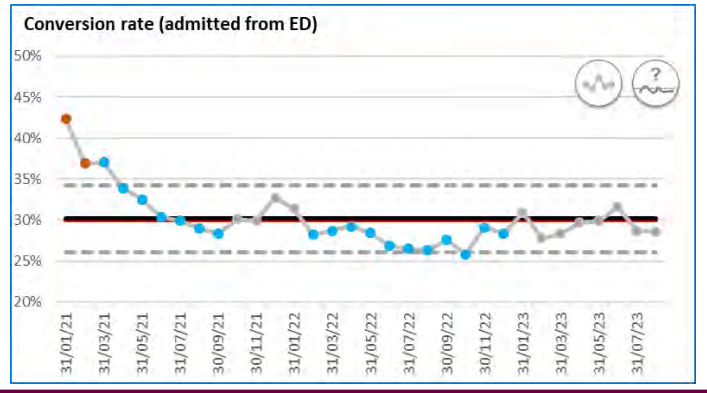
Key Areas of Focus

- e-Trauma , implementation and integration group commenced with dedicated T&O Lead in post; testing and implementation plan in place. Digital ED link to VFC has ceased due to Agyle implementation, which will delay e-trauma VFC implementation. Risk register updated as increase in delays in fracture clinic reviews is causing capacity issues.
- Ongoing work to minimise and mitigate industrial action impact on the trauma service, which brings a large increase in administrative burden to cancel and reschedule patients.
- Liaison with Trust operational flow project around timely admission and discharge (TAD) continues to support reduction in high level of MRFD patients across trauma (28%).
- Trauma escalation in place to identify additional operating capacity, Escalation policy under review.
- Pre alert process to re-launch once key training complete (Fib Block on ward). Ringfencing of #NOF admission beds achieved.

Responsive – (Emergency) Patient Flow







Data Description and Target

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

Performance

Bed occupancy is stable but not reducing and continues to include high levels of escalation throughout August at 93.5%.

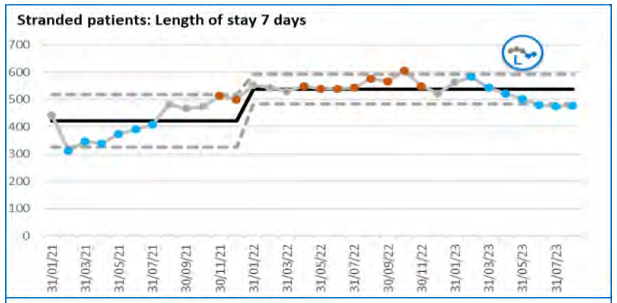
Additional surge capacity has been required to support the flow from ED, high occupancy, maintaining elective activity and emergency care demand. An average of 51 daily escalation beds were required in August.

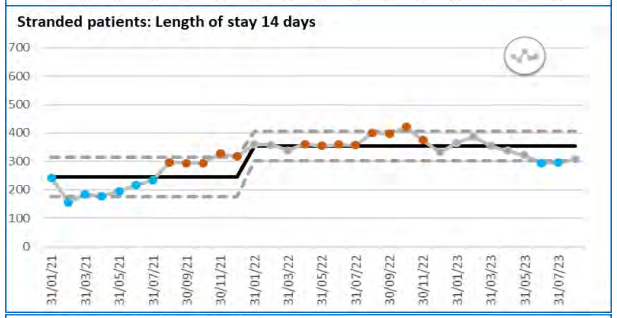
- High occupancy continued to be impacted by high numbers of patients with No Criteria to Reside.
- August saw a small reduction in ED conversion rate (28.6%) and more patients were discharged than admitted with a net difference of 20 patients. There remained a consistent need to open surge capacity to manage high occupancy and MRFD levels.

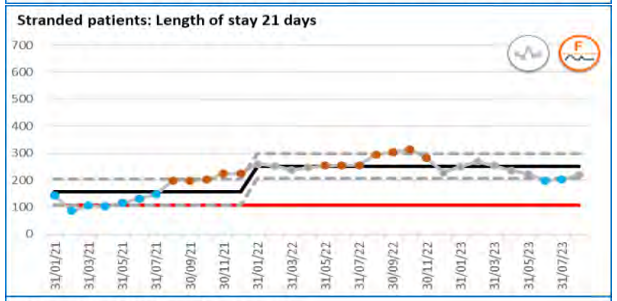
Key Areas of Focus

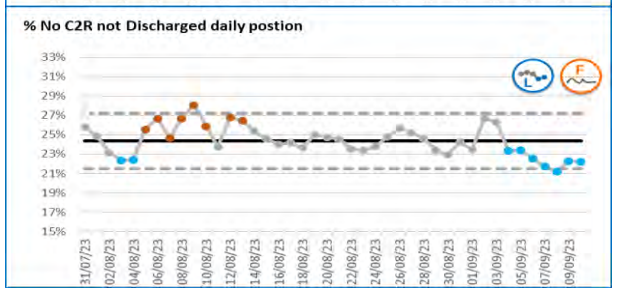
- Revised focus on Timely Admission and Discharge (TAD) process and significant improvement in utilisation rates of Departure Lounges.
- The Discharge to Assess model continues to embed, with System working in place to identify gaps in service provision and where flow through the out of hospital capacity has not achieved the required pace to prevent delays in hospital.
- Review of daily bed management and escalation processes are in place to further improve oversight and targeted actions to manage the daily flow pressures from all teams.

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









Data Description and Target

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

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

Performance

August reported marginal increases in numbers of patients waiting >14 days in UHD beds.

UHD has been consistently showing as an outlier in the South West with a higher percentage of bed base occupied by patients with NCtR, for August this remained at c23-26%. UHD met with the ICB executive leads in August to provide assurance relating to data processes and reporting. The ICB ambition to achieve a 30% reduction in Q1 of NCtR was not achieved by any provider in Dorset, and the 50% reduction by the end of Q2 remains extremely challenging and would require a reduction of 100 patients.

Daily validation process has been put in place from late July and throughout August to ensure accuracy of data, this has had a marginal impact reported performance. The challenge of delayed patients in beds remains the key issue both in terms of reporting and operational pressures and escalation.

Key Areas of Focus

UHD have met with the ICB, and with Bournemouth Poole and Christchurch Council (BPC) to identify the work and numbers of patients required to achieve the 50% reduction and ease operational pressures. Initial targets for reductions in specific groups of complex patients have been agreed with BPC for September.

Further meetings with the ICB discharge and flow leads are scheduled to agree plans to achieve concurrent 50% reductions for patients to pathways or care that is commissioned.

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

UHD Urgent and Emergency Care

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Arrival time to initial assessment	Aug 23	16	15		?	18	5	31
Clinician seen <60 mins %	Aug 23	27%	-			27%	15%	40%
Patients >12hrs from DTA to admission	Aug 23	2	0		?	91	-32	214
Patients >12hrs in dept	Aug 23	723	-			625	92	1158
4 hour safety standard	Aug 23	62.9%	76.0%		F	62.4%	53.9%	71.0%
Ambulance handovers	Aug 23	4454	-	↑		3974	3465	4483
Ambulance handover >60mins breaches	Aug 23	560	0		F	463	53	872
Bed Occupancy (capacity incl escalation)	Aug 23	94%	85%		F	94%	92%	96%
Stranded patients: Length of stay 7 days	Aug 23	476	-	L		538	483	593
Stranded patients: Length of stay 14 days	Aug 23	308	-			354	301	407
Stranded patients: Length of stay 21 days	Aug 23	220	108		F	252	207	297
UHD NCTR % - all delays	Aug 23	40.0%	-	L		48.4%	41.1%	55.6%
Non-elective admissions	Aug 23	6233	-			5917	5028	6806
> 1 day non-elective admissions	Aug 23	3821	-			3728	3115	4341
Same Day Emergency Care (SDEC)	Aug 23	2410	-			2187	1813	2561
Conversion rate (admitted from ED)	Aug 23	28.6%	30.0%		?	30.2%	26.1%	34.2%

Sustainable Servicers

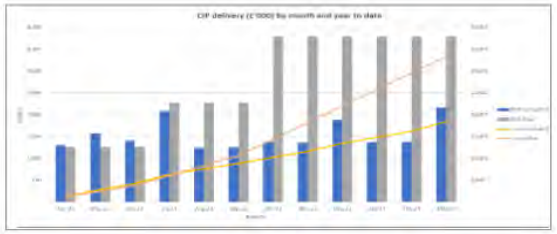
Pete Papworth
Chief Finance Officer

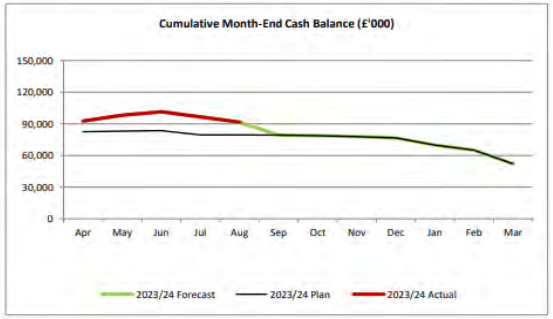
Operational Lead:
Andrew Goodwin, Deputy Chief Finance Officer

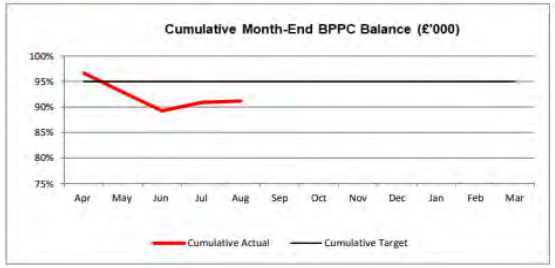
Committees:
Finance and Performance Committee

Finance

FINANCIAL INDICATORS	Year to date		
	Budget £'000	Actual £'000	Variance £'000
Control Total Surplus/ (Deficit)	(5,160)	(11,686)	(6,526)
Capital Programme	57,247	25,975	31,272
Closing Cash Balance	79,527	91,604	12,077
Public Sector Payment Policy	95.0%	91%	(3.8)%







Commentary

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

At the end of August 2023 the Trust has reported a deficit of £11.7 million against a planned deficit of £5.2 million representing an adverse variance of £6.5 million. This is mainly due to energy cost inflation £1.6 million, the net cost of the Nursing, Junior Doctors and consultant strikes £2.3 million, unfunded escalation costs of £1.3 million together with premium cost pay overspends in the Care Groups. This has been off-set in part by additional bank interest due to a higher cash holding and recent movement in Bank of England base rates and reduced depreciation charges due to the timing of capital expenditure. Elective Recovery Performance for April and May has been published by NHSE in relation to the variable elements of commissioner contracts, and has been reflected within the August YTD position. This has resulted in a £1.5 million commissioner contract income reduction due to the activity delivered against the Trusts NHSE required trajectory.

Cost Improvement Programme savings of £8.3 million have been achieved as at 31 August against a target £8.2 million. This includes non recurrent savings of £4.9 million. The full year savings requirement is £33.3 million which represents a significant challenge. Current savings plans total £19.5 million representing a shortfall of £13.8 million and a recurrent shortfall of £21.4 million. Mitigating this shortfall continues to be the key financial focus for the Trust with the implementation of a dedicated Project Management Officer supporting CIP identification and delivery.

At 31 August the Trust has a rephased capital budget of £129.4 million, including £102.8 million of centrally funded schemes including the acute reconfiguration and the New Hospital Programme. At the end of August 2023 the Trust has committed capital expenditure of £26 million against a plan of £57.2 million representing an underspend of £31.2 million. This underspend mainly relates to STP Wave 1, phasing of IT works and the Once Dorset Pathology scheme. The STP Wave 1 full year forecast remains consistent with the plan and the NHP plan reflects the latest cashflow agreement with NHS England.

CAPITAL	Year to date		
	Budget £'000	Actual £'000	Variance £'000
Estates	8,291	2,621	5,670
IT	4,230	1,740	2,491
Medical Equipment	1,755	1,183	572
Donated Assets	270	268	2
Strategic Capital	42,701	20,164	22,537
Total	**57,247**	**25,975**	**31,272**

As at 31 August 2023 the Trust is holding a consolidated cash balance of £91.6 million which is fully committed against the future Capital Programme. The current cash balance is higher than planned due to the successful award of capital funding for multiple schemes alongside a rephasing of the capital programme spend. The balance attracts Government Banking Services interest of 5.14% at current rates, together with a PDC benefit of 3.5%.

In relation to the Public Sector Payment Performance the Trust is currently delivering performance of 91.2% against the national standard of 95%, reflecting the positive impact of the recovery actions taken in August

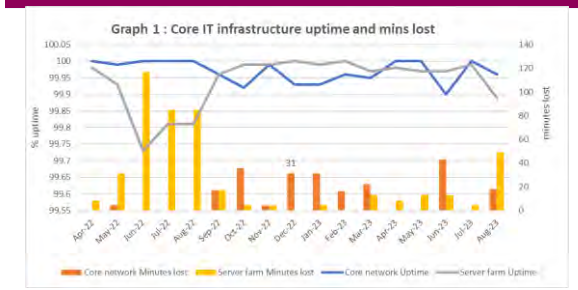
Digital Dorset / Informatics

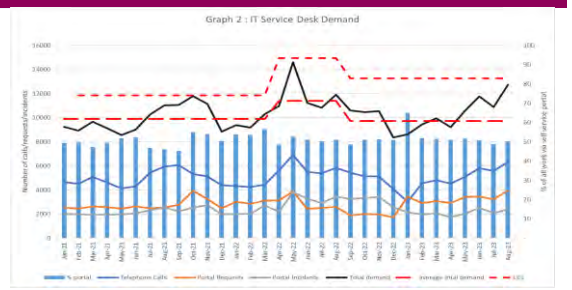
Peter Gill
Chief Information Officer

NHS
University Hospitals Dorset
NHS Foundation Trust

Well Led - Informatics

Business as usual / Service Management





Projects / Developments / Security / IG

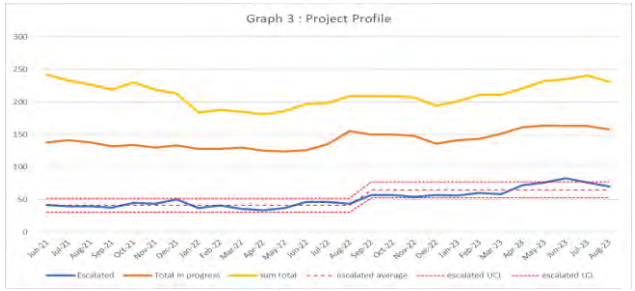


Table 5: Training Statistics

Total Trained in August: 610

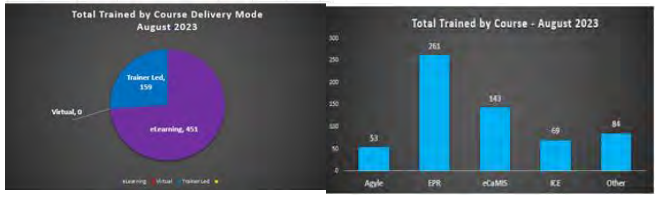


Table 4: Information Asset Compliance

All Active Assets

Status	Total	%
Draft Only (Pending Updates)	7	2.60%
Awaiting IAO Review/Approval	20	7.43%
Awaiting IG Review/Approval	59	21.93%
DSPT Compliant (2022/23)	183	68.03%
Total	269	

Table 6: Cyber Security - Obsolete systems

	Supported	Obsolete
Windows Desktops	97.9%	2.1%
Windows Servers	90.6%	9.4%

Table 7: FOI compliance

	Total rec'd	Compliance
March '23	60	70%
April '23	58	76%
May '23	57	70%
June '23	61	72%

Commentary

Graph 1: The uptime remained above the expected level (99.9)

Graph 2: The Service Desk Demand remains within the bounds of common cause variation - the sharp uptick over the last 3 months which is approaching the upper limit will be monitored carefully

Graph 3. The graph shows a step change (as per the Statistical Process Control analysis) in the number of escalated projects from September 2022. This is unsustainable and Informatics continues to work through the Patient First Process entitled Corporate Project Filter to address this. 12 projects were completed in August, including the completion of a wireless network upgrade at RBH and deployment of an e-mortality solution to the Poole site. 4 projects were terminated for various reasons.

Table 4: Progress was made on the Information Asset Compliance work but at the point of submitting the national return only 68% of our high priority assets had the sufficient level of assurance.

Table 5 shows the staff trained by system in Aug.

Table 6: nearly 98% of our Windows desktop devices are now on supported operating systems and c91% of our server estate.

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 27 September 2023

Agenda item: 6.2

Subject:	Protecting and Expanding Elective Capacity - Self-Assessment
Prepared by:	Judith May, Director of Operational Performance and Oversight
Presented by:	Judith May, Director of Operational Performance and Oversight

Strategic themes that this item supports/impacts:	Systems working and partnership ☒ Our people ☒ Patient experience ☒ Quality: outcomes and safety ☒ Sustainable services ☒ Patient First programme ☒ One Team: patient ready for reconfiguration ☐
BAF/Corporate Risk Register: (if applicable)	BAF Risk 1 - Risk of not meeting the patient national constitutional standards for Planned Care (No patients waiting more than 65 weeks on referral to treatment (RTT) pathway by March 2024) Risk 1074 – Timely Access to Planned Care
Purpose of paper:	Decision/Approval
Executive Summary:	This paper outlines action in two areas: 1. NHS acute trusts were written to on 4 August 2023 with a letter on 'Protecting and expanding elective capacity' (Appendix 1). This letter sets out the next steps on outpatient transformation and three key actions for trusts, to: • Revisit our plan on outpatient follow up reduction, to identify more opportunity for transformation. • Set an ambition that no patient in the 65-week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023. • Maintain an accurate and validated waiting list by ensuring that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with December 2022 validation guidance) by 31 October 2023, and ensure that RTT rules are applied in line with the RTT national rules suite and local access policies are appropriately applied.

	In the letter trusts were asked to complete a self assessment template against each of the three actions above. Appendix 2 sets out a draft response for consideration by the Board. The supporting information in the appendix outlines the performance and/or actions in place to meet the national ambitions for outpatient transformation. The Board is asked to review the supporting information and make an assessment of the level of assurance reached. 2. Following an earlier national letter in May 2023 on elective care which set out the priorities for elective and cancer recovery, the Board asked to be provided with an update in September 2023 on two areas. This update is detailed below: **a. Where is the Trust against full roll-out of tele dermatology?** Progress has been made on the implementation of teledermatology at UHD. Scoping work has been undertaken for the IT integration works required to receive images from ERS into the PAS system. A solution has been found however, the preferred model would be to enhance the use of Consultant Connect due to the solution providing the most effective output for clinicians in terms of clinical content, image quality, and a reduction in integration work required. Consultant Connect is currently being re-commissioned and work is ongoing to secure the contract to go live with the teledermatology solution as soon as possible. UHD continues to work with NHS Dorset and the Wessex Cancer Alliance on medium and longer term teledermatology options, including the expansion of CDC activity to implement community photo clinics and Artifial Intelligence (AI) triaging solutions to support demand in primary care. **b. All patients waiting for inpatient procedures should be contacted by their provider at least every three months**. The Trust has plans in place to ensure that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with validation guidance) by 31 October 2023 in order to meet the national ambition. These are detailed in the paper attached.
Background:	The Trust's recovery of outpatient activity in April-August 2023 was c.83% for first outpatients and 90.5% for follow up attendances against 19/20 baselines, alhough these numbers are expected to rise once all clinics are updated and coded. In the most recent letter dated 4 August 2023, trusts are asked to provide assurance against a set of activities that will drive outpatient recovery at pace. Each provider is asked to ensure that this work is discussed and

	challenged appropriately at Board, undertake a board self-certification process and have it signed off by trust chairs and chief executives by 30 September 2023.
Key Recommendations:	Members of Board are asked to: 1. Note the update provided on the two areas arising from the Board's review of the elective checklist in June 2023. 2. Confirm the level of assurance proposed within the self assessment 'Protecting and expanding elective capacity' template and any follow up assurance required.
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 ☒ The enclosures will be made available to NHS England and the Dorset Integrated Care Board to confirm that the Board has reviewed and discussed specific outpatient operational priorities and has signed off the completed checklist. The areas within the self assessment cover operational delivery, quality and finance.
CQC Reference:	Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well Led ☒ Use of Resources ☒

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Operational Delivery Group	07/09/2023	Content confirmed as an accurate reflection of the operational position
Trust Management Group	12/09/2023	Submission to Board agreed

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

To:
- NHS acute trusts:
  - chairs
  - chief executives
  - medical directors
  - chief operating officers

cc.
- NHS England regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

4 August 2023

Dear Colleagues,

Protecting and expanding elective capacity

In May, we wrote to you outlining the priorities for elective and cancer recovery for the year ahead. Last week, as part of the winter letter, we also asked you to maintain as far as possible ring-fenced elective and cancer capacity through winter.

We would like to thank you for your continued hard work in these areas, in the face of significant wider operational challenges, including ongoing industrial action. Thanks to the efforts put in by staff across the NHS, we have now virtually eliminated pathways waiting over 78 weeks, down by 94% since the peak of 124,000 in September 2021 (and now representing c0.1% of the total list), and significantly decreased the number of patients with urgent suspected cancer waiting longer than 62 days from a high of 34,000 to around 21,000 today.

However, one area where we know there remains more to do is outpatients. We have listened to your feedback on the support you need for this transformation and have set out the next steps below.

National support for outpatient transformation

To support outpatient transformation, we have met with royal colleges, specialist societies and patient representatives to agree a way forward, working in partnership, to champion and enable outpatient recovery and transformation. At the 'call to arms', colleges agreed to:

- review their guidance on outpatient follow-ups
- support new approaches to increasing wider outpatient productivity, including reducing variation in clinical templates, patient discharge, and following clinically-informed access policies.

Together with this clinical leadership, we need to build on the expectation of freeing up capacity and increasing productivity. This can be achieved through reducing follow up appointments with no procedure, fully validating RTT waiting lists, reducing variation in clinical templates, moving to patient-initiated follow-up where appropriate, following clinically-informed access policies and implementing new ways of working, such as group outpatient follow ups, reviewing clinical pathways and workforce models.

We are continuing to provide support to trusts in this area, through the following:

- Regional support
- NHS England's GIRFT outpatient guidance
- Action on Outpatients series
- The Model Health System
- Support to specific trusts via NHS England's GIRFT Further Faster programme, NHSE Tiering programme and Elective Care Improvement Support Team (IST) – learning from the Further Faster programme will be shared in the Autumn
- Access to additional capacity through the NHS Emeritus Consultant programme
- Luna weekly data quality report, which can be accessed by contacting lunadq@mbihealthcaretechnologies.com and Foundry data dashboards
- RTT rules suite
- Elective Care IST Recovery Hub - FutureNHS Collaboration Platform
- Guidance on shared decision making.

Next steps on outpatient transformation

With the majority (c80%) of patient waits ending with an outpatient appointments, we need to increase the pace in transforming outpatient services to release capacity for patients awaiting their first contact and diagnosis. This will be particularly important ahead of and during winter, when pressure on inpatient beds can be at its highest. Nationally, achieving a 25% reduction in follow up attendances without procedures would provide the equivalent to approximately 1m outpatient appointments per month.

This letter therefore sets out further detail on three key actions that we are asking you to take:

- Revisit your plan on outpatient follow up reduction, to identify more opportunity for transformation.
- Set an ambition that no patient in the 65-week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023.

- Maintain an accurate and validated waiting list by ensuring that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with December 2022 validation guidance) by 31 October 2023, and ensuring that RTT rules are applied in line with the RTT national rules suite and local access policies are appropriately applied.

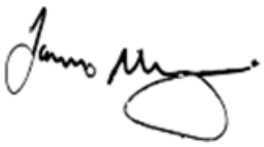
We are now asking trusts to provide assurance against a set of activities that will drive outpatient recovery at pace. This process will require a review of current annual plans, detailing the progress that can be made on outpatients transformation. As part of the above priorities, we are asking each provider to ensure that this work is discussed and challenged appropriately at board, undertake a board self-certification process and have it signed off by trust chairs and chief executives by **30 September 2023**.

The details of this self-certification can be found at Appendix A. Please share this letter with your board, key clinical and operational teams, and relevant committees.

If you are unable to complete the self-certification process then please discuss next steps with your regional team.

Thank you again for colleagues' efforts in this area, which are making a real difference to the timeliness of care we deliver to patients. We look forward to receiving your returns and, as always, if you need to discuss this in more detail, or support in conducting this exercise, please contact england.electiverecoverypmo@nhs.net.

Yours sincerely,



Sir James Mackey
National Director of Elective Recovery
NHS England

Professor Tim Briggs CBE
National Director of Clinical Improvement
Chair, Getting It Right First Time (GIRFT) Programme
NHS England

Appendix A: self-certification

About this self-certification

To deliver elective and cancer recovery ambitions, high-quality waiting list management and ambitious outpatient transformation are vital. We are now asking trusts to complete this return to provide assurance on these recovery plans.

Nationally and regionally, we will use this to identify providers requiring more support, as well as areas of good practice that can be scaled up to accelerate recovery. Please return this to NHS England by **30 September 2023**, via NHS England regional teams.

Guidance for completing the self-certification

The return asks for assurance that the board has reviewed and discussed specific outpatient operational priorities and has signed off the completed checklist. Please return this to your NHS England regional team.

Trust return: [insert trust name here]

The chair and CEO are asked to confirm that the board:

Assurance area	**Assured?**
1. Validation The board: a. has received a report showing current validation rates against pre-covid levels and agreed actions to improve this position, utilising available data quality (DQ) reports to target validation, with progress reported to board at monthly intervals. This should include use of the nationally available LUNA system (or similar) to address data quality errors and identify cohorts of patients that need further administrative and clinical validation. b. has plans in place to ensure that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with validation guidance) by 31 October 2023, and has sufficient technical and digital resources, skills and capacity to deliver against the above or gaps identified. We are developing a range of digital support offers for providers to improve validation. c. ensures that the RTT rules and guidance and local access policies are applied and actions are properly recorded, with an increasing focus on this as a means to improve data quality. For example, Rule 5 sets out when clocks should be appropriately stopped for 'non-treatment'. Further guidance on operational implementation of the RTT rules and training can be found on the Elective Care IST FutureNHS page. A clear plan should be in place for communication with patients.	

d. has received a report on the clinical risk of patients sitting in the non RTT cohorts and has built the necessary clinical capacity into operational plans.	
2. First appointments The board: a. has signed off the trust's plan with an ambition that no patient in the 65 week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023. b. has signed off the trust's plan to ensure that Independent Sector capacity is being used where necessary to support recovery plans. To include a medium-term view using both insourcing and outsourcing, the Digital Mutual Aid System, virtual outpatient solutions and whole pathway transfers. National support and information on utilisation of the Independent Sector is available via the IS Co-ordination inbox england.iscoordination@nhs.net	
3. Outpatient follow-ups The board: a. has received a report on current performance against submitted planning return trajectory for outpatient follow-up reduction (follow-ups without procedure) and received an options analysis on going further and agreed an improvement plan. b. has reviewed plans to increase use of PIFU to achieve a minimum of 5%, with a particular focus on the trusts' high-volume specialties and those with the longest waits. PIFU should be implemented in breast, prostate, colorectal and endometrial cancers (and additional cancer types where locally agreed), all of which should be supported by your local Cancer Alliance. Pathways for PIFU should be applied consistently between clinicians in the same specialty. c. has a plan to reduce the rate of missed appointments (DNAs) by March 2024, through: engaging with patients to understand and address the root causes, making it easier for patients to change their appointments by replying to their appointment reminders, and appropriately applying trust access policies to clinically review patients who miss multiple consecutive appointments. d. has a plan to increase use of specialist advice. Many systems are exceeding the planning guidance target and achieving a level of 21 per 100 referrals. Through job planning and clinical templates, the Board understands the impact of workforce capacity to provide advice and has considered how to meet any gaps to meet min levels of specialist advice. The Trust has utilised the OPRT and GIRFT checklist, national benchmarking	

data (via the Model Health System and data packs) to identify further areas for opportunity. e. has identified transformation priorities for models such as group outpatient follow up appointments, one-stop shops, and pathway redesign focussed on maximising clinical value and minimising unnecessary touchpoints for patients, utilising the wider workforce to maximise clinical capacity.	
4. Support required The board has discussed and agreed any additional support that maybe required, including from NHS England, and raised with regional colleagues as appropriate.	

Sign off

Trust lead (name, job title and email address):	
Signed off by chair and chief executive (names, job titles and date signed off):	

Appendix 2: Protecting and expanding elective capacity – NHSE Template Self-Assessment

Trust return: **University Hospitals Dorset**

The chair and CEO are asked to confirm that the board:

Assurance area	Supporting information	Level of Assurance
1. Validation The board: a. has received a report showing current validation rates against pre-covid levels and agreed actions to improve this position, utilising available data quality (DQ) reports to target validation, with progress reported to board at monthly intervals. This should include use of the nationally available LUNA system (or similar) to address data quality errors and identify cohorts of patients that need further administrative and clinical validation.	a. Data available through the National LUNA (data quality) system is reviewed on a weekly basis by the RTT projects team with oversight by the Associate Director of Business Intelligence and Director of Operational Performance and Oversight. LUNA reports are also used to assure on data quality at the Trust's monthly Data Quality, Income and Coding Group, which reports to the Finance and Planning Group, chaired by Pete Papworth. This data is used to direct BI and RTT Validation team resources to areas where data quality needs addressing. The attached report (Appendix A) demonstrates improvement in the LUNA metrics over the last 12 months. UHD's latest confidence level at the end of August is 98.70% in comparison with SW Providers. The Trust has a robust programme of administrative and technical validation supported by dedicated resources, and the programme includes service specific 'Validation Hubs', a new initiative introduced in 2022. DQ performance has also been a key focus of the Southwest NHSE Validation Pilot, which has provided the Trust with additional waiting list validators since March 2023, and monitors the Trust against its DQ improvement. Internal tracking of validation rates is achieved through monitoring LUNA metrics and local reporting, with oversight delivered by the Planned Care Improvement Group.	1a. Fully Assured
b. has plans in place to ensure that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with validation guidance) by 31 October 2023, and has sufficient technical and digital resources, skills and capacity to deliver against the above or gaps identified. We	b. This is a significant challenge to achieve due to the volume of patients >12 weeks (circa 35k). A plan is in place to meet the target of validating down to 12 weeks and delivery is monitored weekly. The plan is heavily reliant on retaining the resources currently provided through the SW NHSE Validation Pilot and focuses incrementally on validating patients waiting 52, 26 and then 12 weeks by end of October 2023. Multiple ongoing validation exercises which are underway at speciality level in the Trust, will also contribute to achieving this target and are detailed in the Trust's validation programme plan. Bi weekly updates on the plan are submitted to NHSE which show the level of progress. The Trust will review the digital support offers being developed by	1b. Fully Assured

Assurance area	Supporting information	Level of Assurance
are developing a range of digital support offers for providers to improve validation. c. ensures that the RTT rules and guidance and local access policies are applied, and actions are properly recorded, with an increasing focus on this as a means to improve data quality. For example, Rule 5 sets out when clocks should be appropriately stopped for 'non-treatment'. Further guidance on operational implementation of the RTT rules and training can be found on the Elective Care IST FutureNHS page. A clear plan should be in place for communication with patients.	NHSE however we have already successfully used DrDoctor and other digitally-led validation to deliver timely validation, which the plan continues to build on. Letters are used to contact patients who are not digitally enabled. c. The Trust commenced in Spring 2023 a comprehensive, ongoing programme of training to ensure all relevant individuals receive the appropriate level of training and support in relation to RTT rules, waiting list management and the wider Patient Access policy. This year a total of 96 individuals across the organisation have attended and successfully completed a 'Back to Basics' Bootcamp style RTT training session. This has included a bespoke session for individuals working in Admissions, with tailored scenario-based questions and a blended IT training approach. Plans are in place to roll-out further bespoke training sessions to different role groups over the next few months including Outpatients. An intranet-based resource hub has also been developed to centralise all resources and provide up-to-date information regarding RTT and Patient Access. This includes bespoke areas for different staff groups, for them to access the most relevant information related to their role. Any updates to RTT guidance, performance targets and training opportunities are also shared with key stakeholders via a monthly RTT and Patient Access newsletter. These newsletters aim to be a succinct source of headline information to support dissemination of key messages throughout care groups and services. All training and resources are underpinned by the National RTT standards and principles outlined in UHD's Patient Access Policy. The Patient Access Policy underwent a review in March 2023, as per the agreed review cycle timeframe. In collaboration with Dorset County Hospital and NHS Dorset the review was coordinated across the system to maximise alignment across policies and ensure equity for the population of Dorset. The policy outlines how the Trust plans to communicate with patients with regards to access and validation. Governance and oversight of the review and subsequent amendments took place via Dorset's System Elective Care Oversight Group.	1c. Fully Assured

Assurance area	Supporting information	Level of Assurance
d. has received a report on the clinical risk of patients sitting in the non RTT cohorts and has built the necessary clinical capacity into operational plans	d. Non RTT cohorts include patients on the Trust's follow up and planned waiting lists. Management and validation of the planned waiting list is undertaken within specialities and tracking of validation rates occurs at the Operational Delivery Group (ODG). A task and finish group was established in June 2023, with UHD's senior clinical leaders to manage the clinical risk associated with the Outpatient follow-up (non-RTT) waiting list and to agree approaches to tackling the backlog of patients waiting a follow up appointment. A principle was agreed to communicate with all patients who were either 2 or more years 'overdue' (Target Date waiting list) or had not been seen by a consultant in 2 or more years (No Target Date waiting list) and advise them of our intention to close their episode of care. Part of the process includes giving patients a clear route to make contact with the organisation should they consider themselves as still requiring a follow up appointment. The programme plan and approach was signed off by the Trust Management Group in May 2023. This validation exercise aims to help cleanse the follow-up waiting list, enabling a clearer view of patients truly waiting follow-up care. An initial pilot of the digital first approach to the exercise ran over July and August, this is to be followed by a three-phased rollout plan. Subsequently Phase 1 specialities went live on 12 September 2023. A contact centre has been stood up to manage queries from patients and work with services on allocating appointments where one is needed. Progress of the Follow up validation project is captured in a fortnightly update and monitored through the Planned Care Improvement Group. Supplementary information is included in Appendix B to support Board assurance on the validation of the follow up waiting list.	1d. Fully Assured
2. First appointments The board: a. has signed off the trust's plan with an ambition that no patient in the 65 week 'cohort' (patients who, if not treated by 31 March 2024, will have	a. The Trust's Annual 2023/24 Operational plan was signed off by the Board and included the ambition that no patient will be waiting more than 65 weeks for treatment by March 2024. This is also one of the Strategic objectives outlined within the Trust's Patient First Improvement Strategy. In terms of reaching the ambition announced in the recent 'Protecting and expanding elective capacity' letter, that no patient in the 65 week 'cohort' (patients who, if not treated by	2a. Partially Assured

Assurance area	Supporting information	Level of Assurance
breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023.	31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023, the Trust has 13,100 patients in the 65 week 'cohort' (position on 31 Aug 2023). 9,969 of which are on a non-admitted pathway. 1,939 of patients in this group have a future first OPA booked; 4,595 patients have no first OPA recorded and no 1st OPA booked. The remaining patients include those who have had a first OPA but are awaiting diagnostics, a subsequent appointment or whom will be discharged subsequent to completion of an admin action. On 20 September 2023, an enhanced support meeting with Care Group senior leadership teams and General Managers was Chaired by the Chief Executive and Chief Operating Officer. A review of the actions in place to deliver on this target was undertaken and assurance sought of further mitigations planned. Five services were highlighted as at risk of not having capacity to provide all patients in the 65ww cohort with a first contact by 31 October. These were: Respiratory, Dermatology, Neurology, Community Paediatrics, Gynaecology, and ENT. A set of actions were agreed at the meeting to be completed. Several services within this group have patient pathways which do not transfer from a non-admitted to an admitted pathway (i.e it is fully non-admitted), as such the risk that these patients will not complete their RTT pathway by March 2024 if not seen for a first outpatient appointment by 31 October 2023 is reduced.	
b. has signed off the trust's plan to ensure that Independent Sector capacity is being used where necessary to support recovery plans. To include a medium-term view using both insourcing and outsourcing, the Digital Mutual Aid System, virtual outpatient solutions and whole pathway transfers.	b. The Trust Board has signed off the annual operational plan which includes information on how the Trust will work with the Independent Sector to support elective recovery. The Trust has subsequently agreed a spending plan against elective recovery funding, which includes a medium-term plan to use both insourcing and outsourcing to optimise capacity for addressing its strategic aim to eliminate 65 week waits. The National Digital Mutual Aid system (DMAS) has been used by the Trust in seeking mutual aid support to eliminate 104 week waits and continues to be a consideration in managing 65 week waits.	2b. Fully Assured

Assurance area	Supporting information	Level of Assurance
3. Outpatient follow-ups The board: a. has received a report on current performance against submitted planning return trajectory for outpatient follow-up reduction (follow-ups without procedure) and received an options analysis on going further and agreed an improvement plan.	a. Information regarding elective activity levels against the Trust's operational planning return, including performance against the submitted plan for a reduction in outpatient follow-ups was reported to the Finance and Performance Committee on 17 July 2023. The Trust's 2023/24 Annual Operational plan, agreed by Trust Board, included a trajectory for outpatient follow up reduction and confirmed that the Trust was not planning to meet the national ask to reduce outpatient follow up activity by 25%. The trajectory agreed was a reduction of 5% compared to the 19/20 baseline. The rationale being the Trust has a significant backlog of patients overdue a follow up appointment, which at the beginning of April 2023 was 34,302. An improvement plan for reducing the outpatient follow up backlog was approved at Trust Management Group on 9 May 2023 as outlined above. April to August performance against the submitted operational planning trajectory was 90.5% (plan of 95%). Performance against this trajectory is tracked during monthly Care Group performance reviews with the Chief Operating Officer via the Operational Delivery Group and during Care Group Quarterly Performance review meetings with the wider Executive team.	3a. Fully Assured
b. has reviewed plans to increase use of PIFU to achieve a minimum of 5%, with a particular focus on the trusts' high-volume specialties and those with the longest waits. PIFU should be implemented in breast, prostate, colorectal and endometrial cancers (and additional cancer types where locally agreed), all of which should be supported by your local Cancer Alliance. Pathways for PIFU should be applied consistently between clinicians in the same specialty.	b. The Trust's Annual Operation plan included plans to achieve a minimum PIFU rate of 5% and PIFU performance is monitored through the Operational Delivery Group. The Trust successfully met the national PIFU target in Q4 2022/23. However, the most recent PIFU performance, recorded in July 2023 based on June's attendances, stands at 3.63%. This calculation includes patients who have transitioned to PIFU or have been incorporated into SOS pathways. The Trust is currently in the process of phasing out SOS pathways, opting to exclusively employ PIFU. Consequently, there has been a decline in SOS patient numbers, which previously constituted a significant portion of the PIFU performance. As part of our Follow Up Reduction programme, we have also introduced new local attendance outcomes to improve the accuracy of data capture related to PIFU and non-PIFU outcomes. While the number of SOS cases is	3b. Fully Assured

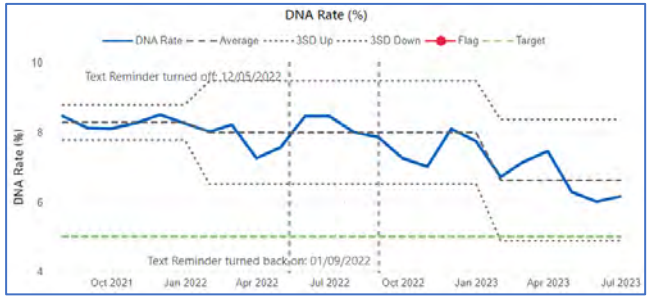
<table>
<tr><th>Assurance area</th><th>Supporting information</th><th>Level of Assurance</th></tr>
<tr><td></td><td>
decreasing, our PIFU figures are rising, but they have not yet reached the threshold required to meet the national target.

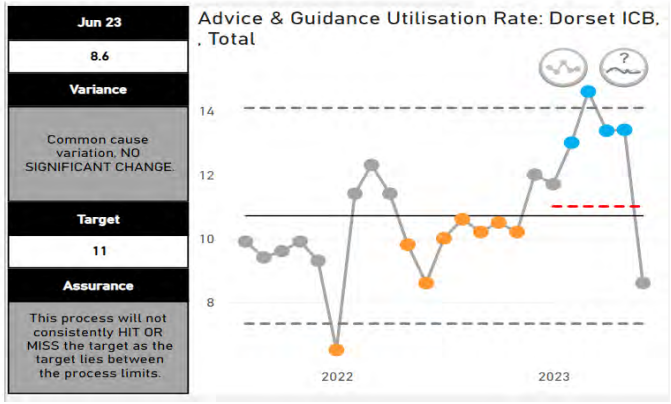
The Trust nevertheless is above the median on a number of the supporting indicators monitored nationally including as follows:

<table>
<tr><th>Indicator name</th><th>UHD Value July 2023</th><th>National Median July 2023</th><th>UHD Position July 2023</th></tr>
<tr><td>Episodes on active PIFU pathway</td><td>21,651</td><td>5,816</td><td>16th/135</td></tr>
<tr><td>Episodes discharged to PIFU</td><td>1,225</td><td>280</td><td>27th/109</td></tr>
<tr><td>Completed PIFU pathways</td><td>1,562</td><td>435</td><td>13th /92</td></tr>
<tr><td>Episodes moved to PIFU</td><td>552</td><td>565</td><td>67th /131</td></tr>
<tr><td>Appointments initiated by patients</td><td>6</td><td>95</td><td>72nd /81</td></tr>
</table>
Source: National Provider Elective Recovery Outpatient Collection Dashboard

For both ‘episodes moved to PIFU’ and ‘appointments initiated by patients’, low is good in the table above.

We have a plan to meet the national target. PIFU is part of a suite of pathway improvement measures services have been asked to plan for, where an option exists to convert follow up clinic slots to new patient slots in order to deliver the planned elective activity trajectories. The use of PIFU is also an integral safety net within the plan for eliminating 2 year overdue follow ups, whereby patients who meet the criteria for PIFU but not discharge, will be placed on PIFU following validation. Gynaecology has been the pilot service on which the approach has been tested and patients have successfully moved onto PIFU in July/August. Further rollout of PIFU is aligned to the 3 phases of the 2 year+ follow up reduction project; phase 1 commencing on 11th September 23.
</td><td></td></tr>
</table>

Assurance area	Supporting information	Level of Assurance
c. has a plan to reduce the rate of missed appointments (DNAs) by March 2024, through: engaging with patients to understand and address the root causes, making it easier for patients to change their appointments by replying to their appointment reminders, and appropriately applying trust access policies to clinically review patients who miss multiple consecutive appointments.	PIFU has been implemented in breast, prostate, colorectal and endometrial cancers, as part of the roll out of the Remote Monitoring System for Cancer and is supported by Wessex Cancer Alliance funding. These cancer PIFU episodes are not currently counted in the Trust's numbers, it is therefore probably that the Trust in underreporting against PIFU. Work is ongoing to ensure that the cancer PIFU pathways are counted against the Trust's performance trajectory going forwards. Finally, there is a Standing Operating Procedure in place for operating PIFU in UHD which is localised in each speciality to promote consistency between clinicians in the same speciality. c. The current rate of missed appointments is 6.2% (July 2023) and is demonstrating a reducing trend. As part of the Trust's Digital Outpatient Transformation Programme, digital appointment reminders via the introduction of DrDoctor commenced in May 2023. 60% of clinics are live with text reminder notifications to patients and clinics across a further 7 specialities are in scope for expansion of the functionality. The Trust also plans to go live with Endoscopy using text reminders at the end of September 2023.  Implementation of the DrDoctor Patient Portal, which will allow basic rescheduling and in the next phase, two-way advanced rescheduling of appointments is in the process of being implemented. The Trust is expected to go live with a pilot in Gynaecology and Physiotherapy	3c. Fully Assured

Assurance area	Supporting information	Level of Assurance
d. has a plan to increase use of specialist advice. Many systems are exceeding the planning guidance target and achieving a level of 21 per 100 referrals. Through job planning and clinical templates, the Board understands the impact of workforce capacity to provide advice and has considered how to meet any gaps to meet min levels of specialist advice. The Trust has utilised the OPRT and GIRFT checklist, national benchmarking data (via the Model Health System and data packs) to identify further areas for opportunity.	(Christchurch only) on 4th September 2023. This functionality will support a further reduction in DNA by way of enabling patients to be able to cancel their appointments via a link embedded within their text reminder message as well as accessing the patient portal via which to rebook. Spreading the use of the DrDoctor 'quick question' functionality to support validation of waiting lists by asking patients if they still require their appointment will also help reduce the wait list size and positively impact on DNA's. All specialities are being encouraged to use this as part of their validation tools and work is live in Oral & Maxillo-Facial Surgery and Ophthalmology currently. d. 11,393 specialist advice requests have been responded to year to date at UHD (April-August 2023) across 23 specialities. The highest volume being in dermatology. The target for advice and guidance is 16/100 and is measured at a system/ICB level. Dorset ICB's performance is illustrated below. The latest data available is for June 2023 when the system delivered 8.6 per 100 referrals. The reduction compared to May 2023 is due to a coding delay. At the next refresh we expect to see this position improve comparable to May's level and above the ICB's planned trajectory. **Dorset ICB Advice and Guidance Utilisation Rates**  An assessment against GIRFT recommendations in 2021/22 identified four services where an opportunity for Specialist Advice and Guidance pathways existed and Cardiology was also identified as a priority locally (Appendix C). All specialties identified have subsequently	3d. Partially Assured

Assurance area	Supporting information	Level of Assurance
	implemented advice and guidance. Further to this Gastroenterology and Hepatology are currently in the early planning stages of moving to a full specialist advice and guidance model, which will impact positively on the ICB's overall performance against this target. Further work is needed to undertake a comprehensive review using the OPRT and GIRFT checklist, and national benchmarking data (via the Model Health System and data packs) to identify additional areas of opportunity and to develop a roadmap for rolling out or scale up advice and guidance pathways across the Trust in order to support demand management.	
e. has identified transformation priorities for models such as group outpatient follow up appointments, one-stop shops, and pathway redesign focussed on maximising clinical value and minimising unnecessary touchpoints for patients, utilising the wider workforce to maximise clinical capacity.	e. The Outpatient Assessment Clinic at Dorset Health Village is part of UHDs 'Think Big' initiative to help tackle our waiting lists and bring diagnostic services closer to the community. The facility was designed to enable increased collaboration between workforce groups, high throughput, and improved flow of patients. Thereby, increasing efficiencies and enhancing the patient experience. In the development of the model, the initial four anchor services (Ophthalmology, Orthopaedics, Breast Screening and Dermatology) were challenged to re-design their pathways based on the opportunities the space presented. All services who use the facility have improved the clinical value and / or capacity of their clinics: Services which have used or currently use facility include: • Ophthalmology – high volume cataract and macular • Breast screening • Orthopaedics – Hip and Foot and Ankle • AAA screening • General surgery (Hernia) – high volume clinic • Physiotherapy • Maternity and Maternity Stop Smoking • Rheumatology podiatry • Gastroenterology In planning / upcoming services include: • Orthopaedic Hip (expansion of current service) • Orthopaedic Hand	3e. Partially Assured

Assurance area	Supporting information	Level of Assurance
	• Orthopaedic Knee • Gynaecology PMB assessment • DEXA scanning • Oncology • Ultrasound This facility was designed to be a 'testbed of innovation' and an opportunity for services and the organisation to try new ways of working. There is a continual process of quality improvement – led by the feedback received from staff, volunteers, and patients as well as review of performance and activity levels. Learnings and ways of working are also being used to drive efficiencies in clinics at the main hospital sites, with planning and delivery of more focussed clinics to contribute to maximising clinical value and expediting pathways for patients underway. In addition to the OAC, other examples of transformation being undertaken at speciality level, which focus on maximising clinical value and minimising unnecessary touchpoints for patients include the implementation of triage hubs for example in Gastroenterology and Hepatology to enable patients to be triaged straight to test. A one-stop approach is also being proposed by ENT services to support its management of paediatric longwaiters; the service will be running 'super' clinics for paediatrics in October followed by a 'super theatre' period later in the year to manage any patients in this group who require surgery. Further action is needed to identify additional transformation opportunities which deliver high volume outpatient activity and pathway redesign focussed on maximising clinical value and minimising unnecessary touchpoints for patients, utilising the wider workforce to maximise clinical capacity.	
4. Support required The board has discussed and agreed any additional support that maybe required, including from NHS England, and raised with regional colleagues as appropriate.	The current areas where additional support is required are: • Ongoing support from the SW Region and ICB to fund an enhanced level of validation resource until March 2024 • NHSE is asked to continue to share the details of exemplar sites regarding outpatient transformation • NHSE is asked to support any exclusions recommended in relation to section 2a. above	

Sign Off

Trust lead (name, job title and email address):	
Signed off by chair and chief executive (names, job titles and date signed off)	

University Hospitals Dorset
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Protecting and expanding elective capacity - Self-Assessment

Appendices

31st August 2023

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Appendix A: National LUNA Data Quality Dashboard

Overview of solution & current performance

31st August 2023

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LUNA Data Quality Solution

Purpose of solution

- Tool developed as part of the National Data Quality Improvement Programme to highlight areas on waiting lists where data quality should be reviewed with a view to support the wider elective recovery programme
- The tool is a guide as to where potential corrections might be required depending on local configurations of PAS system

Process

- UHD weekly patient level waiting list data submitted every Wednesday
- LUNA process checks for data completeness and assesses performance against data quality metrics with an aim to publish in the LUNA Dashboard by the following Wednesday
- 19 DQ metrics monitored on a weekly basis – see table

Confidence level

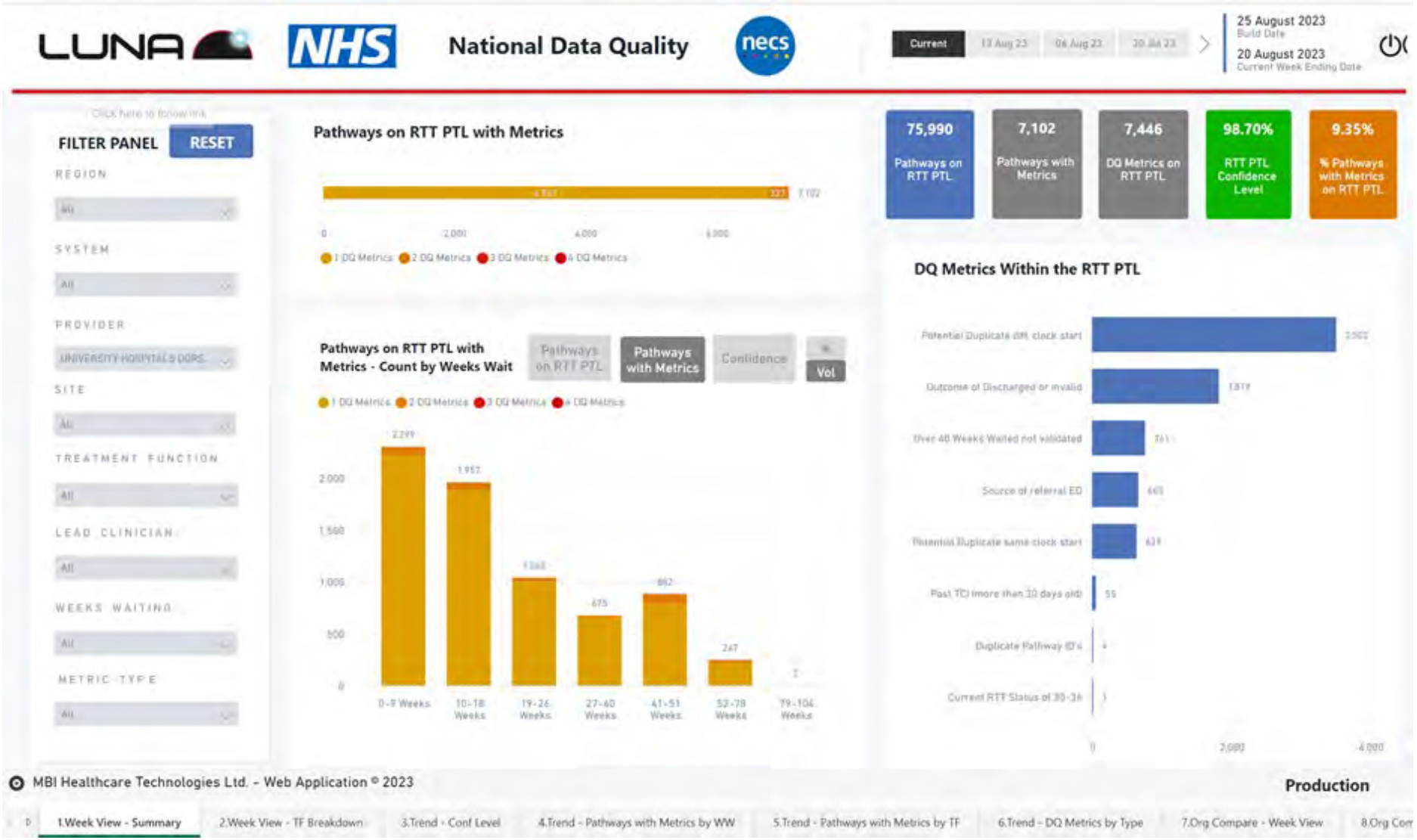
- A weighting is applied to DQ metrics depending on severity and greatest improvement of the overall waiting list quality
- Enabling comparisons of organisations, systems, regions within a single measure regardless of size on a like-for-like basis
- The current national standard has been set to 95%

Metric Code	Metric Description	Confidence Severity
RTT01	Current RTT status is 21 and on RTT PTL (21 Transferred to another Provider)	10
RTT02	Current RTT Status is 98 and on RTT PTL (98 Activity not applicable to RTT)	10
RTT03	Current RTT Status is 92 and on RTT PTL (92 Diagnostics only)	10
RTT04	Current RTT Status is 99 and on RTT PTL (99 RTT status not yet known)	10
RTT05	Current RTT Status of 90, 91 and on RTT PTL	10
RTT06	Current RTT Status of 30-36 on RTT PTL	10
RTT07	Current RTT Status of 10, 11, 12 or 20 with period end date	10
RTT08	Current RTT Status Missing or Current RTT Status Invalid on RTT PTL	20
RTT09	Potential Duplicate Active RTT Pathways (same clock start date)	20
RTT10	Potential Duplicate Active RTT Pathways (different clock start date)	10
RTT11	Last Appointment Outcome of Discharged or invalid and on RTT PTL	20
RTT12	Treatment Function is non-RTT, missing or invalid and on RTT PTL	10
RTT13	Missing clock start date or future clock start date on RTT PTL	20
RTT14	Over 40 Weeks Waited on RTT PTL and have not been validated	10
RTT15	Source of referral from ED and on RTT PTL	10
RTT16	Past TCI (more than 30 days old) on RTT PTL	10
RTT17	Pathways on RTT PTL with a Planned Waiting List Entry or invalid admission method code	10
RTT18	Duplicate PATIENT_PATHWAY_IDENTIFIER	20
RTT19	Source of referral missing or invalid and on RTT PTL	10

LUNA Dashboard

Overview of Dashboard

- **Filter Panel** - to constrain data by Region, System, Provider, Specialty, Clinician, Weeks Wait band or Metric
- **Report Tabs** - navigate between different reports:
  - 1-2: Week Views
  - 3-6: Trends
  - 7-10: Org Comparisons
- **Dashboard elements**
  - Breakdown of total PTL size, DQ Metric rate and Confidence Level
  - Weekly view for each DQ Metric of number within the RTT PTL data
  - Total RTT PTL broken down into weeks waited bands



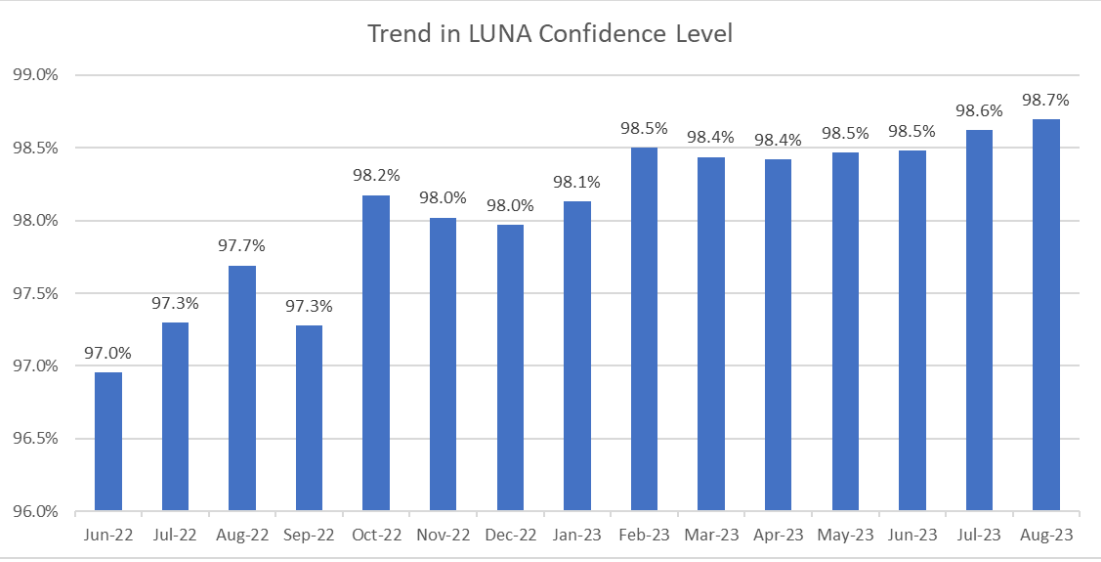
Current Performance

Data Validation & Assurance

- LUNA reviewed on a weekly basis by the RTT projects team with oversight by the Associate Director of Business Intelligence and Director of Operational Performance and Oversight
- Data is used to direct BI and RTT Validation team resources to areas where data quality needs addressing
- LUNA reports provide RTT DQ assurance for the Trust's monthly Data Quality, Income and Coding Group

Trend in the LUNA metrics over the last 12 months

- PAS merger impacted on confidence score but with weekly monitoring and targeted RTT validation using the LUNA solution there has been an improvement in the monthly LUNA confidence level over the last 14 months as shown by the graph below
- Table below shows UHD latest weekly confidence level is 98.70% in comparison with SW Providers



Regional Rank	Organisation Name	Luna Confidence Level	National Rank (out of 135)
1	ROYAL CORNWALL HOSPITALS NHS TRUST	99.7%	13
2	DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	99.6%	21
3	ROYAL DEVON UNIVERSITY HEALTHCARE NHS FOUNDATION TRUST	99.5%	29
4	UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST	99.4%	38
5	UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST	99.3%	52
6	GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	98.8%	81
7	NORTH BRISTOL NHS TRUST	98.7%	84
8	UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST	98.7%	87
9	TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	98.6%	96
10	GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	98.5%	97
11	ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST	98.4%	100
12	SALISBURY NHS FOUNDATION TRUST	98.4%	104
13	SOMERSET NHS FOUNDATION TRUST	0.0%	134

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Appendix B: Follow-up reduction programme

Approach to implementation of 2-year principle

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Proposal

The opportunity – stage 1 (longest waiters and multiple DNAs)

Overview of current challenge

New patients – management of non-responders

Non-responders to ongoing specialty level administrative validation exercises to be **discharged after 2 or 3 communication attempts** in accordance with process agreed with Primary Care and Patient Access Policy.

Follow-up patients – multiple DNA's

All patients who have **DNA'd their past 2 or more appointments** to be issued communication informing them that they have been **discharged to PIFU** (in accordance with Patient Access Policy).
Size of cohort: 127

Safety netting – discharge to PIFU means patients have 6 months to contact service to request an appointment following discharge.

Follow-up patients – target date

All patients who are **overdue 2 years or more** will be issued communication informing them that they have been **discharged to PIFU**.
Size of cohort: 4,045 (end June 2023)

Follow-up patients – No target date

All patients with no target date to be seen, who have **not been seen in 2 years or more** will be issued communication informing them that they have been **discharged but given the option to contact the Trust if they consider they have been discharged in error**. **Size of cohort: 37,170**

Considerations

- Application of **exclusion criteria** includes patients on a cancer pathway, learning disabilities.
- Policy will apply to all specialties, except where written exceptions have been agreed by Care Group Medical Director.
- Correspondence to clearly indicate discharge from **consultant care** (will not affect ongoing nurse or therapy led follow-up).
- **Dedicated call centre** for **defined timescale to manage queries**
- Build in a **buffer period** between **notifying of discharge to PIFU** and **transacting on PAS** to manage queries.
- Ongoing work to improve **front-end processes** e.g., **correct outcomes, Advice and Guidance**, enforcing **Access Policy** rules **re: DNAs** going forward.

Summary

Agreed principles

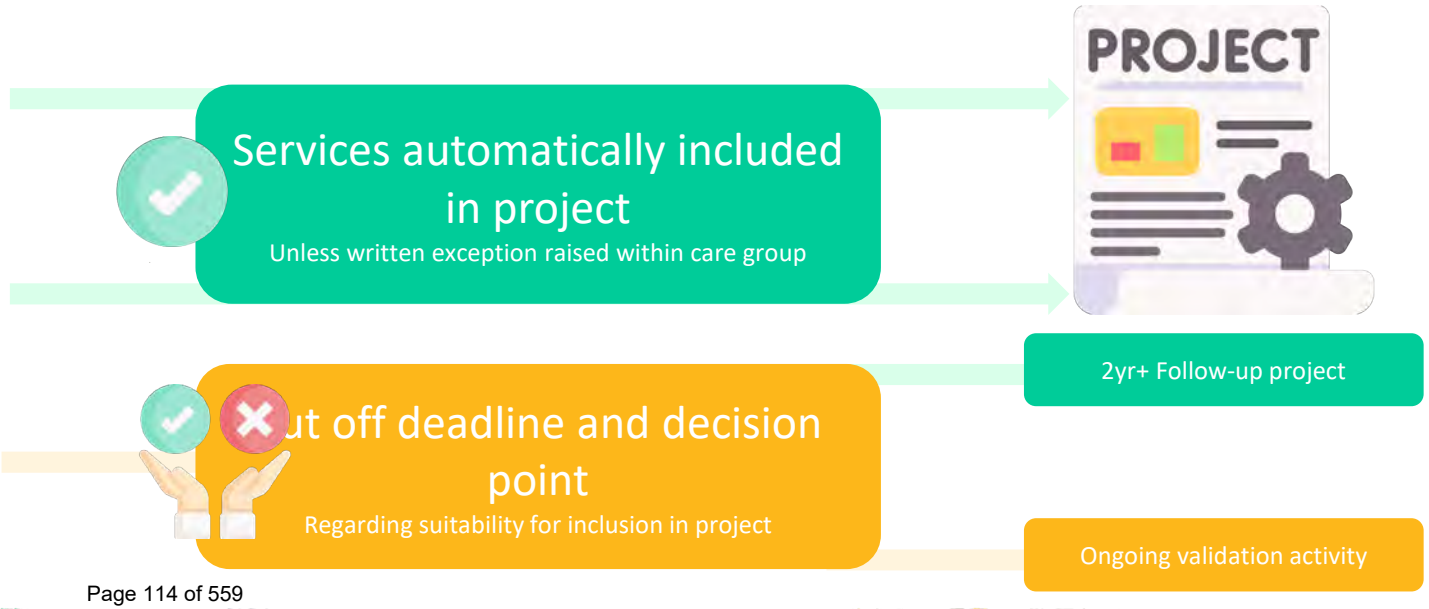
• All patients who are overdue 2 years or more will be issued communication informing them that they have been discharged to PIFU.	Phase 1 Cohort: 4,045
• All patients with no target date to be seen, who have not been seen in 2 years or more will be issued communication informing them that they have been discharged but given the option to contact the Trust if they consider they have been discharged in error.	Phase 1 Cohort: 37,170
• All patients who have DNA'd their past 2 or more appointments to be issued communication informing them that they have been discharged to PIFU (in accordance with Patient Access Policy	Phase 2 Cohort: 127

Application of principles – identifying suitable services

Services where **validation activity** is **completed** and there are no outstanding actions. Patients remain in 2yr+ cohorts and are suitable for inclusion.

Services where **no recent validation** has taken place and patients are identified in 2yr+ cohorts. No exceptions are raised for exclusions.

Services where **validation work is in progress** e.g. digital first, application of logic, clinical review.



Application of 2-year principle

Outpatient follow-up waiting list

University Hospitals Dorset NHS Foundation Trust

Exclusion period – option for clinical decision to 'opt out' of communication project

Service opt out

Manual validation – service performs manual validation of cohort within same timescales

Digital-first communication issued to patients where mobile number held, asking to contact us if they believe they are still waiting for a follow-up appt with consultant.

Patient **acknowledges message and no concern**

Episodes closed or **discharged to PIFU** based on target or no target date.

Patient **does not respond or is undeliverable**

No response

Letter issued to **non-responders** and pts without mobile number with same information

Patient **raises query with the contact centre**

Query logged, where possible **resolved on initial contact** or **escalated to service** to investigate

Service review to **identify appropriate outcome** and next steps for patient

Patient **informed of next steps** by Contact Centre

Follow-up appointment booked where required

Phasing structure – Next Steps

3 distinct phases

The phasing approach has taken into consideration a number of factors including **size of cohorts**, **distributed phasing for leads** (as to not overwhelm services) and **spread across care groups** and directorates within each phase to **inform improvements**.

Where services are not included within a phase this is due to one of two reasons:

- **Zero** or **very small numbers** in 2-year overdue or not seen cohort and therefore manual validation is more appropriate and will take place within same timescales.
- Service has **requested to be excluded** from work and assurance / plan is in place for resolution of position within same timescales as the phases, the progress of which will be **overseen by the wider follow-up reduction programme** and task & finish group.

A summary of the 3 phases and included services is below.

Phase 1 (11th Sept – 5th Oct 2023)

Service	Target date	No target date
Paediatrics		Y*
Cardiology		Q
Breast	Y	Y
Dermatology		Y
Ear, Nose and Throat	Y	Y
Trauma and Orthopaedics	Y	Y
Vascular		Y

Phase 2 (9th Oct – 3rd Nov 2023)

Service	Target date	No target date
Colorectal		Y
Upper GI Surgery		Y
Geriatric Medicine		Q
Community Paediatrics		Y*
Clinical Oncology		Q
General Surgery	Y	Y
Rheumatology		Y
OMF	Y	Y
Cardiology		Q
Haematology		Q

Phase 3 (6th Nov – 1st Dec 2023)

Service	Target date	No target date
Paed Diabetes		Y*
Paed Surgery		Y*
Ophthalmology		Q
Urology	Y	Y
Endocrinology	Y	Y
General Medicine	Y	Y
Diabetes	Y	Y
Respiratory	Y	Y
Rehabilitation		Y

** Cohort included but for patients who have not been seen by a consultant in 2 years and 3 months.*

University Hospitals Dorset
NHS Foundation Trust

Appendix C: Specialist Advice and Guidance

31st August 2023

We are
caring
one team
listening to understand
open and honest
always improving
inclusive

GIRFT Guidance on Advice and Guidance

An assessment against GIRFT recommendations in 2021/22 identified four services where an opportunity for Specialist Advice and Guidance pathways existed and Cardiology was also identified as a priority locally. All specialties identified have subsequently implemented advice and guidance.

Care Group	Host Trust	Specialty	Directorate	Recommendation Type	Date Issued / Visit date	GIRFT Reference	Potential Improvement Opportunity	Implementation status
Medical	PHT	Cardiology	Cardiology and Renal	Local	May-19	Car L30	Advice and guidance and virtual clinics should be part of standard practice to reduce un-necessary follow-ups into clinics. An admission avoidance clinic should be offered to reduce cardiac admissions to Bournemouth.	Complete
Medical	UHD	Dermatology	Medical Specialties	National	Sep-21	DER N19d	Review teledermatology services to inform trust level investment and resourcing decisions	Complete
Specialties	UHD	Maternity and Gynaecology	Women's Health	National	Sep-21	MAG N6a	Treat gynaecology patients in the most appropriate setting for their condition.	Complete
Medical	UHD	Neurology	Medicine	National	Sep-21	NEU N4a,b,c	Implement advice and guidance and a triaging system of outpatient referrals to ensure effective management of referrals, offer earlier management advice, improve clinic waiting times and reduce DNAs.	Complete
Surgical	UHD	Paediatric Trauma and Orthopaedics	Orthopaedics	National	Apr-22	PTO N17b	Optimise processes for managing variants of normal.	Completed

Services where Advice and Guidance Pathways are in operation 2023/24

- Cardiology
- Children's & Adolescent Services
- Dermatology
- Diabetic Medicine
- Diagnostic Endoscopy
- Ear, Nose & Throat
- Endocrinology and Metabolic Medicine
- General Medicine
- Geriatric Medicine
- GI and Liver (Medicine and Surgery)
- Gynaecology
- Haematology
- Neurology
- Ophthalmology
- Oral and Maxillofacial Surgery
- Orthopaedics
- Rehabilitation
- Respiratory Medicine
- Rheumatology
- Surgery - Breast
- Surgery - Not Otherwise Specified
- Surgery - Vascular
- Urology

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 27 September 2023

Agenda item: 6.4

Subject:	Risk Register Report
Prepared by:	Natasha Sage, Head of Risk Jo Sims, Associate Director for Quality Governance and Risk
Presented by:	Paula Shobbrook, CNO

Strategic themes that this item supports/impacts:	Systems working and partnership ☐ Our people ☐ Patient experience ☐ Quality: outcomes and safety ☒ Sustainable services ☐ Patient First programme ☐ One Team: patient ready for reconfiguration ☐
BAF/Corporate Risk Register:	All
Purpose of paper:	Review and Discussion

Executive Summary:

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

To note – Risking Scoring 20+			
Risk no:	Title		Exec Lead
1872	Patient Flow: Risk to patient safety, statutory/performance compliance & reputation - downstream capacity/front door crowding		COO
1784	Critical Path Management		CSTO
1604	Delay in securing UHD and wider Dorset New Hospital Programme (NHP) funds		CSTO
1429	Ambulance handover delays - risk to patient harm, performance and organisational reputation		COO
1460	Ability to meet UEC National Standards and related impact on patient safety, statutory compliance and reputation.		COO

Risks graded 12+ - Compliance with review timescales – to note

No: of risks under review	Number of Risks compliant with Risk Appetite timescales	% of Risks Compliant with Risk Appetite timescales	Month on month position
41	39	95%	⟷

Background:	The report is provided in accordance with the UHD Risk Management Strategy. To provide details of the risks rated 12+ on the UHD NHS Foundation Trust risk register. Work is in progress to enhance the reporting of controls and mitigations within the Risk Register report presented to the Board.
Key Recommendations:	To approve new 12+ risks
Implications associated with this item:	Council of Governors ☐ Equality and Diversity ☐ Financial ☐ Operational Performance ☐ People (inc Staff, Patients) ☐ Public Consultation ☐ Quality ☒ Regulatory ☐ Strategy/Transformation ☐ System ☐
CQC Reference:	Safe ☒ Effective ☐ Caring ☐ Responsive ☐ Well Led ☒ Use of Resources ☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Trust Management Group	12/09/2023	For discussion
Quality Committee	19/9/2023	Meeting has not yet taken place at the time of submission of this report.

University Hospitals Dorset
NHS Foundation Trust

Risk Register Report

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

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

For the period to end August 2023 (as on 05/09/2023)

Risk Register Report

Risk Register

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

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

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 208 approved risks on UHDs Risk register, of which 41 are rated as 12 and above

2. There is 3 new risk rated as 12 and above to be approved by the Board of Directors (Sept 23)

   One new risk was discussed at F&PC and QC in September 23

Risk Ref	**1950 (BAF)**
Risk Rating	20
Risk Title	Graphnet Electronic Patient Record (EPR) is not fit for purpose
Risk Description	There is a risk that the Trust EPR is not fit for purpose for UHD and the wider Dorset System. There is a risk that this impacts on patient flow (1872), patient safety and results acknowledgement (1378) and operational reliability (1805) clinical engagement and staff morale.
Risk Background	UHD has an EPR (Graphnet) using 1990s computer code, to which few coders can now use. UHD is the sole remaining customer. The supplier has indicated it wishes to exit this market as soon as possible. The Medical Staff Committee (MSC) at UHD have written as a body highlighting there are considerable clinical risks with Graphnet, and these are reflected in the Trust risk register. These risks are: i. Inhibited Patient Flow and increased length of stay, due to poor functionality (risk rating 20) ii. Lack of closed loop reporting of results, leading to delayed or missed diagnosis (risk rating 15) iii. Instability and degradation of our current EPR, which will worsen (risk rating of 12) Clinicians are also highlighting the impact of reduced productivity as less patients are seen per clinic, theatre list and ward round due to the time taken navigating multiple disjointed, separate systems. Doctors in training rotating between Trusts see the difference and are less likely to want a career at UHD due to “unsafe, and “labour-intensive IT systems.”
Leads	Peter Gill, CIO
Controls	The majority of the trust IT systems that make up the EPR ecosystem have the following controls in place: o Underpinning legal contracts with software suppliers o Immutable backups (i.e. cannot be affected by malware) o Staff training programmes o Active Information Asset Owners who undertake appropriate audits in line with the Data Security and Protection Toolkit o UHD wide Business Continuity Plan o Dedicated Subject Matter Experts in the clinical applications who maintain them in their optimal state o Teams of people working to ensure that the underlying IT Infrastructure is maintained in an optimal state
Action plan(s)	

Responsibility ('To')	Specialty	Title of Action	Description of action to be taken	Evidence of Effective Implementation	Start date	Due date
Peter Gill		Option appraisal	An option appraisal has been generated. UHD recommends to immediate procurement and implementation of a small core subset of EPR functionality in advance (but linked with) the Dorset wide procurement.		01/08/2023	31/12/2023

Risk Register Report

2 new risks were discussed at QC in August 23

Risk Ref	**1665**
Risk Rating	15
Risk Title	School age Neurodevelopmental service
Risk Description	The school age neuro-developmental service does not have enough capacity to meet demand for children aged 5-16 yr olds who are: - medicated and monitored to manage neurodevelopment issues - referred to the School age Neurodevelopmental service for advice, guidance and treatment.
Risk Background	The school age neurodevelopmental service continue to receive a high number of referrals without the ability to triage and see the children in a timely way. This includes inappropriate referrals which are not identified until triaged. There are multiple children on waiting lists without a named clinician. Staff wellbeing: Staff turnover is an issue in the service with new staff working in the service being stressed and burnout with increasing workloads with angry and desperate families attending. New members of staff have required long term sickness management. The service absorb the waiting times of other organisations such as waiting for Parenting programmes (LA and third party), wait for SALT (Dorset Healthcare) and wait for EPs (LA), further increasing waits and increasing the Trust's reputational risk. Medical staff are due to retire earlier than planned and recruitment into posts for the named clinician and working as part of the team have yet to be successful. The service are breaching the NHSE waiting time target of 78 weeks RTT (zero tolerance) for non-admitted patients
Leads	Exec Lead- Peter Wilson, CMO
Controls	National targets in place-RTT zero tolerance 78 week waits, 65 week target from March 2024 Local contractual expectation (provision of service and rejection of referrals) in place Monitor of patient satisfaction via Complaints and claims Escalation process in place and compliance monitored Dorset Pathway in place and compliance monitored Workforce template agreed Monitoring of staff wellbeing through Absence, sickness & turnover
Action plan(s)	Delyth Howard | Child Health | To monitor the CDC School age service transformation plan | To monitor all service improvement and transformation actions via the CDC School Age transformation meetings | Actions achieved to support the reduction in pressure on the service and improvements to support sustained changes to the service for the mid to long term. | 22/09/2022 | 28/09/2023 David Hannington | Child Health | Engagement with ICB All Age Autism Pathway review | UHD team to be integral in the Dorset wide ICB review of the autism pathway, key stakeholders to represent and contribute to the development of meaningful actions to help shape services going in to the future. | System wide changes to pathways to improve patient and staff experience. Reduction in waiting times, increase in service user satisfaction. | 01/01/2021 | 31/01/2024

Risk Register Report

Risk Ref	**1863**
Risk Rating	12
Risk Title	Impact of Industrial Action on provision of services
Risk Description	If industrial action across healthcare professions, it may cause disruption to delivery of commissioned emergency and elective activity. It is likely to impact on the organisations ability to meet operational standards. The consequence is potential harm to patients and ability to achieve delivery of contracted activity. Staff will also be impacted from a well being and financial perspective.
Risk Background	There have been numerous industrial action days across nursing, medical and ambulance services. There is a potential for other professions to strike. The impact of Industrial Action has resulted in cancellation of elective and urgent care and a requirement to redeploy staff to alternative areas to keep the emergency pathways running. As an organisation this has impacted on our ability to deliver the elective recovery programme and resulted in longer waits for our patients.
Leads	Exec Lead- Mark Mould, COO
Controls	Extensive planning for individual strikes to limit disruption and maintain patient safety. In planning for and then managing the various incidents of Industrial Action, appropriate recourse has been made to the UHD Incident Response Plan and Incident Coordination Centre Standard Operating Procedure. On the day Tactical Command in place to manage the situation live and provide tactical support. Strategic (Gold) Command also in place to manage the wider system response and clear decision making for the Trust. Communication plan in place to keep staff informed. Minimised risk to patients by prioritisation of clinical activities to ensure skilled workforce focus on emergency/urgent care during IA. Training and redeployment of staff to support areas at risk. Regular understanding of the impacts/loss of activity provided by the BI Team. Regular review of LERNS reports to consider harm incidents to patients and staff. On the day safety hubs in place to review any quality/risks identified and requirement immediate intervention.
Action plan(s)	Sophie Jordan | | Develop a corporate SOP for Industrial Action planning and mitigations | Develop a corporate SOP for Industrial Action planning and mitigations | SOP to be attached to the risk | 14/03/2023 | 31/08/2023

Risk Register Report

3. There is 1 risk closed or reduced in month that was previously rated at 12 and above

Ref	Risk rating	Description	Update	Risk Owner	Date risk accepted as a 12+ risk	Last review date	Date closed or reduced
1300	12	If we continue to be unable to provide 24hr specialist care to children up to the age of 18 who attend hospital with Deliberate Self Harm behaviours and Mental Health needs there is a risk to patient safety which will result in harm.	Risk reviewed and replaced by new risk -1951.	Mark Tighe	22/02/2021	15/08/2023	Risk closed 15/08/2023

4. Risk updates

Risk Number	Title	Rating (current)	Last review date	Review for Board	Handler	Executive lead
Partnerships and Population Health						
1460	Ability to meet UEC 4-hour safety standard and related impact on patient safety, statutory compliance and reputation.	20	08/09/2023	08/09 Performance against the 4-hour standard for August 2023 is 62.9% against a plan of 65%. The trajectory increases to 67% for September. Focused actions to recover continue with Enhanced support in place weekly with Exec Team. Current action plan uploaded	Higgins, Michelle	Chief Operating Officer - Mark Mould
1429	Ambulance handover delays - risk to patient harm, performance and organisational reputation	20	08/09/2023	08/09 August reports a marginal improvement on July ambulance handover position, however c1500 hours of lost time are reported. UHD cohort areas remain in place staffed by UHD and SWAST as able. Ongoing actions as part of ED Escalation meeting chaired by Execs weekly	Lister, Alex	Chief Operating Officer - Mark Mould
1872	Patient Flow: Risk to patient safety, statutory/performance compliance & reputation - downstream capacity/front door crowding	20	04/09/2023	Bed occupancy for July was 94.6% (not including escalation/surge beds), as over the recommended 88% to maintain safe flow it continues to be significant factor in not achieving the 4 hour ED standard. The daily average of MFRD patients in August was 193 patients, which is a significant increase on the past 3 months and continues to challenge clinical teams. (25 additional patients per day) Works is ongoing with the discharge team to ensure UHD utilises all available external capacity. However, it is clear that the system does not have sufficient capacity to meet the demand for MRFD patients.	Wersby, Stuart	Chief Operating Officer - Mark Mould

Risk Register Report

				Escalation beds in use also increased in August with 51 beds open on average to maintain the occupancy level above, of which 36 were funded. The 23-24 Winter Plan is progressing with the UHD challenges being shared with the ICC and meetings being set up to consider funding and external capacity support. Winter KLOES will be shared with the region and feedback is expected quickly		
1053	Lack of capacity for elective & non elective activity and associated risk to patient harm due to LLOS and NRTR patients	16	08/09/2023	Actions and Controls reviewed and updated •NCTR – UHD is the most challenged Organisation for No Criteria to Reside (NCtR) in the South West UHD is reporting 230-250 patients daily that do not need to be in an acute hospital bed. There are a mixture of reasons, but the majority are waiting for discharge with care, discharge to residential care or to a Community Hospital. •To achieve ICB milestones there should have been a 30% reduction in Q1, moving to 50% in Q2. Q1 has not been achieved. •UHD executives have met with ICB executives and given assurance around UHD data systems and flow. •UHD have met with Bournemouth and Christchurch Social Services to review the current position and progress actions to address. •The Trust has also identified KPIs to support the required reduction in NCtR. •UHD will meet with the regional 'Home First' leads to develop a system recovery plan to reduce the number of delayed patients in UHD beds approaching winter and escalate issues in delivering this plan.	Gabrielli, Antonia	Chief Operating Officer - Mark Mould
1074	Risks associated with breaches of 18 week Referral to Treatment and long waiter standards.	16	06/09/2023	3 78week waits reported at the end of August, which is an increase on the previous month due to the direct impact of industrial action in month and the high annual leave period effecting the ability to rebook patients in month. 65 week waits breaches also increased resulting in an increased variance to plan. The 65 'at risk' March 2024 cohort however continues to reduce and the variance to plan for this measure has reduced in month. The total waiting list has also seen a significant reduction of over 2,000 patients this month as a result of validation and increased activity. Action plans at speciality level requested to return to plan by end of September 2023.	May, Judith	Chief Operating Officer - Mark Mould
1697	Increased waiting list for SACT treatment/ Capacity on Day units	15	05/09/2023	Continue to receive LERN forms about lack of SACT capacity and day case work being undertaken on in-patient wards.	Miller, Marie	Chief Medical Officer - Peter Wilson
1502	Mental Health Care in a Physical Health environment	15	08/09/2023	Recent changes in health-roster to reflect reasons MHSW/RMN's are required. Recent retirement of MH/Addictions nurse has left a gap on AMU. Currently being advertised. Bespoke MH study days in progress for AMU both sites.	Aggas, Leanne	Chief Nursing Officer & Deputy COO - Paula Shobbrook
1840	OPS Outlying patients	12	08/08/2023	Ongoing meetings with Clinical Site Team and BI team regarding accurate lists of outliers and outlying policy. Also linking in with our transformation work.	Pigott, Lisa	Chief Medical Officer - Peter Wilson

Risk Register Report

				We have had a reduction in length of stay and number of outliers within our department, however we continue to have outliers. We need to discuss in our next Governance meeting regarding if based on reduction in numbers should be downgraded to score of 9, moderate harm but possible.		
1393	Endoscopy capacity & Demand	12	25/08/2023	Continuing CDC work which will increase capacity. Tender process starting in September. WTE Nurses have been interviewed and start dates are to be agreed. WLI work in progress and seeing continued improvement performance in DM01. JAG standards met at Poole - a/w RBH inspection (submitting evidence end of August). updated Action log added.	Lloyd-Hatchard, Kate	Chief Operating Officer - Mark Mould
1292	Outpatient Follow-Up appointment Backlog - Insufficient capacity to book within due dates	12	06/09/2023	• The total overdue follow-up back log has decreased from 34756 in February 2023 to 27633. This is a net reduction of 7,123 (20%). • The overdue 3yr+ cohort has decreased from 5362 in February 2023 to 1584. This a net reduction of 3778 (71%). • This progress has been achieved alongside the management of 'drop-ins' to overdue to cohorts of which there is approximately 2000 – 4000 total overdue follow-up drop ins each month. • A task and finish group has been established with membership from some of UHD's senior clinical leaders to manage risk associated with the trusts Outpatient follow-up waiting list and agree approach to tackling the backlog. In June the T&F group met for the first time and were presented with a summary of the follow-up position and examples of best practice which had taken place in within services in relation to follow-up backlog reduction. These examples of best practice included application of logic and manual validation, both of which indicated high levels of data quality issues within the follow-up waiting list, stemming back to the coronavirus pandemic and merger of the hospitals. Based on this, a principle of communicating with patients who were either showing as 'overdue' 2 or more years (Target Date waiting list) or who had not been seen by a consultant in 2 or more years (No Target Date waiting list), and subsequently closing episodes, was agreed. It was intended that this work would help cleanse the follow-up waiting list – enabling a clearer view of patients genuinely waiting follow-up care, plus the opportunity to potentially identify lost to follow-up patients by giving patients a clear route to make contact with the organisation. • A pilot of this approach has successfully taken place with Gynaecology. In total 1263 communications were issued to patients via digital first approach. A total of 86 queries (7% of cohort) were received via the dedicated contact centre of which 40% could be resolved upon first contact. The other 60% queries were resolved within an average of 3 working days. • Between September – December 2023 across 3 phases this approach will be applied to all specialties who have cohorts which meet the '2yr+ criteria'. Any specialties who have opted out of the communications will manually validate the same cohorts within the timescales, with oversight by the follow-up task and finish group and programme governance.	Jose, Darren	Chief Operating Officer - Mark Mould

Risk Register Report

				• Other work is taking place to explore next stage validation approach e.g., additional logic which could be applied to follow-up backlog and improving processes around outcome codes and follow-up waiting list management to prevent recurrence of size of backlog in the future.		
1386	National Cancer Waiting Times Standards	12	05/09/2023	Cancer Access policy being updated in response to the announcement of version 12 of the National Cancer Waiting Times Standards from Oct 1st 2023. Risk remains around performance due to an increase in referrals and the cumulative effect of the ongoing industrial action. Recovery plans are in place (with a rapid plan for skin attached) with expected recovery in Q2. Despite these challenges, the over 62D position remains stable and clinical reviews are ongoing. RCAs are completed for patients who breach 104 days on an open cancer pathway	Lake, Katie	Chief Operating Officer - Mark Mould
People						
1483	Pharmacy vacancies are affecting patient care	16	10/08/2023	Reviewed however significant shortage of pharmacists, specialist and general rotations challenged, weekend cover for Poole site a particular concern. Senior team to look to support whilst newly qualified pharmacists that have started in post are trained at RBH.	Bleakley, Stephen	Deputy Chief Medical Officer UHD - Ruth Williamson
1397	Provision of 24/7 Haematology/ Transfusion Laboratory Service	16	10/08/2023	RBH Locum gave notice 09/08/2023 which puts the RBH laboratory at further risk - leaving 1 in 5, possibly 1 in 4. Looking at further locum CVs	Macklin, Sarah	Chief Nursing Officer & Deputy COO - Paula Shobbrook
1811	Staff Vacancies and Skill mix deficit - Theatres	15	31/08/2023	Recruitment drive for theatres ongoing GANTT chart produced to track onboarding and session capacity	Bone, Clare	Chief People Officer - Karen Allman
1202	Medical Staffing Women's Health	15	01/09/2023	Risk updated with Clinical Director for Women's Health. Risk grading to remain the same. Increased sickness amongst Consultants. Locum Consultant 12month post declined. Short listing in progress for clinical fellow which will support Antenatal clinics and second tier of on calls. Currently out to advert- Maternity Cover for LW lead Cons. Plans for industrial actions of junior doctors: 20th-23rd Cons 19th-20th adding strain to the delivery of elective caesareans and Antenatal clinics.	Taylor, Mr Alexander	Deputy Chief Medical Officer UHD - Ruth Williamson
1395	Lack of Capacity in Cellular Pathology Causing a Delay in Processing and Reporting.	15	15/08/2023	Linked incidents updated and added from Jan-August 2023 incidents (32) 2 moderates, one of these is health and safety related and a staff injury as a result of the pressure of staff in the laboratory. 1 delayed treatment for lung cancer. 22 no harm/near miss, 8 minor Incident themes are Use of outsourcing 26.4% Laboratory staff pressure/working environment (specimen handling/delay in process/release of reports/admin/sample lost) 26.4% Consultant short staffing/pressure (misplaced cases/mix up of cases/TAT/triage/error) 47%	Massey, Paul	Deputy Chief Medical Officer UHD - Ruth Williamson

Risk Register Report

1221	Medical Staffing Shortages - Medicine and Older Persons Medicine	12	08/09/2023	Discussed at Medical Care Group Governance 6/8/2023 and agreed continues at 12 for now as we continue to have gaps in the medical workforce. We currently have gap in SAS/Registrar level doctors. Still require further recruitment to Consultant Post. GMC training survey results available and RBH remains outlier for several areas including handover and out of hours senior cover.	Pigott, Lisa	Deputy Chief Medical Officer UHD - Ruth Williamson
1498	Patient Safety due to inadequate Medical Registrar Out of Hours Cover (RBH)	12	25/08/2023	Risk reviewed and remains current. To be re-reviewed next month following next round of recruitment	Whitney, Sue	Deputy Chief Medical Officer UHD - Ruth Williamson
1692	Safe Staffing - Medical	12	06/09/2023	CMO to identify risk assessor/owner to continue to manage this risk and update the risk register accordingly.	Williamson, Ruth	Chief Medical Officer - Peter Wilson
1283	Radiotherapy radiographer staffing	12	15/08/2023	Risk content reviewed to include all Radiotherapy staffing the service demands. The patients are prioritised according to Royal College of Radiologist categories 1-3. The department is reviewing category 2 patients to determine if treatments can be safely delayed. This is to provide capacity for Cat1 patients to be treated within the 31 day target. For example Prostate patients are being delayed to m6 of hormones, instead of M5. Currently 34 patients wating. BCC are being delayed as benign conditions DCIS breast patients will be reviewed for their suitability to be delayed. 4 x Linacs currently run 9 hours per day. Where possible extended days are being run – subject to staffing Voluntary weekend working Requests for planned servicing of equipment to be conducted outside of clinical to avoid loss of capacity	Tanner, Mandy	Chief Nursing Officer & Deputy COO - Paula Shobbrook
1758	Chemotherapy production in pharmacy now at capacity and limiting patients accessing treatment	12	23/08/2023	Screening locums had contract extended to end of October which helps to mitigate further pharmacist resignations. Cancer services and pharmacy team are investigating commissioning Lloyds Homecare to provide additional SACT support. Current capacity limits remain.	Bleakley, Stephen	Deputy Chief Medical Officer UHD - Ruth Williamson
1642	Midwifery Staffing	12	26/08/2023	midwifery vacancy has reduced to 15% this month. Our trajectory shows that our vacancy will be between 3-8% before the end of the year. We continue to work towards recruiting 12 IEM before the end of the year. recruitment and retention midwife has now commenced.	Taylor, Kerry	Chief Nursing Officer & Deputy COO - Paula Shobbrook

Risk Register Report

1843	Paediatric acute medical staffing	12	08/09/2023	August CH QR group cancelled due to IA - review score at Sept CH QR. Consultant and middle grade rota more robust following recruitment. SHO tier more challenged due to several deanery gaps - plans to mitigate.	Tighe, Mark	Deputy Chief Medical Officer UHD - Ruth Williamson
1493	Absence, Burnout and PTSD	12	05/09/2023	The comparison data has been received, which shows a decrease in stress/anxiety/depression compared to previous year.	Mardon, Irene	Chief People Officer - Karen Allman
1303	Therapy Staffing	12	08/09/2023	Locums and bank staff are being prioritised for IP teams for OT at PGH Winter funding monies agreed, plan to be generated by Oct '23 Out for advert for B6 OT/PT- OPS Skill mix consideration for B6/B5 roles at RBH Review feasibility of B6 rotations due in Nov based on safe staffing levels	Godden, Rebekah	Chief Nursing Officer & Deputy COO - Paula Shobbrook
1771	Radiology Service Demands/ Radiologist staffing	12	07/09/2023	Reviewed at Radiology Q+R Meeting; Risk to remain the same, recruitment ongoing but further retirements from the team. Outsourcing figures increasing to meet demand, review of in-house reporting numbers being undertaken.	Knowles, James	Deputy Chief Medical Officer PH - Matt Thomas
1492	Resourcing Pressures - Staffing	12	04/09/2023	Momentum is being maintained for HCSW recruitment, with the pipeline having over 100 candidates under offer during August. £30k of Direct Support has been awarded by NHS England, which will in part be used by Nursing Workforce to fund a role focused on how we best utilise the capacity of the significant student population in the Bournemouth area. There are 3 HCSW recruitment events scheduled in September, and we are participating in the NHS England HCSW Application Form project this month too. It is proposed that we deploy a recruitment app, developed and trialled by University of Southampton NHS Trust, to attract and engage HCSW applicants.	Gill-Parker, Tracy	Chief People Officer - Karen Allman
1876	Inability to provide Medical cover for Maternity Triage service out of hours	12	23/08/2023	Recruitment process on 25/7/23 x1 candidate did not accept the post and x1 appointed. Currently actively recruiting.	Rumani, Genc	Chief Medical Officer - Peter Wilson
Quality (Safety and Outcomes)						
1214	Risk of misdiagnosis/ incorrect treatment from use of ungoverned Point of Care devices.	16	03/08/2023	Update requested re progress of POCT task and finish group	Massey, Paul	Chief Medical Officer - Peter Wilson
1276	Unsafe and delayed patient care due to delays in surgery for # Neck of Femur patients	15	25/08/2023	improved performance (>50%) No change to risk, action plan updated	West, John	Chief Operating Officer - Mark Mould

Risk Register Report

1378	Lack of Electronic results acknowledgement system	15	02/08/2023	Task and finish group to lead an evaluation of the options and the implementation of a solution to mitigate this risk	Hill, Sarah	Chief Information & IT Officer - Peter Gill
1647	Ineffective and inconsistent patient handover processes	12	05/09/2023	Transfer of information from ED review has been undertaken and the preliminary findings and recommendations have been shared	Wilson, Peter	Chief Medical Officer - Peter Wilson
Sustainable Services						
1784	Critical Path Management	20	06/09/2023	06/09/2023: Risk increased from 16 to 20 due to delays in construction of the new ward building. The timeline for Reconfiguration Move 1 has been delayed by 5-6 months so now looking at autumn 2025. NHP scheme and beds required for RBH site will not be ready until late 2025. Review proposed to move some services when BEACH building is ready (March 2025). A small T&F Group has been set up to meet during July and August to understand risks and mitigations on Maternity, Critical Care and RBH ED moving in March 2025.	Killen, Stephen	Chief Strategy and Transformation Officer - Richard Renaut
1604	Delay in securing UHD and wider Dorset New Hospital Programme (NHP) funds	20	06/09/2023	06/09/2023: OBC approved 21/7/23 but some conditions have been imposed. Awaiting written confirmation of approval. Adjustments made to scope to bring work within NHP budget (£262.7m) and paper submitted to NHP investment committee. Alternative funding sources are being investigated for those schemes now out of scope of NHP. The schemes are to be retained within the £262.7m, and TMB have agreed a Trust wide approach to attracting future funding for the £30m shortfall of schemes. A task and finish group will be set up to review the deferred list and agree the priority order to attract investment for the shortfall. S&T team will continue to lobby NHP National Team and others to secure the funding elsewhere.	Killen, Stephen	Chief Strategy and Transformation Officer - Richard Renaut
1881	Financial control total 2023/24	16	22/08/2023	The finance and performance committee agreed the current risk rating.	Papworth, Pete	Chief Finance Officer - Pete Papworth
1595	Medium Term Financial Sustainability	16	22/08/2023	The finance and performance committee agreed the current risk rating.	Papworth, Pete	Chief Finance Officer - Pete Papworth
1416	GIRFT and Model Hospital	16	05/09/2023	Reviewed, new controls introduced from September. Need to wait until there is time for approach to embed and generate additional opportunities before can change risk rating. No change	Rushforth, Helen	Chief Finance Officer - Pete Papworth
1355	Lack of integration between the Electronic	15	30/08/2023	Plan is to end to end work through with a live patient and clinician in early September when they return from leave. Then all documentation will be	Roberts, Michele	Deputy Chief Medical Officer

Risk Register Report

	Referral System (eRS) & Electronic Patient Record (ePR)			produced to support a go live end September / early October for the first specialty.		UHD - Ruth Williamson
1594	Capital Programme Affordability (CDEL)	12	22/08/2023	The finance and performance committee agreed the current risk rating.	Papworth, Pete	Chief Finance Officer - Pete Papworth
1260	Ensuring Estates are compliant with regulatory standards (SFG20/HTM00) across fire, water, electricity, gases and air handling	12	25/08/2023	Risk score to remain the same. Staffing level risk to be articulated and added to the risk register. Increasing use of contractors to remain on target.	Bhukal, Bernard	Chief Strategy and Transformation Officer - Richard Renaut
1805	EPR Stability Issues	12	08/09/2023	Review of the Solar Winds monitoring solution is underway with Graphnet as the final element of the review. Improved stability over the last month or so but still unclear if the issues are resolved.	Hill, Sarah	Chief Information & IT Officer - Peter Gill

Risk Heat Map- UHD

Current Risk Grading		Likelihood				
		No Harm (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Severity	Almost Certain (5)	1	11	8	6	
	Likely (4)	1	32	13	8	
	Possible (3)	1	43	32	8	
	Unlikely (2)		9	21	7	4
	Rare (1)			2		1

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

Risk Register Report

Current Risk Score– UHD total	August 22	Sept 22	Nov 22	Dec 22	Jan 23	Feb 23	March 23	April 23	May 23	Jun 23	Jul 23	Aug 23
Very Low (1-3)	1	2	2	2	3	2	4	5	5	4	5	**3**
Low (4-6)	71	67	67	68	69	71	70	67	63	63	72	**76**
Moderate (8-10)	92	91	85	78	80	82	75	73	78	78	82	**86**
Moderate (12)	17	17	17	17	19	19	19	18	20	21	22	**21**
High (15 -25)	22	22	22	23	23	25	24	21	24	21	20	**22**
Total number of risks under review	203	199	193	188	194	199	192	184	190	187	201	**208**

5. Compliance

Summary of compliance UHD overall:

Current Risk Grading	*No: of risks under review*	*Number of Risks compliant with Risk Appetite timescales*	*% of Risks Compliant with Risk Appetite timescales*	*Month on month position*
12 and above	41	39	95%	⟺
8 to11	88	78	89%	⬆ 2%
4 to 7	77	70	92%	⟺
1 to 3	3	3	100%	⬆20%
Total	**209**	**190**	**91%**	⬆ **2%**

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 27 September 2023

Agenda item: 6.4

Subject:	CQC Update
Prepared by:	Jo Sims, Associate Director for Quality Governance and Risk
Presented by:	Paula Shobbrook, Chief Nursing Officer

Strategic themes that this item supports/impacts:	Systems working and partnership ☐ Our people ☐ Patient experience ☐ Quality: outcomes and safety ☒ Sustainable services ☐ Patient First programme ☐ One Team: patient ready for reconfiguration ☐
BAF/Corporate Risk Register: (if applicable)	All
Purpose of paper:	Review and Discussion
Executive Summary:	The Trust has received the following inspection CQC inspection reports: • Urgent and emergency services at The Royal Bournemouth Hospital • Urgent and emergency services and outpatient services at Poole Hospital, The Outpatient Assessment Clinic at Dorset Health Village. The inspections were undertaken on the 27 and 28 June 2023 and published on the CQC's website on 14 September 2023. In the accompanying press statement, Roger James, CQC deputy director of operations in the south, said: "*When we inspected University Hospitals Dorset NHS Foundation Trust, we found capable leaders who had the skills to run services well using reliable systems, and staff who worked exceptionally well together with the aim of providing people with the most effective care and treatment. However, we saw long-standing, nationally reflected, issues with access and flow throughout the whole Dorset health and care system, creating pressures on demand and capacity. Coastal towns such as Bournemouth had been overwhelmed with the number of people needing access to services, not just through the*

	traditional busy winter period but also through the height of the summer holidays. The reports have identified a number of "must" and "should" actions for the Trust. The Trust has until 12 October 2023 to provide the CQC with details of the actions that will be taken to meet the regulatory requirements. This work is in progress with a number of actions already completed.
Background:	A short notice announced focused inspection was carried out by the CQC on the 27 and 28 June 2023. The inspection focused on the care and treatment in urgent and emergency services at The Royal Bournemouth Hospital, Poole Hospital, outpatients at Poole Hospital and The Outpatient Assessment Clinic at Dorset Health Village. As it was a focused inspection, no ratings were produced but CQC focused on the key questions of well-led, safe and responsive for these services as well as caring for urgent and emergency services at both hospitals. University Hospitals Dorset NHS Foundation Trust is yet to receive a rating by CQC for its services or hospital locations
Key Recommendations:	To note.
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	12/09/2023	Noted.
Quality Committee	19/09/2023	Noted.

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

University Hospitals Dorset NHS Foundation Trust

Poole Hospital

Inspection report

Longfleet Road
Poole
BH15 2JB
Tel:

Date of inspection visit: 27June 2023 28 June 2023
Date of publication: 14/09/2023

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at Poole Hospital

Inspected but not rated

University Hospitals Dorset NHS Foundation Trust provides acute and emergency services to people living in Poole, Bournemouth and East Dorset. University Hospitals Dorset NHS Foundation Trust provides a wide range of hospital and community-based care to a population of 771,000 based in the Dorset, New Forest and south Wiltshire areas.

On 1 October 2020, The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust merged to form a new organisation.

The trust provides a wide range of hospital and community-based care; and employs approximately 8,400 members of staff, both clinical and non-clinical. The trust has not been rated since the merger in October 2020. The hospital's ratings were inherited from the previous provider.

We carried out a focused inspection with a short notice on 27 and 28 June 2023. The inspection was carried out because we had concerns about care and treatment in some areas of urgent and emergency care and outpatients. We did not look at all key lines of enquiry but limited these to areas where concerns had been raised.

Urgent and emergency services

Inspected but not rated

- The service had enough staff to care for patients and keep them safe most of the time, although the skill mix and experience was not always optimal. Leaders did their best to cover unplanned absence and balance the skill mix and maintain frequent and tailored high-quality training for all clinical staff.
- Staff had the skills and knowledge to protect patients from abuse and acted when it was necessary. The service mostly controlled infection risk well but we observed a few lapses from staff in meeting trust policy around dress code. There was effective cleaning and infection prevention and control and we saw a visibly clean and well-organised department.
- There were long-standing national issues with access and flow through the whole health and care pathway. The south west of England was no different, and coastal towns such as Poole had been overwhelmed with patients and a lack of capacity for many months, including a very difficult winter period.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. A new patient record system had just been installed and was being rolled-out carefully and adapted to work for the department's needs. Staff felt respected, supported and valued. Teamwork was exceptional and highly valued by all staff. However, given the issues with demand and capacity, patients having growing health and care needs, including mental health, and growing demand for the service, staff morale was hard to maintain.

However,

- Patients' records were not always completed sufficiently well, particularly for longer-stay patients, to demonstrate staff met care needs, assessed risks to patients, and acted on them.

Is the service safe?

Inspected but not rated

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. They could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. They described well how they would identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. They knew how to make a safeguarding referral and who to inform if they had concerns.

We observed the arrival of a frail elderly patient who was clearly vulnerable and with cognitive impairment. They were unkempt and looked unable to care for themselves at that time. Staff were observed being patient and compassionate. Staff said how the safeguarding process had already started and it was recognised they would not be able to return home unless something was arranged to provide them with safe care.

Urgent and emergency services

Cleanliness, infection control and hygiene

The service mostly controlled infection risk well but we observed a few lapses in evidence-based practice from staff. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas, including those at height, were visibly clean and had suitable furnishings which were clean and well-maintained. Most of the furniture such as beds, chairs, and mattresses were in good condition to allow for effective cleaning and all the curtains appeared in good condition, were disposable, and dates showed regularly changed. Some of the chairs in the waiting room were showing signs of wear and tear and the plastic covers were cracking slightly in places, but otherwise visibly clean.

Staff mostly followed infection control principles. However, we did observe some staff not 'bare below the elbow' to enable safe and effective handwashing or contamination from clothing. In contravention of trust policy, we observed a small number of staff either wearing nail varnish, watches or rings which were not plain bands.

We saw good adherence from staff to hand washing and infection control procedures. Staff were wearing gloves and aprons when it was required for their interactions with patients. Most washed their hands or used alcohol gel before and after any interactions with patients or when entering or leaving the department. We did notice patients and visitors coming into the waiting area were not actively using the hand gel provided or being encouraged to do so either in the waiting area or moving into the treatment/triage areas. However, we did observe people coming into the assessment area with their relative/friend (called the 'pitstop') being asked to gel their hands on arrival.

There were cleaning staff working throughout the department during our visit. The areas we checked were clean and free from dust. We observed staff cleaning equipment after patient contact. However, some of the storage areas were small and did not have sufficient room for all the equipment being kept there. This meant some was on the floor (some in boxes) which made effective cleaning of these floors more difficult. In the resuscitation area we noted some chipped paint which could have been easily remedied, but also notices taped to doors with surgical tape, which was against infection prevention and control guidance.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment mostly kept people safe. However, there were limited facilities to keep children separate from adult patients when waiting to be seen.

The layout of the department had evolved over many years and as with most older emergency departments, had expanded into other areas of the hospital which made the environment not ideal for safety, visibility, and efficiency. The main patient waiting area in A&E was not big enough for the number of patients waiting at busy times. Staff told us it could fill up easily and patients ended up standing, which could cause obstruction, or waiting outside (although this area was undercover, but was also the ambulance arrival bay). This was recognised by staff as an issue and was on the departments risk register. However, with the unit relocating in 2024/2025 to the Bournemouth hospital major extension and new emergency department, there were no plans to increase the capacity of the waiting area. The area was clean and tidy and there was cold water provided for those waiting, but the machine was out of service.

Live camera feed was provided in the reception area for staff to monitor as reception and streaming staff in the reception area could not see all those waiting due to some areas being obscured. The triage room was small but did provide patients with privacy and confidentiality from other patients in the waiting area. The reception facilities were

accessible and suitable for meeting and talking with people who used wheelchairs. The doors into the rest of the department were locked with swipe card access for authorised personnel. The hospital did not have a helicopter landing area, but helicopters could land in the vicinity and be met by an emergency ambulance crew. The Ambulance crews had direct access to the department and their own entrance.

One area recognised by the trust was the failure to meet some of the guidance for provision of a safe environment for children. The Royal of Paediatric and Child Health Standard for Children in Emergency Care Settings recommends emergency departments have specific areas for children. These include waiting and treatment areas and those for families in a crisis. The emergency department in Poole Hospital did have a specific treatment area for children, but no waiting area. Children also had to access their treatment area through the department. There was a small room in ambulatory care where children and families were sometimes able to wait, but the protocol for use of this room was unclear. When we were in the department it was being used as a form of observation room for adult patients. Children were therefore not protected or removed from seeing and hearing adult patients, some with complex needs.

In order to maximise occupancy in the department for the frequent times of high capacity and demand, the majors bays had patients fairly close together. This made moving a patient's bed quite an artform for the experienced porters, but staff and visitors needing to regularly move out of the way.

The resuscitation area had four bays, one able to accommodate a child, and was well stocked with the required equipment, including that for children, pregnancy complications, and other specialist areas of treatment. We were told the bays could get full in times of high demand, but a four-bedded area was not untypical provision for a department of its size. There had been improvements to the area when it had changed locations, swopping with the children's treatment area, and now had glass doors added to provide improved infection control and privacy and dignity. It was also now located immediately adjacent to the ambulance receiving area and 'pitstop' for rapid assessment.

We observed patients had been given and shown how to use their call bell. The patients we asked said staff had responded quickly to them using their call bell – although most had used them infrequently.

Clinical waste was disposed of carefully and those bins we saw for the disposal of sharp instruments were not overfull. General waste bins were regularly emptied by the cleaning staff.

The department had investment to ensure a safe space for patients with Mental health problems which had been recognised as meeting Psychiatric Liaison Accreditation Network (PLAN) standards set by the national college of psychiatrists. However, staff told us there was a lack of ligature managed rooms for the number of patients with mental health problems seen in the department. Ligature managed rooms are safer spaces for patients experiencing thoughts of ending their lives. This meant patients required higher levels of nursing care than may have been appropriate to meet their physical health needs. This risk was recognised by staff and was on the departments risk register.

To resolve inconsistencies in stock levels staff within the department had developed and embedded a system that used quick response codes (QR codes) for reordering stock of medical consumables. Scanning a QR code enabled stock levels to be counted and included an automated process that emailed the individuals responsible for monitoring and procuring consumables. A QR code is a scannable image that can instantly be read using a smartphone camera. The phone can translate the QR code into something that can be easily understood by humans.

Urgent and emergency services

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration. However, the provision of longer-term care for patients who were delayed in being handed over for further treatment was not well documented or described.

Staff used a recognised tool to triage patients, this helped them assess how quickly they needed to be seen. The tool included recognising potential sepsis, stroke and heart attack. Staff were aware when a patient was assessed at risk from falls, pressure ulcers or other potential unintended harms. Risk assessments were being completed and a flag raised to alert staff on the electronic patient record. Pressure relieving and falls prevention equipment was being used when indicated.

Staff used the National Early Warning Score (version 2 – NEWS2) for adults and children over the age of 12 patients and the Paediatric Early Warning Score (PEWS) for children under the age of 12. The patient records we saw all had a completed NEWS or PEWS. We reviewed 16 records of NEWS and 6 records of PEWS scores and found the assessment of the patient and subsequent scoring to be in line with guidance. Patients who were registering a high NEWS or PEWS score had regular reviews and updates, and had been flagged for medical review as required. The new electronic patient records system that was being rolled out contained an inbuilt NEWS and PEWS scoring system to assist staff in recognising patients with a high NEWS score.

The emergency physician in charge and the nurse in charge had regular structured meetings throughout the day to monitor the activity in the department. They used an electronic monitoring tool for oversight of the patients which included NEWS and PEWS score and time spent in the department. They discussed every patient and reviewed progress of plans to reduce risk. If the number of patients in the department was reaching capacity, they could escalate the situation to senior hospital leaders. Once in escalation staff from outside the department were asked to increase their efforts to the transfer of patients who were well enough to move onto a ward. Hospital leaders could also move staff from other areas of the hospital to increase staffing levels.

We were concerned about the documentation of needs of those patients who were remaining in the department for longer periods of time than would be typical for an emergency department and clinical team. There was no structured extended care plan in use which gave clear evidence of the management of patients' longer term medical and nursing needs. This included, for example, showing early recognition of time-critical medicines, regular repositioning for skin integrity, and assurance of hydration and nutrition needs being met. We did not see these needs going unmet, but the structured documentation which could be audited and checked for compliance and assurance for the department leaders was not evident.

The senior nursing team carried out a monthly audit of the environment. The audit carried out in June 2023 found of the 4 patient experiences that were included, none had their call bell within reach and none had a drink or water jug (1 was nil by mouth). However, all the patients had their pain adequately controlled. We were not shown an action plan to address the aspects of the audit that were non-compliant.

The assessment of patients who were brought into the department by ambulance or identified as acutely unwell on arrival was carried out by a rapid assessment team in the 'pitstop' area. There were three bays in the pitstop arrival area set aside for ambulance arrivals with higher levels of equipment. This was adjacent to the resuscitation unit. This early assessment enabled rapid diagnostic tests to be arranged, risks to be identified and requests made for any speciality input.

Urgent and emergency services

One of the key members of the wider team for keeping patients safe was the hospital ambulance liaison officer, or 'HALO'. This was a paramedic employed by the NHS ambulance service and on duty at certain planned times of probable capacity escalation. The HALO reported a good working relationship with the emergency department team and well-managed prioritisation of the sicker patients.

Staff referred children and adult patients experiencing mental health problems to mental health teams based within the hospital. However, staff told us patients sometimes needed to wait a long time to be seen by these teams especially overnight and at the weekend and especially for the Child and Adolescent Mental Health Services (CAMHS). This was a risk recorded on the departments risk register.

During our inspection in 2016, we were concerned that was inconsistent use of patient identification bands in the department. We saw these risks had been removed by the introduction of an administrative process that ensured patient identification bands were generated as soon as the patient was admitted to majors.

Nurse/paramedic staffing

The service maintained enough nursing/paramedic staff and support staff at most times with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

There had been improvements in the number of nursing staff in the department with the recruitment of new nursing staff, including international nurses. However, senior departmental nursing staff were honest and open that this meant the workforce did not yet have the skill mix and experience required to be fully efficient at all times. As a result, an increased and improved learning and development programme had been brought in to support staff in embedding and improving their skills and experience. This involved embedded practice educators, who were experienced nurses whose role was to train, educate and improve skills through various options including bedside teaching. We recognised, as did the department, this would take time to be fully realised.

International nurses joining the department had a three-day induction and were linked with a band 6 nurse-mentor to support them. The department had its own practice educators who were closely linked with the international nurses. The practice educators worked with the practice education team across the trust to share themes and areas for further development for international nurses. The nurses studied all the main clinical competencies and were evaluated on progress.

The international nurses were also provided with mental health and practical support, and pastoral care if needed. A trust team in the HR department provided support entirely for international staff. There was a new programme of enhanced learning for band 5 nurses from a minority background to progress to band 6 roles.

There continued to be regular use of agency nursing staff for unplanned and other absence. Many were regular workers for the department. The service had recently employed a paramedic who told us they felt well supported and found the role a really good opportunity to build stronger relationships being from a different clinical background.

Medical staffing

The service maintained enough medical staff at most times with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Urgent and emergency services

Senior leaders told us they did not have enough consultants to meet the guidelines recommended by the Royal College for Emergency Medicines and the Royal College of Paediatrics and Child Health for the size of the department and some shifts were not fully covered. To mitigate the risk, doctors from other areas of the hospital were sometimes used, and Emergency Department Consultants worked cross site between Poole and Bournemouth Hospitals when required. As the recruitment of doctors had sometimes been difficult, which followed a national trend, the trust had invested in employing Advanced Nurse Practitioners (ANPs) and Physician Associates (PAs) to mitigate the risk of not always having enough doctors. ANPs are health care professionals that have undertaken additional training in major presentations (Majors Assisting Practitioners) to allow them to assess, diagnose, and treat patients including prescribing medication and referring on to other services. PAs undertake training equivalent to a junior doctor and perform a similar role to ANPs but are unable to prescribe or order radiological investigations at present. The ANPs and PAs were well managed in terms of oversight and skill mix. The trust had innovative recruitment plans for overseas clinicians with a strong culture around settling in international medical graduates including funding degrees to improve recruitment and retention of medical staff. A business case had also been submitted to obtain funding to employ a larger number of junior doctors and ANPs to support the clinical workforce both in and out of hours.

We overheard senior doctors regularly asking their colleagues if they had taken a recent break and if not, when they might do that. A senior doctor told us they recognised the safety risks with staff not having any time to rest during the day, and this had become harder to monitor when the department was overwhelmed with patients. A couple of staff said they felt guilty taking a break but recognised the advantages of doing so.

Records

Staff mostly kept detailed records of patients' care and treatment, but had no clear consistent record to show how extended care was being safely provided. The system used was primarily electronic and had just been replaced with new software which was still in development to make it optimal for the service.

The department used a combination of electronic notes and a reducing numbers of paper documents for recording patient care and treatment. A new electronic notes system was in use and was being upgraded in real time as staff identified ways in which it could be improved to provide clearer oversight of risks to patients.

We saw 8 sets of patients records that did not record intentional rounding of patients. Intentional rounding, often referred to as rounding, is a process used by nursing staff to carry out regular checks, usually hourly, with patients using a standardised protocol. Rounding addresses issues of positioning, pain, personal needs, and placement of items, in an emergency department it might also include an assessment of patients' psychological wellbeing and a review of their time critical medicines. When we raised this as an issue with the senior leadership team, they said they would ask for the new electronic patient notes system to be modified to include a section to record rounding.

Is the service caring?

Inspected but not rated

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Urgent and emergency services

Staff were kind and caring with patients and families. This included staff across the department in different roles. We met a number of patients and their families and all of them were happy with the care and compassion they had received. This included anxious patients, both adults and children, who were taken through the comprehensive triage process. It also included compassion and understanding shown to patients who were waiting for long periods in the waiting room and in the department.

We observed kindness and staff treating people well. They gave as much time to the patient and any family as possible and were respectful and considerate of their privacy and dignity. They were non-judgemental and respected people's rights to make their own choices, even when they were not in their perceived best interests.

We were concerned about the patient experience when having to speak to both the streaming nurse and then receptionist when booking in to the department. We observed this was both frustrating and confusing for a number of patients, and not ideal for those who were unwell.

We recognised and were told how staff found it hard to have to explain and apologise, and too often, to patients who were being held in the department due to issues with capacity elsewhere in the hospital. We observed how staff were understanding and apologetic to patients in the waiting room and explained how some patients needed more urgent care.

Is the service responsive?

Inspected but not rated

Access and flow

Alongside and as a result of long-standing local and national issues in the whole health and care pathway, people could not always access the service when they needed it and receive the right care promptly. Waiting time standards, handover times from ambulance crews, and time spent in the department were frequently missing national standards or comparable results.

There were long-standing local and national issues with access and flow through the whole health and care pathway. The south west of England and many coastal towns such as Poole had been overwhelmed with patients and a lack of capacity for many months. This was not restricted to the predicted higher activity in winter, but extended throughout the year including the height of the summer holiday period. As a result, the hospital was frequently unable to take patients from the emergency department to a ward bed at the time the patient was assessed and ready to be handed over for further care and treatment.

Subsequently, not all patients could get access to the service in a timely and clinically safe way, and some were remaining in the department for longer than was clinically or psychologically optimal. For example, of the 10 patients in majors, 1 of them had been there for 11 hours and 4 were ready to be transferred to a ward. However, these patients had to remain in the department because there were no porters available to transfer them. When patients remained in the department and continued to require nursing care, this sometimes created a blockage that meant new patients waiting to come into the department were delayed. There had been lengthy delays for ambulance crews waiting to handover patients and consequently patients were waiting longer in the community for care and treatment from the emergency services. This was fully recognised by the trust board and assessed as a high risk on the corporate risk register.

Urgent and emergency services

Nevertheless, managers and staff worked hard to make sure patients did not stay longer than they needed to. Patients were prioritised in terms of clinical need and those who were urgent were seen as quickly as possible. There was a clear focus on the departmental dashboard where length of stay and clinical need were clearly indicated and staff were aware of each patient's needs and reasons for any delays.

At times when the department was full, they used an escalation corridor to treat up to 4 additional patients. During periods of significant pressure, the hospital had an arrangement with the ambulance service to cohort patients in a hospital corridor. This improved the ability of ambulance crews to respond to emergencies within the community. The cohorting corridor contained 10 beds and was staffed by the ambulance service. Staff told us they understood the benefits of offloading ambulances but sometimes worried about the high risk patients who were being looked after there. Patient observations, blood tests, ECGs still needed to be carried out by the hospital staff so performing these tasks in addition to the doing this for the maximum number of patients that the department expects to deal with, meant nurses could be looking after more patients that the hospital had planned staff numbers for. However, when the department was at this level of escalation hospital leaders would move staff from other departments to provide support to the nursing team.

Data showed how, along with all NHS emergency departments, the trust was not meeting the national standard for admitting, discharging or transferring 95% of patients within 4-hours of arrival. University Hospitals Dorset NHS FT had been part of an NHS pilot for the last three years, trialling the use of other clinical standards for emergency departments. This trial had recently been ended and the trust reverted to reporting its performance against the 4-hour standard.

The trust's percentage of patients waiting more than four hours from the decision to admit to admission increased (deteriorated) considerably from 24.0% in May 2022 to 39.6% in December 2022. There was then a reduction to 31.7% in March 2023. The trust's performance was considerably better than the England and South West averages until September 2022, but since then its performance has been much closer to the averages. For comparison in March 2023 trust performance was 31.7% compared to the South West average of 33.8%.

There was a considerable increase in the number of the trust's patients waiting more than 12 hours from the decision to admit to admission from 113 in September 2022, to 332 in December. This was followed by a reduction to 185 in March 2023.

The trust consistently reported a much longer (worse) median time from arrival to treatment compared to the England average from May 2021 to February 2023. There was a considerable reduction from two hours eight minutes in December 2022, to one hour 46 minutes in February 2023, but this was still considerably worse than the England average of one hour eight minutes. The trust's median total time in A&E was consistently longer (worse) than the England average from May 2021 to February 2023. There was a considerable increase from 4 hours 13 minutes in August 2022, to 5 hours 2 minutes in December 2022. This was followed by a reduction to 4 hours 44 minutes in February 2023. However, this was still considerably worse than the England average of 3 hours 4 minutes.

We saw information that showed the trust has improved its performance in all of the above metrics in the three months before we inspected. In addition, it is important to give the metrics context and point out that A&E attendances at the trust were higher than 60% of other hospitals in the country and there were more patients being treated by the trust than most other trusts in the country. Overall trust activity rates increased by 31% between March 2021-February 2022.

Urgent and emergency services

The trust was part of a multidisciplinary team discussing frequent attenders, and what could be considered to support these patients with other services which were designed more for their needs. This included representation from the emergency departments, ambulance service, and social services. Regular attenders at A&E had care plans devised and these were evaluated at these meetings to determine if they were working or what else might be considered.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

University Hospitals Dorset (UHD) NHS FT ran two emergency departments in Dorset, this one located in Poole and another located at The Royal Bournemouth Hospital. UHD was a merger of two existing NHS trusts in south Dorset in 2020. Since that time, the emergency departments had been joining their senior teams together to gradually share leadership and resources and develop mutual systems and processes.

Staff told us they felt well supported by their senior team. They said they were visible and approachable and the department worked well as a strong team. All those we met in the staff team said they felt confident and able to speak up to senior staff and managers. There was a learning culture in the department and effective support for staff to train and develop into more senior roles and learn new skills.

Most staff said they regularly saw the trust leadership in the department and felt supported by members of the executive particularly by the chief operating officer when the department was in extreme escalation.

Culture

Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff in the department felt valued by one another. We observed staff working well together, knew each other well, and were supportive and kind. This extended to teamwork with other services and specifically the NHS ambulance service where staff reported good working relationships. We noted how staff were regularly checking on each other to see if they were due a break and if it had been taken. The senior leadership team told us how they were most proud of the emergency department team and how they had been incredible to work with, with great tenacity and enthusiasm despite the challenges faced. They were also proud of the training offered and how that had developed over time with the practice educators to be an effective and valued service.

A number of staff said how the introduction of international nurses and doctors and staff from different ethnic backgrounds had done much to improve the culture and positive diversity of skills and life-experience. There was a principle embedded in the department of the need to mentor, support and train new staff, and to provide them with confidence and grow their experience.

However, there was a concern we raised with the trust about a number of international staff not recognising the role of the Freedom to Speak Up Guardian. We recognised staff had possibly been overwhelmed with new information on joining the trust, and there was a lot to learn. This role is an UK national role which is not as universally recognised as other healthcare jobs (and might have other names in other countries). It could have been well explained and introduced, but had not been well understood. However, staff from minority backgrounds did tell us they had both formal and informal networks and were not concerned about speaking up to their own managers or colleagues.

We were concerned about the number of staff who told us they no longer reported some incidents. For example, some staff said they no longer reported incidents of violence or aggression unless it was “severe”. Other staff told us they had stopped reporting long waits for mental health support for patients. However, staff who told us they reported incidents of violence, aggression, and verbal abuse from patients said they received a good level of support from managers as aftercare.

The trust had a policy to support staff experiencing bullying or harassment from colleagues. We spoke to a member of staff who had used this policy. They told us they felt fully supported by the trust and their incident had been fully resolved.

The annual NHS staff survey for the trust which took place between October and November 2022 uses a scores range from 1 to 10 – a higher score indicates a better result. The results showed the trust scored below the average for three elements: ‘We are Safe and healthy’ (5.8), ‘We are always learning’ (5.3) and ‘Morale’ (5.6). Three elements were above the average ‘We are compassionate and inclusive’ (7.3), ‘We each have a voice that counts’ (6.7) and ‘We are a team’ (6.7). We are recognised and rewarded’ reduced from 5.9 to 5.7 and ‘We each have a voice that counts’ deteriorated from 6.8 to 6.7.

Nearly three quarters of staff (73.6%) at the trust said they would feel secure raising concerns about unsafe clinical practice which is better than the national average of 70.7%. Just over one in five staff (21.2%) believe the provider is adequately staffed, worse than the national average of 25.5%.

The Workforce Disability Equality Standard (WDES) is a set of measures which enable NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. The trust WDES results for staff with a long-term condition or illness were notably different to results for staff without a long-term condition or illness at the trust, indicating poorer experiences for staff with long-term conditions or illnesses. These results were consistent with the national response to these measures.

The Workforce Race Equality Standard is a set of measures which enable NHS organisations to compare the workplace and career experiences of staff from ethnic minority groups with their white colleagues. The results for the trust show that a much higher proportion of staff from all other ethnic groups had experienced harassment, bullying or abuse and discrimination from managers or other staff in the previous 12 months, than their white colleagues. They also had less belief that their organisation provides equal opportunities for career progression, indicating poorer experiences for them.

We spoke to representatives of the diversity and inclusion network for the trust who told us about initiatives they planned to raise awareness around racial discrimination and to promote inclusivity.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Urgent and emergency services

The department was aware of its performance, resilience and risk from a local dashboard designed to provide live data throughout the day and night. This was visible to all staff in the department and was used, for example, when one department had less capacity than the other and it might have been beneficial for patients to divert ambulances to the other emergency department.

The department used an internally-designed version of the NHS national 'operational pressures escalation level' (OPEL) framework known as the 'emergency department capacity level tool'. This was refined to use data which took into account other aspects of the hospital's resilience. The leadership team were open and honest about this tool and considered how 'escalation fatigue' (in that they felt the department to always be in higher levels of risk and escalation) had meant response to the tool from decision makers had been limited of late.

It should be noted there was no specific knowledge in the local senior team of how the trust's emergency departments were represented with the Integrated Care System or Board.

One of the recognised risks for the emergency department was with the provision of clinical support for patients experiencing a mental health crisis. There was little provision out of hours and at night when the department felt this was the most demanding time for patient's needs. As a response to recognising the growing need for mental health care, the department was looking at more multidisciplinary work with patients who were regular users of the service or people who were homeless and/or rough sleepers.

Outstanding practice

We found the following outstanding practice:

- Urgent and emergency care had developed a system that used QR codes for reordering stock, this automated process included emails being sent to individuals with a role in stock monitoring and procurement. The system had resolved inconsistencies in stock levels.

Areas for improvement

MUSTS

Poole Hospital Emergency Department

- The trust must ensure it provides safe care and treatment to patients at all times and demonstrate this through clear and complete record keeping for all care interactions. It must demonstrate all patients remaining in the department for what might be considered as an extended stay have all their needs met and these are clearly documented. Regulation 17(2)(c).

SHOULDS

Poole Hospital Emergency Department

- The trust should consider the patient experience when requiring them to speak to first the streaming nurse and then the receptionist particularly if the patient is unwell and has to stand for some time at either touch point.

Urgent and emergency services

- The trust should require all staff to follow infection prevention and control guidance at all times, including the safe use of personal protective equipment and the dress code.
- The trust should work closely with the integrated care board to continue to address the significant and serious delays faced by some patients waiting in the department for a hospital bed and remaining in the community as ambulances are delayed in their handover of patients. Access and flow through the hospital and responsiveness to patients was adversely impacted by the pressures throughout health and social care. There should be consideration as to how to manage 'escalation fatigue'.
- The trust should work with the Freedom to Speak Up Guardian to educate and encourage those staff who did not recognise this role to be an integral part of the otherwise well-respected service.
- Hospital leaders should encourage staff to report all incidents of violence and aggression, and long waits for mental health support for patients.

Outpatients

Inspected but not rated

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Managers monitored the effectiveness of the service and made sure staff were competent. Key services were available 5 days a week.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders ran services well and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. Staff were committed to improving services continually.

However:

- People could not always access the service when they needed it and had long waits for treatment.
- The service used multiple information systems as well as paper records for triage and booking of appointments. This meant there was a reliance on staff to ensure tracking of appointments.
- Surgical safety checklists were not completed which could lead to patients having the wrong surgery.

Is the service safe?

Inspected but not rated

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Nursing staff received and kept up-to-date with their mandatory training. Records showed 92.9% of staff had completed their training against a target of 90%. It was comprehensive and met the needs of the patients and staff. Managers monitored compliance and alerted staff when they needed to update their training. Staff told us they received reminders when their training was due, and their managers discussed this with them.

In July 2022, The Health and Social Care Act 2022 introduced a requirement that regulated service providers must ensure their staff receive learning disability and autism training appropriate to their role. This training was not in the current list of mandatory training for staff at the Trust, this will commence once the government has published the Code of Practice for the training as agreed by the Dorset Integrated Care Board (ICB).

Outpatients

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Records sent to us by the Trust show that 100% of nursing staff had completed level 2 adult safeguarding training and 97.3% had completed level 2 child safeguarding training. The department had a paediatric safeguarding lead trained to level 3.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff followed safe procedures for children visiting the department. The Trust had a standard operating procedure (SOP) for children who were not brought for their appointments, this included how to respond when a child did not attend a scheduled appointment.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. It was difficult for staff to keep some of the equipment and the premises visibly clean.

Most of the clinical areas were clean and had suitable furnishings which were clean and well-maintained. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. However, some of the seats in the waiting areas were fabric covered and stained, staff told us that it was difficult to clean these seats. They were wiped at the end of each outpatient session. Documents sent by the Trust showed there was a long-term plan to refurbish the waiting area and to replace the chairs.

The service did not always perform well for cleanliness. The environmental audit for infection control was not completed for 5 months from July 2022 until June 2023. Environmental audits for phlebotomy and the plaster room were undertaken as part of the main outpatient audit. However, results for each area were not separately reported. The Trust sent us documents to show that action plans were in place to improve this.

The infection control environmental audit for the main outpatient department was completed for 7 months between July 2022 and June 2023 and only achieved the compliance target for 1 month during that time. Evidence sent by the Trust showed that there had been issues completing the audits due to increased pressure on workload and staff sickness, audits submitted after the deadline were noted as non-submission. Work has been ongoing to improve the compliance through staff training and support from the infection control team.

We observed 1 procedure in a treatment room where staff followed infection control principles including the use of personal protective equipment (PPE). However, the hand hygiene audit data showed that compliance in the main outpatient area had only been met for 2 months between July 2022 and June 2023. This had been recognised by the Trust, senior staff told us they were supporting junior staff members to challenge poor practice in the department. The low rates of hand hygiene compliance were attributed to clinical staff visiting the department and not the staff who worked in the department permanently.

Outpatients

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The main outpatient department was located on the ground floor of the hospital. This required patients coming from the main entrance or car park to use the stairs or a lift to go up from the lower ground level. There was a covered walkway from the car park to the hospital building. We saw wheelchairs available for patients in the covered walkway. Wheelchair patients could also access OPD from the emergency entrance without using a lift via the Urgent Treatment Centre (UTC) corridor.

National guidance for the design and layout of OPD takes into consideration that many patients who attend may have mobility problems and recommend the OPD should be located on the ground floor and that parking areas for disabled people and wheelchairs should be provided close to the main entrance. When parts of the OPD are not located on the ground floor the guidance recommends easy access by lift and stairs must be provided and access and circulation routes to and within the OPD should be sufficiently direct and clearly signposted to prevent patients losing their way (NHS Health Building Note Guidance 12).

Patients told us that it was very difficult for them and their carers to find car parking spaces, especially disabled spaces and that there was not enough space at the drop off point outside the hospital. Patients said they had to leave home early to get a parking space and be on time for their appointment. However, the trust had plans to move staff parking to another site to make more spaces for patients to park on site.

Records sent to us by the Trust showed a draft SOP for Children and Young people in Outpatients Department, this SOP had not yet been approved for use. The SOP stated that waiting rooms will provide separate areas for children and young people. During the inspection, we saw there was a ‘beach hut’ play area for children but this would not provide enough space for all children waiting for appointments. Parents were offered to use the 'beach hut' but often chose not to do so. The OPD aimed to manage the flow of children through the department to reduce the numbers of children in the area at one time. We saw children waiting in areas with adults and did not see a separate waiting area, this was not in line with national guidelines from the Nursing and Midwifery Council (NMC) 2016.

Hospital leaders understood the problems with the design and maintenance of the facilities. There was a long-term plan in place to refurbish the waiting area including walls and floors, and to replace the chairs to include extra seating in the clinical area.

Staff carried out safety checks of specialist equipment. We saw records that showed weekly checking of the resuscitation trolleys.

The service had enough suitable equipment to help them to safely care for patients.

Staff disposed of clinical waste safely. The domestic and clinical waste bins were clearly identified and emptied regularly. Sharps and hazardous waste bins were stored safely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. Risk to patients on the waiting list was not always identified.

Outpatients

New and existing patients sometimes had to wait for a long time to be seen by a doctor. In June 2023 the total waiting list size was 74,483 patients with 30,719 patients overdue a follow up appointment. The trust identified patients whose condition had deteriorated while they were waiting through the validation process or at their follow up appointments, so they could understand what had happened and learn from it. Waiting lists were amanged at speciality level with clinical oversight reviews and administrative validation. This meant that patients were being contacted to see whether they still needed to be seen or if they could be removed from a waiting list.

Staff responded promptly to any sudden deterioration in a patient's health. Staff told us about a recent incident where a patient became unwell in the department and how they managed this, they knew who to call and what to do if there was a medical emergency. There were guidelines for staff to follow if a patient or visitor became unwell. The OPD had processes to admit patients who were too unwell to continue to be seen as an outpatient.

Staff met at the beginning of each day to share information to keep patients safe.

We observed one minor surgical procedure in the treatment centre. Staff checked the patient details and consent form prior to the procedure. However, staff did not complete the World Health Organisation (WHO) Surgical Safety Checklist. This is a national checklist designed to reduce surgical errors and enhance patient safety. The Trust had a policy regarding use of the World Health Organisation (WHO) Surgical Safety Checklist. The policy states it should be used for all patients including those having procedures under local anaesthetic. We looked at 3 patient notes following minor procedures and saw the checklist was not completed. We informed senior staff who immediately took action to address this. Following the inspection we were told that these records were being audited.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough nursing and support staff to keep patients safe. Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The manager could adjust staffing levels daily according to the needs of patients. Staff could rotate to work across various sites if needed. The number of nurses and healthcare assistants matched the planned numbers. The service had low vacancy rates for nursing staff. However, they had high vacancy rates for administration staff. The vacancy rate for administration staff was 14.94% in June 2023 this equated to 15.84 whole time vacancies for band 3 patient administrators. Managers told us that they were looking at ways to make the role more attractive such as offering flexible working, developing the role and having a clearer structure and career progression pathway. The trust informed us they had recently held a successful administration open day event where 12.86 posts had been offered.

The service had high sickness rates. The sickness rate for nursing staff was 10.3% over the last 12 months against the trust target of 3%. The service employed bank nurses to help cover staff absence. Managers requested bank staff who were familiar with the service. They made sure all bank staff had a full induction.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Outpatients

Patient notes in the treatment centre were not always completed fully, we reviewed 3 sets of paper notes in the treatment centre and found that the surgical checklist was not being completed consistently.

Most records were stored electronically with some paper records used in the treatment centre.

All staff could access records easily. They were stored securely. When patients transferred to a new team, there were no delays in staff accessing their records.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. All medicines and prescribing documents were managed and stored safely. Prescription forms were securely stored and records of their use completed.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff told us they reported incidents electronically and received feedback on the incident once a manager had reviewed it. They raised concerns and reported incidents and near misses in line with the organisation's policy. Reports from investigations showed managers investigated incidents thoroughly. There was evidence that changes had been made as a result of identified learning from incidents. Staff received feedback from investigation of incidents, both internal and external to the service. For example, staff told us about a safeguarding incident, how this was managed and that they received feedback following the incident.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Managers shared learning about never events and serious incidents with their staff and across the organisation. Never events are defined as serious incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Managers debriefed and supported staff after any serious incident.

Is the service responsive?

Inspected but not rated

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of the local population. For example, they offered virtual appointments for some specialities.

Outpatients

Facilities and premises were appropriate for the services being delivered. The service had systems to help care for patients in need of additional support.

Managers monitored and took action to minimise missed appointments. Patients were sent text message reminders prior to their appointments. Managers ensured that patients who did not attend appointments were contacted.

The service relieved pressure on other departments when they could treat patients in a day. For example, they provided day case surgery in the treatment centre for some dental patients.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff mostly made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Reasonable adjustments were made to help patients access services. We observed staff booking transport to and from the hospital for patients who required it. Patients with mobility difficulties were supported by porters when they were moved to the discharge lounge.

Patients were encouraged to use the self check-in stations at the entrance of the OPD, these were touch screen monitors. The monitors offered check-in in different languages and told the patient which waiting area to use for their appointment. We saw some patients struggling to use these and were concerned that the main reception was not obvious to the patients as the screen was frosted which obscured the signage behind the desk. We saw patients going to another reception area desk to check in. Reception staff said that the screens could also cause problems for patients with hearing loss as they could not hear what the staff were saying.

Access and flow

People could not always access the service when they needed it or receive the right care promptly. Waiting times from referral to treatment were not always in line with national standards.

Managers monitored waiting times and tried to make sure patients could access services when needed to receive treatment within agreed timeframes and national targets. In March 2022 there were 16,503 patients overdue follow up appointments, this figure went up to 46,556 in April 2022. We were told that this was due to two computer systems being merged and there were duplications, these were being checked during the validation process. However, the trust still had a significant backlog of patients waiting to be seen by some of the different OPD services. In June 2023 there were 30,594 patients overdue OPD follow up appointments. The backlog of patients waiting to be seen was partly due to the COVID-19 pandemic and associated social distancing requirements when patients could either not be seen at all or could only be invited to attend in small numbers. Recent staff industrial action had also affected the department as some clinics had been cancelled.

From March 2021 to February 2022 there were 694,982 OPD appointments at the trust, this was an increase of 23% from the previous 12 months. Initiatives to reduce backlogs had been introduced, for example insourcing clinics and patient waiting list initiatives running at the weekends.

Outpatients

The maximum number of weeks patients should wait to be seen by a doctor is set by the NHS Constitution to try and ensure people are seen in a specific timeframe. The longest time the Constitution says people should wait is 18 weeks for most non urgent referrals, and 2 weeks for a suspected cancer. Trusts are required to put in place systems and dedicated teams to ensure patients are tracked and monitored along their 2-week or 18-week pathway, with audit processes in place to ensure appointments have been made.

The total number of patients on the waiting list was 74,483 in June 2023 with 55.1% of patients being seen within the 18-week performance standard against a national target of 92%. There were 32 patients who had waited over 78 weeks for treatment. However, the Trust had no patients waiting for over 104 weeks and were planning to eliminate waits of over 65 weeks for elective care by March 2024.

From January to March 2023 only 76.9% of patients were seen by a specialist within 14 days of an urgent referral for suspected cancer. The faster diagnosis standard sets out that patients will be diagnosed or have cancer ruled out within 28 days of being referred for suspected cancer, 71.9% of patients met this standard in June 2023 against a target of 75%. The trust had not met this standard in the 12 months before our inspection.

Staff told us that most clinics ran on time. On the rare occasion they ran late it was because the doctor arrived late because they had been caught up in surgery or on a ward, because patients who needed to be seen urgently had been added to the list, or because an appointment had run over due to the complexity of a case or a distressed patient.

Managers worked to keep the number of cancelled appointments to a minimum. Staff told us it was rare for clinics to be cancelled and when this did happen it was usually due to staff sickness and an inability for staff to be sourced to cover the clinic. When patients had their appointments cancelled, managers made sure they were rearranged for as soon as possible.

Within OPD there were different IT systems for patient referrals and patient records. There was a lack of integration between these systems which meant the different systems were not able to communicate and share data with one another. This required administrative staff to print the referrals and send them to the individual specialities for triage and then upload them on to another system once they were returned. Managers told us that there was work under way to move this to an electronic format with a pilot starting in August 2023 so that the triage could be done electronically to reduce the risk of errors in the booking process.

Following a clinic appointment, patients were given a paper outcome form to give to the receptionist, this showed the outcome of the appointment and whether they required another appointment. The receptionists had to input this information on to the computer system. Managers told us they were working with the IT department to change this system to an electronic outcome form that would be completed by the clinician following the appointment which was being trialled.

Managers told us that the trust had plans to upgrade their digital systems and were planning to introduce a new Electronic Patient Record (EPR) system in 2025.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Outpatients

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service.

Staff could give examples of how they used patient feedback to improve daily practice. For example, staff told us they had provided water fountains for patients following feedback.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The OPD had a clear senior management leadership structure. Matrons from other departments were supporting OPD staff because the OPD matron had retired. A new matron had been recruited to start in September 2023. There was a team of band 7 nurses who managed the department daily alongside the matrons. Senior staff told us that they were well supported by matrons from other departments and had been buddied with other matrons for support.

The trust ran 4 outpatient departments in Dorset. Since the merger in 2020, the outpatient departments had been working together to share leadership and resources and develop mutual systems and processes.

Leaders had the skills and abilities to run the service, they were committed to providing safe patient care and supporting their staff. Staff told us leaders were visible and approachable. Staff told us they were well supported by their line managers.

During our inspection we met with the senior leadership team and local leaders. Senior leaders told us about the issues the service faced and plans they had to overcome these. The main risks were the administrative staffing levels, the risk of using partly paper-based referral management and the lack of capacity to book follow up appointments within their given timeframes.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was a clear vision and set of values including quality and sustainability. There was a realistic strategy for achieving the priorities and delivering good quality sustainable care. Staff knew and understood what the vision, values and strategy were, and their role in achieving them. The service had priorities such as eliminating all patients waiting over 65 weeks for treatment by March 2024 and were on target to achieve this, this was included in the trust Operational Plan for 2023/24.

Outpatients

There was a strategy aligned to local plans in the wider health and social care economy, and services had been planned to meet the needs of the relevant population. For example, the OAC had been set up to deliver care closer to the community and had included various stakeholders in the planning process including patient governors and the public at engagement events.

Progress against delivery of the strategy and local plans was monitored and reviewed. The trust had implemented an outpatient transformation programme with clear objectives and timelines, this was part of a Dorset-wide outpatient transformation programme. Following the inspection the trust informed us that the previous OPD matron is returning part time in September 2023 for a year to support with the transformation work with the outpatient's service.

Culture

Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff we spoke to felt supported, respected, valued and were positive and proud to work in the organisation, they told us that the culture and morale in the OPD had improved. The culture was centred on the needs and experience of people who used services. Actions taken to address behaviour and performance was consistent with the vison and values, regardless of seniority.

The senior nurses had introduced ‘thank you Thursday’ as a way of thanking colleagues, they had also arranged social events for all staff such as crazy golf and a staff barbeque. The department recently created a staff room with all staff involved in its development. Staff told us this had made a big difference for them as they did not have to leave the department for breaks.

Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution, and appropriate learning and action was taken because of concerns raised. The culture encouraged openness and honesty at all levels within the organisation, including people who used services, in response to incidents.

There were cooperative, supportive and appreciative relationships among staff. Teams and staff worked collaboratively, there were daily huddles where staff could raise issues. Some staff told us they felt that ‘everyone is listened to equally’. Managers told us they worked together across all 4 outpatient sites, they met regularly to discuss issues and support each other, they were working together to standardise policies across the 4 OPD sites.

The annual NHS staff survey for the trust took place between October and November 2022. OPD Poole nursing staff results showed that 60.9% looked forward to going to work and 79% felt the organisation treats staff who are involved in an incident fairly. However, nearly three quarters of nursing staff (73.9%) in Poole OPD said they would feel secure raising concerns about unsafe clinical practice which is better than the national average of 70.7%. There was an action plan developed from the results of the staff survey, this included areas for the senior nursing team to focus on. For example, giving staff the opportunity to attend courses to gain new skills and looking at progression posts within the department.,

Governance

Leaders operated effective governance processes. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Outpatients

There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. These were regularly reviewed and improved. Leaders monitored key safety and performance metrics such as the 18 week wait times.

Most levels of governance and management functioned effectively and interacted with each other. Some leaders told us there could be improvements in communication between the OPD and the medical and surgical care groups. The trust had 3 care groups; these oversaw the governance for medical, surgical and other specialities.

The OPD governance of waiting lists was managed by the individual specialisms that saw outpatients, for example, ophthalmology or urology and their wider core service. Governance arrangements were not coordinated as a single OPD. There were different committees that met to discuss performance and risk, their concerns were escalated to the Board of Directors.

Staff at all levels were clear about their roles and understood what they were accountable for, and to whom.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

The trust had systems for recording, reviewing and managing risks. There was a risk register for OPD, each risk had been given a score depending on the level of risk and these were reviewed regularly. For example, we saw minutes of meetings showing the risk score of for staffing levels had reduced as the service recruited more staff.

The OPD quality and risk group met monthly, we reviewed minutes of the meetings and saw that risks and issues were discussed and actions identified to reduce their impact. Leaders were clear on the links to trust wide groups and committees to escalate risks and issues.

There were arrangements for identifying, recording and managing risks, issues and mitigating actions. There was alignment between recorded risks and what staff said was 'on their worry list'. The main risks were insufficient capacity to book follow-up appointments within due dates, outpatient staffing and the risk of using partly paper-based systems for referral triage. Board members were aware of the extreme risks, and these were reviewed by them monthly.

Information Management

The service collected data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required, however, not all information systems were integrated.

Information was used to measure improvement. For example, the trust had recently achieved no patients waiting over 104 weeks for elective treatment. They analysed key performance data monthly and reported on this.

Staff had sufficient access to information. Senior leaders showed us the 'outpatient dashboard' an IT function which supported specialities to understand where they were against the outpatient performance targets. There were clear service performance measures, which were reported and monitored with effective arrangements to ensure that the information used to monitor, manage and report on quality and performance was accurate. Reports of patient backlogs were regularly sent to individual specialities to manage their waiting lists.

There were arrangements to ensure data or notifications were submitted to external bodies as required. There were also arrangements (including internal and external validation) to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards. Lessons were learned when there were data security breaches. For example, during the test phase of a new system, 20,000 text messages were sent in error by an external provider. We saw meeting minutes of the incident and lessons learnt.

Not all information systems were integrated, this was a known risk on the trust risk register. There were plans in place to implement some changes in the short term to help mitigate these risks. Senior leaders told us there were plans to upgrade digital systems by 2025.

Engagement

Leaders and staff actively and openly engaged with patients and the public to plan and manage services. They collaborated with partner organisations to help improve services for patients.

People's views and experiences were gathered and acted on to shape and improve services. The service used the family and friends test to capture patient feedback. In April 2023, the Poole OPD had 16235 responses and 94% of responses said their experience was good. We saw friends and family information posters displayed with 'you said' and 'we did' showing what the service had done to improve following feedback. However, the staff survey results showed that only 56.5% of staff felt able to make suggestions to improve the work of the team, and only 34.8% felt able to make improvements happen in their area of work.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and understanding of the needs of the relevant population, and to deliver services to meet those needs. The Dorset Elective Health Inequalities Group was established in 2022. They aimed to ensure that patients with a learning disability had their first outpatient appointment within 18 weeks, and they monitored population health data to assess the impact of the elective recovery programmes on patients' access, experience and outcomes.

The trust were part of the Outpatient Transformation Programme Steering Group, this was a collaboration between the trust and partners/stakeholders.

The OAC collaborated with partner organisations and included free services which supported individuals to move more, drink less, stop smoking and maintain a healthy weight.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.

Leaders and staff aspired to continuous learning, improvement and innovation. The Trust had seen a progression of digital outpatient transformation in 2022/23 they had launched a patient portal (DrDoctor), installation of virtual consulting pods, extension of Bookwise (a scheduling system for the booking of clinics and rooms) room booking capability for Christchurch and Poole, and introduction of InTouch digital check in at Bournemouth and Christchurch hospitals.

Outpatients

The trust had started to implement patient initiated follow up (PIFU). This is when a patient initiates an appointment when they need one, based on their symptoms and individual circumstances. This ensures patients can see a specialist sooner than planned if they need to, as well as avoid an unnecessary trip to hospital if they have no need to be seen. It also helps clinicians manage their waiting lists in a safe and effective way. For patients, this means more choice and flexibility around when they access care.

There were standardised improvement tools and methods, and staff had the skills to use them. Learning from internal and external reviews was effective and included those related to mortality or death of a person using the service.

There were systems to support improvement and innovation work, data systems, and processes for evaluating and sharing the results of improvement work. For example, there was a health inequalities programme using data systems and processes to evaluate and improve the equity of access, experience and outcomes to reduce health inequalities.

Areas for improvement

Action the trust MUST take to improve:

Poole Outpatients

- The trust must continue to do all that is reasonably practicable to reduce waiting times to treatment. Regulation 12(2)(a)(b).

- The trust must ensure that surgical safety checklists are completed in line with national guidance, so surgical safety is improved. Regulation 12(2)(a)(b).

Action the trust SHOULD take to improve:

Poole Outpatients

- The trust should ensure staff receive training in how to interact appropriately with autistic people and people who have a learning disability. This should be at a level appropriate to their role. Regulation 18(2)(a).

- The trust should ensure that chairs in the waiting room are covered in a wipeable material for infection control purposes. Regulation 12(2)(h).

- The trust should ensure that environmental audits are completed regularly and that they continue to challenge poor hand hygiene practice. Regulation 12(2)(h).

- The trust should have a separate waiting area for children in line with NMC guidance.

- The trust should ensure it meets accessibility standards so people with protected characteristics are not unfairly disadvantaged and have equal access to services. Regulation 9(1)(a)(b).

Our inspection team

For the urgent and emergency care service a team of 1 inspector, 1 CQC senior advisor and 2 independent specialist advisors visited the emergency department and the urgent treatment centre. We spoke with 32 members of staff (including managers, doctors, nurses, healthcare assistants, healthcare professionals, receptionists and administrative staff). We reviewed 24 sets of patient notes, we attended 1 meeting.

For the outpatient department a team of 1 inspector and 1 specialist advisor visited Poole Outpatients. We spoke with 10 members of staff (including managers, nurses, healthcare assistants, dental nurses and receptionists). We spoke with 6 patients, reviewed 3 sets of notes and observed 1 patient undergoing a minor surgical procedure.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

University Hospitals Dorset NHS Foundation Trust

The Royal Bournemouth Hospital

Inspection report

Castle Lane East
Bournemouth
BH7 7DW
Tel:

Date of inspection visit: 27June 2023 28 June 2023
Date of publication: 14/09/2023

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at The Royal Bournemouth Hospital

Inspected but not rated

University Hospitals Dorset NHS Foundation Trust provides acute and emergency services to people living in Poole, Bournemouth and East Dorset. University Hospitals Dorset NHS Foundation Trust provides a wide range of hospital and community-based care to a population of 771,000 based in the Dorset, New Forest and south Wiltshire areas.

On 1 October 2020, The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust merged to form a new organisation.

The trust provides a wide range of hospital and community-based care; and employs approximately 8,400 members of staff, both clinical and non-clinical. The trust has not been rated since the merger in October 2020. The hospital's ratings were inherited from the previous provider.

We carried out a focused inspection with a short notice on 27 and 28 June 2023. The inspection was carried out because we had concerns about care and treatment in some areas of urgent and emergency care. We did not look at all key lines of enquiry but limited these to areas where concerns had been raised.

Urgent and emergency services

Inspected but not rated

- The service had enough staff to care for patients and keep them safe most of the time, although the skill mix and experience was not always optimal. Leaders did their best to cover unplanned absence and balance the skill mix and maintain frequent and tailored high-quality training for all clinical staff.
- Staff had the skills and knowledge to protect patients from abuse and acted when it was necessary. The service mostly controlled infection risk well but we observed some lapses from staff in meeting trust policy around dress code and management of their personal protective equipment. There was effective cleaning and we saw a visibly clean and well-organised department.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. Teamwork was exceptional and highly valued by all staff. However, given the issues with demand and capacity, patients having growing health and care needs, including mental health, and growing demand for the service, staff morale was hard to maintain.

However,

- There were long-standing national issues with access and flow through the whole health and care pathway. The south west of England was no different, and coastal towns such as Bournemouth had been overwhelmed with patients and a lack of capacity for many months, including a very difficult winter period.
- Patients' records were not always completed sufficiently well, for longer-stay patients particularly, to demonstrate staff met care needs, assessed risks to patients and acted on them.
- We were concerned that some of the standards of nursing care fell short of preserving and maintaining the privacy and dignity of patients at all times.
- Some of the practices for caring for patients needing to remain in the department for extended periods of time gave rise to possible risks; including the use of canvas stretchers and patients left lying in a shearing position.
- Although urgently addressed at the time, there were issues with the practice for labelling patient samples which did not meet trust policy.
- There was a lack of some patient visibility for the staff responsible for the safety of the department and the reception area was not always suitable for people using wheelchairs to do so safely.

Is the service safe?

Inspected but not rated

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. They could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. They described well how they would identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. They knew how to make a safeguarding referral and who to inform if they had concerns.

There had been an increase in patients leaving the department due to long waits for treatments. A process of alerting children's services if parents or carers left the department before their child had been seen had been implemented. This ensured the welfare of the child was assessed and to encourage parents and carers to return to the department with their child.

Cleanliness, infection control and hygiene

The service mostly controlled infection risk well but we observed some lapses from staff in meeting trust policy around dress code. Staff used equipment and control measures to protect patients, themselves and others from infection, although we saw lapses from some staff in the management of personal protective equipment. They kept equipment and the premises visibly clean.

All areas, including those at height, were visibly clean and had suitable furnishings which were clean and well-maintained. Most of the furniture such as beds, chairs, and mattresses were in good condition to allow for effective cleaning and all the curtains appeared in good condition, were disposable, and dates showed regularly changed.

Staff mostly followed infection control principles. We saw mostly good adherence from staff to hand washing and infection control procedures. However, we did see some staff wearing gloves during more than one interaction with patients. Some staff were wearing gloves without removing and replacing them when required by trust policy. Most washed their hands or used alcohol gel before and after any interactions with patients or when entering or leaving the department, but we observed this policy had become lax with some staff. We did notice patients and visitors not actively using the hand gel provided or being encouraged to do so either in the waiting area or moving into the treatment/triage areas. Compliance with the hand hygiene audit in April 2023 was 80%. Senior hospital leaders explained the process of aligning quality audit processes across the trust meant new metrics were being used at the hospital which required time to be embedded. Compliance with this audit rose to 84% in May 2023.

There were cleaning staff working throughout the department during our visit. The areas we checked were clean and free from dust. We observed staff cleaning equipment after patient contact.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment mostly kept people safe.

The main patient waiting area in A&E was of a reasonable size to accommodate people, and had safe and well-maintained fixtures and fittings. It was light and spacious with toilets for visitors and a vending machine. However, there were problems with clear visibility of all patients. The room was mostly square, but the walled entrance area built into the waiting room blocked visibility for the reception team of those patients who sat around the side of the entrance. On our visit we observed how many patients seemed to prefer this area as it gave a view to outside from the windows. Although there was live feed from cameras of the waiting area, including the area obscured from reception, the screens with the images were in the rapid assessment area and not the reception area. We spent some time observing if the screens were watched from the rapid assessment area, but did not see this happening with any regularity. However, with the unit relocating in 2024/2025 to a new emergency department on the site, there were no plans to reconfigure the department.

We were concerned with how the reception facilities were not fully accessible and suitable for meeting and talking with people who used wheelchairs. We observed how at times this made hearing and talking with staff at the reception desk (who were behind clear safety screens) unsafe for patients some of whom were trying to stand from a wheelchair to do this. This was not an issue with the adjacent nurse streaming service where the desk was at a low height designed for wheelchair users.

Urgent and emergency services

While we were talking with staff in the reception area, three patients arrived who were unwell and having trouble standing. At that time there were no wheelchairs anywhere to quickly provide for those patients. Staff ended up touring the department to locate them. We were told the availability of wheelchairs was a “lottery” and mostly they were located at the Urgent Treatment Centre where patients were often redirected. Staff said they were not aware of a system for bringing them back or making sure the emergency department always had them available.

The hospital standard wheelchairs were also, we found, hard to manoeuvre. We assisted a patient and their friend to get to the urgent treatment centre, located along an outside pathway in the next part of the building. This proved tricky and the chair was heavy and hard work. The friend was recommended to pull it backwards by staff, but this added its own risk from them tripping or falling. We were concerned as to how any frail or elderly people would have managed to make this journey with a patient. Our other concern about reception was whether the patient experience had been considered with there being two touchpoints when booking in at reception. The patient was first met by the streaming nurse, but then had to attend the next window to give more information to the reception staff. Although we could see the clinical expediency in this arrangement, we could also see the frustration or confusion for the patient or relative/friend, particularly those who were feeling unwell.

There was a lack of some equipment needed to carry out examinations on patients. We saw staff looking for stethoscopes and pen torches and not being able to find any. Although staff recognised this issue and those listed above as risks to patient safety they were not reflected in the department’s risk register.

We observed the handling of patient samples (blood taken and stored in small bottles for analysis in this instance) did not always meet trust policy and procedure. Although urgently addressed at the time, there were issues with the practice for labelling patient samples which did not meet trust policy. For example, we saw blood request forms being printed after blood had been taken, samples being taken away from the patients’ bedside to be labelled, and samples given to colleagues to label. This issue was on the departments risk register. The risk register identified that if staff do not follow the policy for patient identification and labelling of samples this may result in delays in patient care.

Compliance with environmental checks was 39% in April 2023. Senior hospital leaders explained the process of aligning quality audit processes across the trust meant new metrics were being used at the hospital which required time to be embedded. The compliance with these checks rose to 81% in May 2023.

Ambulance crews had direct access to the department and their own entrance. The hospital had a helicopter landing area located immediately outside of the department and we were told well-rehearsed safety procedures would be commenced to safeguard everyone in the vicinity when a landing was being made.

The trust met the environmental recommendations from the Royal College of Paediatrics and Child Health Standard for Children in Emergency Care Settings in having specific areas for children. However, the waiting area was small and not as child-friendly as it could have been, but we were told there were plans to improve the décor with some new wall-paintings. The emergency department also had a specific treatment area for children although with children having to access their treatment area through the department. Children were therefore not always protected or removed from seeing and hearing adult patients, some with complex needs.

The triage room located within the waiting area provided patients with privacy and confidentiality from other patients. The doors into the rest of the department were locked with swipe card access for authorised personnel.

The resuscitation area had three bays, one able to accommodate a child, and was well stocked with the required equipment, including that for children, pregnancy complications, and other specialist areas of treatment. We were told the bays could get full in times of high demand, but a three-bedded area was not untypical provision for a department of its size.

Clinical waste was disposed of carefully and those bins we saw for the disposal of sharp instruments were not overfull, although some were a little far away from the treatment area, specifically in majors. General waste bins were being regularly emptied by the cleaning staff.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration. However, the provision of longer-term care for patients who were delayed in being handed over for further treatment was not well documented or described. Not all patients were given the optimum equipment for risks from skin damage.

Staff were aware when a patient was assessed at risk from falls, pressure ulcers or other potential unintended harms. Risk assessments were being completed and a flag raised to alert staff on the electronic patient record. Pressure relieving and falls prevention equipment was being used when indicated. However, we were told, with the advice of the moving and handling team, patients brought in by ambulance were left on stretcher canvasses for the duration of their A&E stay to make their onwards transfer to a ward less onerous for staff. Stretchers or patient trolleys are designed to be compact and are easier to manoeuvre than a hospital bed, they also offer close access to the patient for examination and emergency care. However, the mattresses are generally thinner, so less comfortable and suitable for short periods. We saw 2 patients who were resting on stretcher canvasses in a shearing position. Shearing refers to skin tissues being moved in the opposite direction to internal body structures which may lead to deep tissue injury. The hard stretcher canvas is more likely to cause shearing than a softer surface. One of the patients we observed in a shearing position was left for over 90 minutes without being repositioned despite the concerns we raised with the nursing team.

Staff used the National Early Warning Score (version 2 – NEWS2) for adults and children over the age of 12 patients and the Paediatric Early Warning Score (PEWS) for babies and children under the age of 12. Those records we saw were all completed. We reviewed 3 records of NEWS scores and found the assessment of the patient and subsequent scoring to be in line with guidance. Patients who were registering a high NEWS score had regular reviews and updates, and had been flagged for medical review as required.

The emergency physician in charge and nurse in charge had regular structured meetings throughout the day to monitor the activity in the department. They used an electronic monitoring tool for oversight of the patients which included NEWS and PEWS score and time spent in the department. They discussed every patient and reviewed progress of plans to reduce risk. If the number of patients in the department was reaching capacity, they could escalate the situation to senior hospital leaders. Once in escalation, staff from outside the department were asked to increase their efforts to enable the transfer of patients who were well enough, out of A&E and onto a ward, hospital leaders could also move staff from other areas of the hospital to increase staffing levels.

We were concerned about the documentation of needs of those patients who were remaining in the department for longer periods of time, than would be typical for an emergency department and clinical team. There was no structured extended care plan in use which gave clear evidence of the management of patients' longer term medical and nursing

needs. This included, for example, showing early recognition of time-critical medicines, regular repositioning for skin integrity, and assurance of hydration and nutrition needs being met. We did not see these needs going unmet, but the structured documentation which could be audited and checked for compliance and assurance for the department leaders was not evident.

The senior nursing team carried out a monthly audit of the environment. The audit carried out in June 2023 was compliant with all aspects of the patient experience. Of the 5 patient experiences that were included, all had their call bell within reach and the only patient that was not nil by mouth had a water jug on their table. All patients had their pain adequately controlled.

The assessment of patients who were brought into the department by ambulance or identified as acutely unwell on arrival was carried out by a clinical team in the rapid assessment area. There were separate bays in the unit set aside for ambulance arrivals with higher levels of equipment and a full team of clinical staff to assess the patient. This early assessment enabled rapid diagnostic tests to be arranged, risks to be identified and requests made for any speciality input.

One of the key members of the wider team for keeping patients safe was the hospital ambulance liaison officer, or 'HALO'. This was a paramedic employed by the NHS ambulance service and on duty at certain planned times of probable capacity escalation. The HALO reported a good working relationship with the emergency department team and well-managed prioritisation of the sicker patients. They were based with the team in the rapid assessment unit and able to quickly respond to the need for escalation or clinical diverting of patients.

We observed how the system for urgently contacting clinical staff was sometimes not working effectively. There was a need at one point for clinical staff to assess a situation quite urgently with a patient (this was not a significant medical emergency, such as cardiac arrest, when there was an effective process). The phone call from the streaming nurse in reception to the rapid assessment team went unanswered (as they were likely to be busy with other patients). We understood there was a system for the rapid assessment team, the ambulatory care team and the nurse in charge to rapidly communicate with each other, for example, but this did not extend to the reception team. We reported this to the leadership team to look for a possible solution.

Staff referred children and adult patients experiencing mental health problems to mental health teams based within the hospital. However, staff told us patients sometimes needed to wait a long time to be seen by these teams especially overnight and at the weekend and especially for the Child and Adolescent Mental Health Services (CAMHS).

The department was not designated to provide emergency treatment to children. This service was delivered by Poole Hospital and the ambulance service conveyed all children and young people there. For children who attended the department there was a process to ensure they were conveyed by emergency ambulance to Poole Hospital if they required emergency treatment. In the 12 months before our inspection 581 children had been transferred, 561 to Poole Hospital, 5 to the A&E department in Salisbury and 15 to the A&E department in Southampton.

Nurse/paramedic staffing

The service maintained enough nursing/paramedic staff and support staff at most times with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

Urgent and emergency services

There had been improvements in the number of nursing staff in the department with the recruitment of new nursing staff, including international nurses. However, senior departmental nursing staff were honest and open that this meant the workforce did not yet have the skill mix and experience required to be fully efficient at all times. As a result, an increased and improved learning and development programme had been brought in to support staff in embedding and improving their skills and experience. This involved embedded practice educators, who were experienced nurses whose role was to train, educate and improve skills through various options including bedside teaching. We recognised, as did the department, this would take time to be fully realised.

International nurses joining the department had a three-day induction and were linked with a band 6 mentor to support them. The department had its own practice educators who were closely linked with the international nurses. The practice educators worked with the practice education team across the trust to share themes and areas for further development for international nurses. The nurses studied all the main clinical competencies and were evaluated on progress.

International nurses were provided with mental health and practical support, and pastoral care if needed. A trust team in the HR department provided support entirely for international staff. There was a new programme of enhanced learning for band 5 nurses from a minority background to progress to band 6 roles.

There continued to be regular use of agency nursing staff for unplanned and other absence. Many were regular workers for the department.

Medical staffing

The service maintained enough medical staff at most times with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Senior leaders told us they did not have enough consultants to meet the guidelines recommended by the Royal College for Emergency Medicines and the Royal College of Paediatrics and Child Health for the size of the department and some shifts were not fully covered. To mitigate the risk, doctors from other areas of the hospital were sometimes used, and Emergency Department consultants worked cross site between Poole and Bournemouth Hospitals when required. The recruitment of doctors had sometimes been difficult, which followed a national trend, the trust had invested in employing Advanced Clinical Practitioners (ACPs) and Physician Associates (PAs) to mitigate this. ACPs are health care professionals that have undertaken additional training to allow them to assess, diagnose, and treat patients including prescribing medication and referring on to other services. PAs undertake training equivalent to a junior doctor and perform a similar role to ACPs but are unable to prescribe or order radiological investigations at present. The ACPs and PAs were well managed in terms of oversight and skill mix. The trust had innovative recruitment plans for overseas clinicians with a strong culture around settling in international medical graduates including funding degrees to improve recruitment and retention of medical staff. A business case had also been submitted to obtain funding to employ a larger number of junior doctors and ACPs to support the clinical workforce both in and out of hours.

Junior doctors, ACPs and PAs told us consultants were approachable and supportive and could be relied on to offer advice on medical and non-medical issues, for example identifying a safeguarding concern.

Records

Staff mostly kept detailed records of patients' care and treatment, but had no clear consistent record to show how extended care was being safely provided.

Urgent and emergency services

The department used a combination of electronic notes and some reducing numbers of paper documents for recording patient care and treatment. A new electronic notes system was about to be introduced, in preparation for this staff were receiving training on the new system.

We reviewed 10 sets of patients records, which did not consistently contain a record of intentional rounding. Intentional rounding, often referred to as rounding, is a process used by nursing staff to carry out regular checks, usually hourly, with patients using a standardised protocol. Rounding addresses issues of positioning, pain, personal needs, and placement of items, in an emergency department it might also include an assessment of patients' psychological wellbeing and a review of their time critical medicines.

Is the service caring?

Inspected but not rated

Compassionate care

Staff treated patients with compassion and kindness, but there were a couple of lapses of respect for privacy and dignity. Staff did take account of people's individual needs, but the lack of wheelchairs and the difficult journey to the urgent treatment centre for frail patients or carers had not been considered in terms of patient experience.

Staff were kind and caring with patients and families. This included staff across the department in different roles. We met a number of patients and their families and all of them were happy with the care and compassion they had received. We observed and overheard staff talking warmly with patients and relatives and reassuring them. This was particularly evident in the interactions in the ambulatory care unit and the Majors B area. Here, most patients were all able to stay in rooms rather than all cubicles and this appeared to prompt staff to regularly check on them as they were not immediately visible.

We observed staff giving as much time to the patient and any family as possible. They came across as non-judgemental and respected people's rights to make their own choices, even when they were not in their perceived best interests.

However, we were concerned about a small number of lapses in respect for people's privacy and dignity. We observed two patients, one in Majors A and the other in the observation area, who were either fully exposed or from the waist downwards. None of the staff in the immediate area had noticed this and a number had walked past without observing this or helping the patient. One patient was clearly confused but did not have sufficient support to keep them safe and maintain their dignity. We sat within the Majors A area for some time and at the time, when the department did not feel overwhelmed and was well staffed, observed a group of quite vulnerable patients. We observed how they had insufficient nursing attention in terms of their risks and dignity while nevertheless a large group of staff were based at the end of the area working at computers and desks.

There was also an issue for a relative of a patient who had arrived separately by ambulance, but, it transpired, had been taken elsewhere in the hospital for tests and not booked in at the emergency department. This was the correct clinical pathway in this situation, but the reception staff had not been trained to know of this potential diversion of the patient. This caused significant anxiety to the relative when being informed their whereabouts of the patient was unknown. We fed this back to the senior team at the time in order for them to consider the system used in this circumstance and if it could be improved.

Urgent and emergency services

Is the service responsive?

Inspected but not rated

Access and flow

Alongside and as a result of long-standing local and national issues in the whole health and care pathway, people could not always access the service when they needed it and receive the right care promptly. Waiting time standards, handover times from ambulance crews, and time spent in the department were frequently missing national standards or comparable results.

There were long-standing local and national issues with access and flow through the whole health and care pathway. The south west of England and many coastal towns such as Bournemouth had been overwhelmed with patients and a lack of capacity for many months. This was not restricted to the predicted higher activity in winter, but extended throughout the year including the height of the summer holiday period. As a result, the hospital was frequently unable to take patients from the emergency department to a ward bed at the time the patient was assessed and ready to be handed over for further care and treatment.

Subsequently, not all patients could get access to the service in a timely and clinically safe way, and some were remaining in the department for longer than was clinically or psychologically optimal. There had been lengthy handover delays for ambulance crews and patients known to be waiting longer in the community for care and treatment from the emergency services. This was fully recognised by the trust board and assessed as a high risk on the corporate risk register.

Nevertheless, managers and staff worked hard to make sure patients did not stay longer than they needed to. Patients were prioritised in terms of clinical need and those who were urgent were seen as quickly as possible. There was a clear focus on the departmental dashboard where length of stay and clinical need were clearly indicated and staff were aware of each patient's needs and reasons for any delays.

We observed a meeting where staff from across the hospital discussed capacity with the aim of improving flow. These meetings take place twice every day. At the meeting we saw staff working together to benefit patients waiting to be transferred out of A&E.

Data showed how, along with all NHS emergency departments, the trust was not meeting the national standard for admitting, discharging or transferring 95% of patients within 4 hours of arrival. University Hospitals Dorset NHS FT had been part of an NHS pilot for the last three years, trialling the use of other clinical standards for emergency departments. This trial had recently been ended and the trust reverted to reporting its performance against the 4 hour standard.

The trust's percentage of patients waiting more than four hours from the decision to admit to admission increased (deteriorated) considerably from 24.0% in May 2022 to 39.6% in December 2022. There was then a reduction to 31.7% in March 2023. The trust's performance was considerably better than the England and South West averages until September 2022, but since then its performance has been much closer to the averages. For comparison in March 2023 trust performance was 31.7% compared to the South West average of 33.8%.

There was a considerable increase in the number of the trust's patients waiting more than 12 hours from the decision to admit to admission from 113 in September 2022, to 332 in December. This was followed by a reduction to 185 in March 2023.

Urgent and emergency services

The trust consistently reported a much longer (worse) median time from arrival to treatment compared to the England average from May 2021 to February 2023. There was a considerable reduction from two hours eight minutes in December 2022, to one hour 46 minutes in February 2023, but this was still considerably worse than the England average of one hour eight minutes. The trust's median total time in A&E was consistently longer (worse) than the England average from May 2021 to February 2023. There was a considerable increase from 4 hours 13 minutes in August 2022, to 5 hours 2 minutes in December 2022. This was followed by a reduction to 4 hours 44 minutes in February 2023. However, this was still considerably worse than the England average of 3 hours 4 minutes.

However, the department saw a reduction (improvement) in the percentage of ambulance handovers taking more than 60 minutes from 48.8% in December 2022 to 10.3% in May 2023. This coincided with an overall improvement for the regional ambulance service, South West Ambulance Service.

We saw information that showed the trust has improved its performance in all of the above metrics in the three months before we inspected. In addition, it is important to give the metrics context and point out that A&E attendances at the trust were higher than 60% of other hospitals in the country and there were more patients being treated by the trust than most other trusts in the country.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

University Hospitals Dorset (UHD) NHS FT ran two emergency departments in Dorset, this one located in Bournemouth and another located at Poole Hospital. UHD was a merger of two existing NHS trusts in south Dorset in 2020. Since that time, the emergency departments had been joining their senior teams together to gradually share leadership and resources and develop mutual systems and processes.

Staff told us they felt well supported by their senior team. They said they were visible and approachable and the department worked well as a strong team. All those we met in the staff team said they felt confident and able to speak up to senior staff and managers. There was a learning culture in the department and effective support for staff to train and develop into more senior roles and learn new skills.

A number of staff said they regularly saw the trust leadership in the department and felt supported by the executive team particularly when the department was in extreme escalation. However, other staff felt the trust leadership team were not visible. They said things like A&E had been "abandoned" and "forgotten" by trust leaders and previously when the department was in escalation trust leaders would have been visible and asking what they could do to help.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care, although with some observed lapses. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Urgent and emergency services

Staff in the department felt valued by one another. We observed staff working well together, knew each other well, and were supportive and kind. This extended to teamwork with other services and specifically the NHS ambulance service where staff reported good working relationships.

The senior leadership team told us how they were most proud of the emergency department team and how they had been incredible to work with, with great tenacity and enthusiasm despite the challenges faced. They were also proud of the training offered and how that had developed over time with the practice educators to be an effective and valued service.

There was a principle embedded in the department of the need to mentor, support and train new staff, and to provide them with confidence and grow their experience.

However, there was a concern we raised with the trust about a number of international staff not recognising the role of the Freedom to Speak Up Guardian. We recognised staff had possibly been overwhelmed with new information on joining the trust, and there was a lot to learn. This role is a UK national role which is not as universally recognised as other healthcare jobs (and might have other names in other countries). It could have been well explained and introduced, but had not been well understood. However, staff from minority backgrounds did tell us they had both formal and informal networks and were not concerned about speaking up to their own managers or colleagues.

We asked staff about a number of issues we had found, such as wheelchairs not being available, staff not being able to find a patient for a relative, and an internal call for assistance going unanswered. We asked staff if these would be reported as incidents, and they were honest in admitting they probably would not be. One member of staff said, “they are somewhat normal life.”

The annual NHS staff survey for the trust (which was not broken down by separate departments) which took place between October and November 2022 uses a scores range from 1 to 10 – a higher score indicates a better result. The results showed the trust scored below the average for three elements: ‘We are Safe and healthy’ (5.8), ‘We are always learning’ (5.3) and ‘Morale’ (5.6). Three elements were above the average ‘We are compassionate and inclusive’ (7.3), ‘We each have a voice that counts’ (6.7) and ‘We are a team’ (6.7). We are recognised and rewarded’ reduced from 5.9 to 5.7 and ‘We each have a voice that counts’ deteriorated from 6.8 to 6.7.

Nearly three quarters of staff (73.6%) at the trust said they would feel secure raising concerns about unsafe clinical practice which is better than the national average of 70.7%. Just over one in five staff (21.2%) believe the provider is adequately staffed, worse than the national average of 25.5%.

The Workforce Disability Equality Standard (WDES) is a set of measures which enable NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. The trusts WDES results for staff with a long-term condition or illness were notably different to results for staff without a long-term condition or illness at the trust, indicating poorer experiences for staff with long-term conditions or illnesses. These results were consistent with the national response to these measures.

The Workforce Race Equality Standard is a set of measures which enable NHS organisations to compare the workplace and career experiences of staff from ethnic minority groups with their white colleagues. The results for the trust show that a much higher proportion of staff from all other ethnic groups had experienced harassment, bullying or abuse and discrimination from managers or other staff in the previous 12 months, than their white colleagues. They also had less belief that their organisation provided equal opportunities for career progression, indicating poorer experiences for them.

Urgent and emergency services

We spoke to representatives of the diversity and inclusion network for the trust who told us about initiatives they planned to raise awareness around racial discrimination and to promote inclusivity.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The department was aware of its performance, resilience and risk from a local dashboard designed to provide live data throughout the day and night. This was visible to all staff in the department and was used, for example, when one department had less capacity than the other and it might have been beneficial for patients to divert ambulances to the other emergency department.

The department used an internally-designed version of the NHS national 'operational pressures escalation level' (OPEL) framework known as the 'emergency department capacity level tool'. This was refined to use data which took into account other aspects of the hospital's resilience. The leadership team were open and honest about this tool and considered how 'escalation fatigue' (in that the department felt always to be in higher levels of risk and escalation) had meant response to the tool from decision makers had been limited of late.

It should be noted there was no specific knowledge in the local senior team of how the trust's emergency departments were represented with the Integrated Care System or Board.

The risk register did not recognise risks around the delays of provision of clinical support for patients experiencing a mental health crisis. There was little provision of mental health support for out of hours and at night when the department felt this was the most demanding time for patient's needs. However, as a response to recognising the growing need for mental health care, the department was looking at more multidisciplinary work with patients who were regular users of the service or people who were homeless and/or rough sleepers.

During our inspection in 2016, we were concerned that complaints were not always processed within the trust's agreed timescales. The hospital had introduced a process to resolve complaints in collaboration with the Patient Advice and Liaison Service (PALS) within a short time frame. This included having a dedicated PALS officer to contact complainants so whenever possible an early resolution to a complaint could be found. This reduced the amount of complaints requiring a full investigation allowing the trust to process the more complex complaints more quickly.

Areas for improvement

MUSTS

The Royal Bournemouth Hospital Emergency Department

- The trust must ensure the premises and equipment are suitable for purpose. The trust must review the safety of the main waiting area in the emergency department. There was a lack of some patient visibility for the staff responsible for the safety of the department and screens with live feed located elsewhere. The reception area was not suitable for persons using wheelchairs to do so safely. Regulation 15 (1)(c).

Urgent and emergency services

- The trust must ensure it provides safe care and treatment to patients at all times and demonstrate this through clear and complete record keeping for all care interactions. It must demonstrate all patients remaining in the department for what might be considered as an extended stay have all their needs met and these are clearly documented. Regulation 17(2)(c).
- The trust must ensure patients are not left in a shearing position through the regular monitoring and repositioning of patients. Regulation 12(2)(a)(b).
- The trust must ensure staff adhere strictly to policies and procedures when taking and labelling samples from patients. Regulation 12(2)(a)(b).
- The trust must ensure care of patients is given with dignity and respect. The trust must ensure high standards of nursing care are in evidence which include ensuring the privacy and dignity of patients, particularly those who are confused or anxious. Regulation 10(2)(a).

SHOULDS

The Royal Bournemouth Hospital Emergency Department

- The trust should consider the patient experience when requiring them to speak to first the streaming nurse and then the receptionist particularly if the patient is unwell and has to stand for some time at either touch point.
- The trust should look at how to improve communication with relatives when a patient is brought to the emergency department by ambulance but diverted elsewhere for urgent tests and not booked in.
- The trust should consider the patient experience and staff efficiency when there are no wheelchairs available in the department for unwell or unstable patients. It should also consider the hospital wheelchairs being hard to safely manoeuvre for some people. The experience of a child patient and their family or carer should be improved in the waiting area at all times.
- The trust should require all staff to follow infection prevention and control guidance at all times, including the safe use of personal protective equipment and the dress code.
- The trust should consider how to ensure the reception team are able to contact staff for assistance at all times.
- The trust should consider its policy on the use of canvas stretchers for longer stay patients.
- The trust should work closely with the integrated care board to continue to address the significant and serious delays faced by some patients waiting in the department for a hospital bed and remaining in the community as ambulances are delayed in their handover of patients. Access and flow through the hospital and responsiveness to patients was adversely impacted by the pressures throughout health and social care. There should be consideration as to how to manage ‘escalation fatigue’.
- The trust should work with the Freedom to Speak Up Guardian to educate and encourage those staff who did not recognise this role to be an integral part of the otherwise well-respected service.
- The trust should introduce a system that captures all risks facing the department so they can be included on the departmental risk register.

Our inspection team

A team of 1 inspector, 1 CQC senior advisor and 2 independent specialist advisors visited the emergency department and the urgent treatment centre. We spoke with 43 members of staff (including managers, doctors, nurses, healthcare assistants, healthcare professionals, receptionists, administrative staff and a volunteer). We spoke with 5 patients. We reviewed 16 sets of patient notes, we attended 3 meetings.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

University Hospitals Dorset NHS Foundation Trust

The Outpatient Assessment Clinic at Dorset Health Village

Inspection report

64-68 Dolphin Centre
Poole
BH15 1SQ
Tel:

Date of inspection visit: 27June 2023 28 June 2023
Date of publication: 14/09/2023

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at The Outpatient Assessment Clinic at Dorset Health Village

Inspected but not rated

University Hospitals Dorset NHS Foundation Trust provides acute and emergency services to people living in Poole, Bournemouth and East Dorset. University Hospitals Dorset NHS Foundation Trust provides a wide range of hospital and community-based care to a population of 771,000 based in the Dorset, New Forest and south Wiltshire areas.

On 1 October 2020, The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust merged to form a new organisation.

The trust provides a wide range of hospital and community-based care; and employs approximately 8,400 members of staff, both clinical and non-clinical. The trust has not been rated since the merger in October 2020. The hospital's ratings were inherited from the previous provider.

We carried out a focused inspection with a short notice on 27 and 28 June 2023. The inspection was carried out because we had concerns about care and treatment in some areas of outpatients. We did not look at all key lines of enquiry but limited these to areas where concerns had been raised.

Outpatients

Inspected but not rated

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Managers monitored the effectiveness of the service and made sure staff were competent. Key services were available 5 days a week.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. Staff were committed to improving services continually.

However:

- People could not always access the service when they needed it and had long waits for treatment.
- The service used multiple information systems as well as paper records for triage and booking of appointments this meant there was a reliance on staff to ensure tracking of appointments.

Is the service safe?

Inspected but not rated

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Nursing staff received and kept up-to-date with their mandatory training. Records showed 90.69% of staff had completed their training against a target of 90%. It was comprehensive and met the needs of the patients and staff. Managers monitored compliance and alerted staff when they needed to update their training. Staff told us they received reminders when their training was due, and their managers discussed this with them.

In July 2022, The Health and Social Care Act 2022 introduced a requirement that regulated service providers must ensure their staff receive learning disability and autism training appropriate to their role. This training was not in the current list of mandatory training for staff at the Trust, this will commence once the government has published the Code of Practice for the training as agreed by the Dorset Integrated Care Board (ICB).

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Records sent to us by the Trust show that 100% of nursing staff had completed level 2 adult safeguarding training and level 2 child safeguarding training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff followed safe procedures for children visiting the department. The OAC did not have any clinics where children would attend for appointments, but there were times when parents/carers would bring children with them for their appointments.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

The clinical areas were clean and had suitable furnishings which were clean and well-maintained. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

The service did not always perform well for cleanliness. The environmental audit for infection control was not submitted for 7 months from July 2022 to June 2023. However, the results of the audit for April to June 2023 were completed and compliance was between 98.3% and 100%. The Trust sent us documents to show that action plans were being put in place to improve compliance with this audit.

Evidence sent by the Trust showed that there had been issues completing the audits due to increased pressure on workload and staff sickness, audits submitted after the deadline were noted as non-submission. Work has been ongoing to improve the compliance through staff training and support from the infection control team.

The hand hygiene audit data showed that compliance in the OAC had been poor. This had been recognised by the trust and been noted as a reporting error. Further training was given to staff completing the audits and the hand hygiene compliance was 100% from April to June 2023.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The OAC was located on the second floor of a department store in a shopping centre in Poole. Access to the second floor was via a lift, stairs or escalator. There was a bus stop, taxi rank and train station nearby and patients told us that parking in the multi-storey car park was more accessible than at the main hospital site with more disabled spaces available.

Volunteers were situated at the entrance to the store to guide patients. There was clear signage for the department. The volunteers had hand-held computer devices to complete the check-in for the patients and directed them to the department. The electronic check in notified the clinic staff when patients had arrived.

Outpatients

National guidance for the design and layout of OPD takes into consideration that many patients who attend may have mobility problems and recommend the OPD should be located on the ground floor and that parking areas for disabled people and wheelchairs should be provided close to the main entrance. When parts of the OPD are not located on the ground floor the guidance recommends easy access by lift and stairs must be provided and access and circulation routes to and within the OPD should be sufficiently direct and clearly signposted to prevent patients losing their way (NHS Health Building Note Guidance 12).

Staff carried out safety checks of specialist equipment. We saw records that showed weekly checking of the resuscitation equipment.

The service had enough suitable equipment to help them to safely care for patients. However, not all of the clinic rooms had sinks for hand washing. We were told that the rooms without sinks were used for 'dry clinics' only where staff could use the alcohol hand gel for hand hygiene purposes. Sinks were easily accessible in the corridor outside each clinic room.

Staff disposed of clinical waste safely. The domestic and clinical waste bins were clearly identified and emptied regularly. Sharps and hazardous waste bins were stored safely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. Risk to patients on the waiting list was not always identified.

New and existing patients sometimes had to wait for a long time to be seen by a doctor. In June 2023 the total waiting list size was 74,483 patients with an additional 30,719 patients overdue a follow up appointment. The trust identified patients whose condition had deteriorated while they were waiting through the validation process or at their follow up appointments, so they could understand what had happened and learn from it. Waiting lists were being validated in each speciality, this meant that patients were being contacted to see whether they still needed to be seen or if they could be removed from a waiting list.

Staff responded promptly to any sudden deterioration in a patient's health. Staff told us about an incident where a patient fell on the escalator and how they managed this, they knew who to call and what to do if there was a medical emergency. There were guidelines for staff to follow if a patient or visitor became unwell. Following the incident a standard operating procedure (SOP) was updated, staff and volunteers were aware of the processes to follow. Patients were offered to use the lift or the stairs first, rather than the escalator, if the volunteers were concerned about patient mobility, they would call a member of staff to assess the patient.

Staff met at the beginning of each day to share information to keep patients safe.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough nursing and support staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The manager could adjust staffing levels daily according to the needs of patients. Staff could rotate to work across various sites if needed. The number of nurses and healthcare assistants matched the planned numbers. Cover was provided for staff absence and managers requested bank staff who were familiar with the service. They made sure all bank staff had a full induction and understood the service.

The service had low vacancy rates for nursing staff. However, they had high vacancy rates for administration staff. The vacancy rate for administration staff was 14.94% in June 2023 this equated to 15.84 whole time vacancies for band 3 patient administrators. Managers told us that they were looking at ways to make the role more attractive such as offering flexible working, developing the role and having a clearer structure and career progression pathway. Administration staff provision was shared across the main OPD on Poole site and the OAC. The trust informed us that they had recently held a successful administration open day where 12.86 posts had been offered.

The service had high sickness rates. The sickness rate for nursing staff was 12.96% over the last 12 months against the trust target of 3%.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were all stored electronically. All staff could access records easily. They were stored securely. When patients transferred to a new team, there were no delays in staff accessing their records.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. All medicines and prescribing documents were managed and stored safely.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff told us they reported incidents electronically and received feedback on the incident once a manager had reviewed it. They raised concerns and reported incidents and near misses in line with the organisation's policy. Reports from investigations showed managers investigated incidents thoroughly. There was evidence that changes had been made as a result of identified learning. Staff received feedback from investigation of incidents, both internal and external to the service. We saw records showing a post incident staff briefing meeting had taken place and the learning from the incident.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. Managers shared learning about never events and serious incidents with their staff and across the organisation. Never events are defined as serious incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Managers debriefed and supported staff after any serious incident.

Outpatients

Is the service responsive?

Inspected but not rated

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of the local population. For example, the outpatient assessment centre was opened in 2021 in response to need for more appointments and to bring diagnostic services closer to the community. Facilities and premises were appropriate for the services being delivered. The service had systems to help care for patients in need of additional support.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. We were told patients attending the hip clinic could see a physiotherapist on the same day and this reduced the number of appointments.

Managers monitored and took action to minimise missed appointments. Patients were sent text message reminders prior to their appointments. Managers ensured that patients who did not attend appointments were contacted.

The service relieved pressure on other departments when they could treat patients in a day. For example, opthalmology patients could have eye tests and their clinician appointment on the same day.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Reasonable adjustments were made to help patients access services. We observed patients with mobility difficulties being supported by health care assistants.

Access and flow

People could not always access the service when they needed it or receive the right care promptly. Waiting times from referral to treatment were not always in line with national standards.

Managers monitored waiting times and tried to make sure patients could access services when needed to receive treatment within agreed timeframes and national targets. However, the trust had a significant backlog of patients waiting to be seen by some of the different OPD services. In June 2023 there were 30,594 patients overdue OPD follow up appointments. The backlog of patients waiting to be seen was partly due to the COVID-19 pandemic and associated social distancing requirements when patients could either not be seen at all or could only be invited to attend in small numbers. Recent staff industrial action had also affected the department as some clinics were cancelled.

Outpatients

From March 2021 to February 2022 there were 694,982 OPD appointments at the trust. This was an increase of 23% from the previous 12-month period. Initiatives to reduce backlogs had been introduced such as insourcing clinics and patient waiting list initiatives running at the weekends.

The maximum number of weeks patients should wait to be seen by a doctor is set by the NHS Constitution to try and ensure people are seen in a specific timeframe. The longest time the Constitution says people should wait is 18 weeks for most non urgent referrals, and 2 weeks for a suspected cancer. Trusts are required to put in place systems and dedicated teams to ensure patients are tracked and monitored along their 2-week or 18-week pathway, with audit processes to ensure appointments have been made.

The total number of patients on the waiting list was 74,483 in June 2023 with 55.1% of patients being seen within the 18-week performance standard against a national target of 92%. There were 32 patients who had waited over 78 weeks for treatment. However, the Trust had no patients waiting for over 104 weeks and were planning to eliminate waits of over 65 weeks for elective care by March 2024.

From January to March 2023 76.9% of patients were seen by a specialist within 14 days of an urgent referral for suspected cancer. The faster diagnosis standard sets out that patients will be diagnosed or have cancer ruled out within 28 days of being referred for suspected cancer, 71.9% of patients met this standard in June 2023 against a target of 75%. The trust had not met this standard in the 12 months before our inspection.

Staff told us that most clinics ran on time. On the rare occasion they ran late it was because the doctor arrived late because they had been caught up in surgery or on a ward, because patients who needed to be seen urgently had been added to the list, or because an appointment had run over due to the complexity of a case or a distressed patient.

Managers worked to keep the number of cancelled appointments to a minimum. Staff told us it was rare for clinics to be cancelled and when this did happen it was usually due to staff sickness and an inability for staff to be sourced to cover the clinic. When patients had their appointments cancelled, managers made sure they were rearranged for as soon as possible.

Within OPD there were different IT systems for patient referrals and patient records. There was a lack of integration between these systems which meant the different systems were not able to communicate and share data with one another. This required administrative staff to print the referrals and send them to the individual specialities for triage and then upload them on to another system once they were returned. Managers told us that there was work under way to move this to an electronic format with a pilot starting in August 2023, so that the triage could be done electronically to reduce the risk of errors in the booking process.

Following a clinic appointment, patients were given a paper outcome form to give to the receptionist, this showed the outcome of the appointment and whether they required another appointment. The receptionists had to input this information on to the computer system. Managers told us they were working with the IT department to change this system to an electronic outcome form that would be completed by the clinician following the appointment which was being trialled in the OAC.

Managers told us that the trust had plans to upgrade their digital systems and were planning to obtain a new Electronic Patient Record (EPR) system in 2025.

Outpatients

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The OPD had a clear senior management leadership structure. Matrons from other departments were supporting OPD staff because the OPD matron had retired. A new matron had been recruited to start in September 2023. There was a team of band 7 nurses who managed the department daily alongside the matrons. Senior staff told us that they were well supported by matrons from other departments and had been buddied with other matrons for support.

The trust ran 4 outpatient departments in Dorset. Since the merger in 2020, the outpatient departments had been working together to share leadership and resources and develop mutual systems and processes.

Leaders had the skills and abilities to run the service, they were committed to providing safe patient care and supporting their staff. Staff told us leaders were visible and approachable. Staff told us they were well supported by their line managers.

During our inspection we met with the senior leadership team and local leaders. Senior leaders told us about the issues the service faced and plans they had to overcome these. The main risks were the administrative staffing levels, the risk of using partly paper-based referral management and the lack of capacity to book follow up appointments within their given timeframes.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was a clear vision and set of values including quality and sustainability. There was a realistic strategy for achieving the priorities and delivering good quality sustainable care. Staff knew and understood what the vision, values and strategy were, and their role in achieving them. The service had priorities such as eliminating all patients waiting over 65 weeks for treatment by March 2024 and were on target to achieve this, this was included in the trust Operational Plan for 2023/24.

There was a strategy aligned to local plans in the wider health and social care economy, and services had been planned to meet the needs of the relevant population. For example, the OAC had been set up to deliver care closer to the community and had included various stakeholders in the planning process including patient governors and the public at engagement events.

Progress against delivery of the strategy and local plans was monitored and reviewed. The trust had implemented an outpatient transformation programme with clear objectives and timelines, this was part of a Dorset-wide outpatient transformation programme.

Culture

Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff we spoke to felt supported, respected, valued and were positive and proud to work in the organisation, they told us that the culture and morale in the OPD had improved. The culture was centred on the needs and experience of people who used services. Actions taken to address behaviour and performance was consistent with the vison and values, regardless of seniority.

The senior nurses had introduced ‘thank you Thursday’ a way of thanking colleagues, they had also arranged social events for all staff such as crazy golf and a staff barbeque. The department recently created a staff room with all staff involved in its development. Staff told us this had made a big difference for them as they did not have to leave the department for breaks.

Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution, and appropriate learning and action was taken because of concerns raised. The culture encouraged openness and honesty at all levels within the organisation, including people who used services, in response to incidents.

There were cooperative, supportive and appreciative relationships among staff. Teams and staff worked collaboratively, there were daily huddles where staff could raise issues. Staff told us they felt that ‘everyone is listened to equally’. Managers told us they worked together across all 4 outpatient sites, they met regularly to discuss issues and support each other, they were working together to standardise policies across the 4 OPD sites.

The annual NHS staff survey for the trust took place between October and November 2022. OPD Poole nursing staff results showed that 60.9% looked forward to going to work and 79% felt the organisation treats staff who are involved in an incident fairly. However, nearly three quarters of nursing staff (73.9%) in Poole OPD said they would feel secure raising concerns about unsafe clinical practice which is better than the national average of 70.7%. There was an action plan developed from the results of the staff survey, this included areas for the senior nursing team to focus on. For example, giving staff the opportunity to attend courses to gain new skills and looking at progression posts within the department.

Outpatients

Governance

Leaders operated effective governance processes. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. These were regularly reviewed and improved. Leaders monitored key safety and performance metrics such as the 18 week wait times.

Most levels of governance and management functioned effectively and interacted with each other. Some leaders told us there could be improvements in communication between the OPD and the medical and surgical care groups. The trust had 3 care groups; these oversaw the governance for medical, surgical and other specialities.

The OPD governance of waiting lists was managed by the individual specialisms that saw outpatients, for example, ophthalmology or urology and their wider core service. Governance arrangements were not coordinated as a single OPD. There were different committees that met to discuss performance and risk, their concerns were escalated to the Board of Directors.

Staff at all levels were clear about their roles and understood what they were accountable for, and to whom.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

The trust had systems for recording, reviewing and managing risks. There was a risk register for OPD, each risk had been given a score depending on the level of risk and these were reviewed regularly. For example, we saw minutes of meetings showing the risk score of for staffing levels had reduced as the service recruited more staff.

The OPD quality and risk group met monthly, we reviewed minutes of the meetings and saw that risks and issues were discussed and actions identified to reduce their impact. Leaders were clear on the links to trust wide groups and committees to escalate risks and issues.

There were arrangements for identifying, recording and managing risks, issues and mitigating actions. There was alignment between recorded risks and what staff said was ‘on their worry list’. The main risks were insufficient capacity to book follow-up appointments within due dates, outpatient staffing and the risk of using partly paper-based systems for referral triage. Board members were aware of the extreme risks, and these were reviewed by them monthly.

Information Management

The service collected data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Not all information systems were integrated. Data or notifications were consistently submitted to external organisations as required.

Information was used to measure improvement. For example, the trust had recently achieved no patients waiting over 104 weeks for elective treatment. They analysed key performance data monthly and reported on this.

Outpatients

Staff had sufficient access to information, senior leaders showed us the 'outpatient dashboard' an IT function which supported specialities to understand where they were against the outpatient performance targets. There were clear service performance measures, which were reported and monitored with effective arrangements to ensure that the information used to monitor, manage and report on quality and performance was accurate. Reports of patient backlogs were regularly sent to individual specialities to manage their waiting lists.

There were arrangements to ensure data or notifications were submitted to external bodies as required. There were also arrangements (including internal and external validation) to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards. Lessons were learned when there were data security breaches. For example, during the test phase of a new system 20,000 text messages were sent in error. We saw meeting minutes of the incident and lessons learnt.

Not all information systems were integrated, this was a known risk on the trust risk register. There were plans to implement some changes in the short term to help mitigate these risks. Senior leaders told us there were plans to upgrade digital systems by 2025.

Engagement

Leaders and staff actively and openly engaged with patients and the public and to plan and manage services. They collaborated with partner organisations to help improve services for patients

People's views and experiences were gathered and acted on to shape and improve services. The service used the family and friends test to capture patient feedback. From April 2022 to March 2023, the OAC OPD had 714 responses and 87.3% of responses said their experience was very good and 10.8% good. However, the staff survey results showed that only 56.5% of staff felt able to make suggestions to improve the work of the team, and only 34.8% felt able to make improvements happen in their area of work.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and understanding of the needs of the relevant population, and to deliver services to meet those needs. The Dorset Elective Health Inequalities Group was established in 2022, they aimed to ensure that patients with a learning disability had their first outpatient appointment within 18 weeks, and they monitored population health data to assess the impact of the elective recovery programmes on patients' access, experience and outcomes.

The trust were part of the Outpatient Transformation Programme Steering Group, this was a collaboration between the trust and partners/stakeholders.

The OAC collaborated with partner organisations and included free services which supported individuals to move more, drink less, stop smoking and maintain a healthy weight.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.

Leaders and staff aspired to continuous learning, improvement and innovation. The Trust had seen a progression of digital outpatient transformation in 2022/23 they had launched a patient portal (DrDoctor), installation of virtual consulting pods, extension of Bookwise (a scheduling system for the booking of clinics and rooms) room booking capability for Christchurch and Poole, and introduction of InTouch digital check in at Bournemouth and Christchurch hospitals.

Outpatients

The trust had started to implement patient initiated follow up (PIFU) this is when a patient initiates an appointment when they need one, based on their symptoms and individual circumstances. This ensures patients can see a specialist sooner than planned if they need to, as well as avoid an unnecessary trip to hospital if they have no need to be seen. It also helps clinicians manage their waiting lists in a safe and effective way. For patients, this means more choice and flexibility around when they access care.

The OAC was opened in 2021 as part of the trusts initiative to help tackle the backlog of outpatient appointments. Since then, they have expanded the roll out of high flow patient assessment clinics at the OAC to include 13 specialities including physiotherapy, dermatology, maternity and colorectal surgery. The service had been awarded a high commendation from the Health Service Journal Awards in 2022 in the 'Performance Recovery Award'.

There were standardised improvement tools and methods, and staff had the skills to use them. Learning from internal and external reviews was effective and included those related to mortality or death of a person using the service.

There were systems to support improvement and innovation work, data systems, and processes for evaluating and sharing the results of improvement work. For example, there was a health inequalities programme using data systems and processes to evaluate and improve the equity of access, experience and outcomes to reduce health inequalities.

Areas for improvement

Action the trust MUST take to improve:

OAC Outpatients

- The trust must continue to do all that is reasonably practicable to reduce waiting times to treatment. Regulation 12(2)(a)(b)

Action the trust SHOULD take to improve:

OAC Outpatients

- The trust should ensure staff receive training in how to interact appropriately with autistic people and people who have a learning disability. This should be at a level appropriate to their role. Regulation 18(2)(a).

- The trust should ensure that environmental audits are completed regularly and that they continue to challenge poor hand hygiene practice. Regulation 12(2)(h).

Our inspection team

A team of 1 inspector and 1 specialist advisor visited the Outpatient Assessment Centre (OAC) at Dorset Health Village. We spoke with 4 members of staff (including managers, nurses and healthcare assistants). We spoke with 3 patients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 27 September 2023

Agenda item: 7.1

Subject:	Freedom to Speak up Bi-annual report 2023/24
Prepared by:	Helen Martin, Freedom to Speak Up Guardian (FTSUG)
Presented by:	Helen Martin, FTSUG

Strategic themes that this item supports/impacts:	Systems working and partnership ☐ Our people ☒ Patient experience ☐ Quality: outcomes and safety ☒ Sustainable services ☐ Patient First programme ☒ One Team: patient ready for reconfiguration ☐
BAF/Corporate Risk Register: (if applicable)	BAF not applicable
Purpose of paper:	Decision/Approval
Executive Summary:	The purpose of bi-annual report (2023/24) is to: • Review our Speaking up culture since April to end August 2023. • 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 6monthly 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:	• We are reminded on how important speaking up is following the trial and verdict of Lucy Letby. Fear and Futility continue to be barriers to speaking up. • Progress since April until end August 2023 including national guidance and local activities. Of note: o Deputy FTSUG commenced end August 2023 for 1 year secondment. o Poor uptake of Speak Up, Listen Up, Follow Up', e-learning modules. Now recommended

	in Guardian Survey (July 2023) to be mandated. o Staff use the FTSU channel more for workplace and relational issues. o At UHD our data shows 40% staff come to FTSU because their line manager is the issue or they are not addressing the issue. o 18% is because they feel insecure in raising concerns. • Case headlines; 102 FTSU referrals since April – end August 2023. Forty-seven from Poole site and 55 cases from RBCH (46:54% respectively). • Staff approach the FTSU team for a number of reasons. The greatest theme had an element of behaviours (53 staff; 52%). This is followed by process and procedures (40 staff; 39%) and then worker safety and wellbeing (8 staff; 8%). • Of the 102 staff who raised a FTSU concern, 26% (27 staff) are from ethnic minority. 85% of cases had elements of attitudes and behaviours (23 staff). • We need to monitor those staff whom are not using the FTSU route and have low confidence in raising concerns (as reported in staff survey) such as emergency, cardiology, surgery and anaesthetics. • Nurses and Midwives accounted for the biggest portion (30%) of FTSU cases, followed by our administrative staff (24%) and medical workforce (12%; ↑4% from 2022/23). • 40% of cases were escalated to the line manager to investigate and action. 41% signposted to experts • All 57 cases raised with FTSU team in Q1, were closed with no further action • Seven staff reported cases anonymously, of which 5 are from staff based at RBCH site (National 9.3%). • Referrals came from operations (5), surgery (10), Corporate (21), WCCSS (27) and Medicine (32). • Learning; o An urgent call for action to develop an Invested and accountable civil and respectful programme. o Merger impact on staff work/life balance. o Differences between RBH/PHT sites o Long and shared learning from organisational restructures. Focus of staff wellbeing o Not belonging – focus on wards o Struggles with cost of living. o Untidy and uncared for working environment. o Detriment when speaking up o FTSU route used more for work and relational issues o Leadership training o E-learning speak up modules on BEAT o Upskill leaders to create psychological safe working environments o Increase in clinical FTSU engagement o Contribute 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	☐
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	09/08/2023	Assurance
Trust Management Group	12/09/2023	Decision/Approval

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

Freedom to Speak Up (FTSU)

Bi-Annual Report 2023/24

1.0 Introduction

We are reminded on how important speaking up is following the trial and verdict of Lucy Letby. It is tragic consequences of not listening and taking appropriate timely action like this which must lead us all to redouble our efforts to make speaking up, listening up and following up, business as usual. Staff tell us that the main barriers to speaking up are fear and futility. Fear of what might happen if you speak up; or a belief that nothing will be done if you do. This has also been illustrated in the evidence given in the trial, by the staff who spoke up. Another high-profile case involving futility with devastating consequences means we need to do much more to overcome this sense (see section 3.11).

As leaders we must demonstrate that we welcome and encourage speaking up, through actions, not just words. That means listening to understand and challenging our own biases; remaining impartial and investigating the matter raised, not the person raising it.

National Guardian
Freedom to Speak Up

"Confidence to speak up comes from knowing that when you speak up, what you raise will be actioned appropriately. It is vital that leaders listen to concerns raised to them. If actions are not taken, workers may remain silent, and that silence can be dangerous."

Dr Jayne Chidgey-Clark, National Guardian for the NHS

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. Whilst this reflects the national picture where 2 in 5 workers in the NHS do not feel able to speak up about anything which gets in the way of them doing their job, this is not the position we want to be in. 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. The role of the FTSU team is to highlight the challenges and act as an early warning system of where failings 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. Consequently, we need to be curious as to why staff choose not to go to their line manager? Since April to end of August 2023, 40% of staff whom come to the FTSU team say that they cannot go to their line manager because either they are the issue or that they are not addressing it. We need to better at this for us to be an embedded speaking up organisation.

We are half-way through 2023 and have some things to celebrate and feel proud of. The FTSU team has expanded, with an additional FTSU guardian in post, Tara Vachell. The investment in

this role will now allow us to meet our current demand but also be able to allow us to act in a more proactive way and help UHD address the barriers to speaking up and contribute to larger projects such as civility. Moreover, 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.

The purpose of this paper is:

- To review our speaking up culture since April (until end of August) and understand why our staff are raising concerns and what we have learnt.
- **ACTION for board:** Approve and support board commitment to speaking up (section 3.1)

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.

UHD is embarking on a refreshed cultural journey through our improvement programme, Patient First. This programme will support our staff to speak up, our line managers to listen up and our senior leaders to follow up. Speak Up, Listen Up and Follow Up are key components to our journey.

2.1 Speaking up at UHD – Our FTSU team

Our deputy FTSUG commenced in post end of August. 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 over 2023

3.1 Speaking up at UHD – 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 behaviours. This commitment is made in September as 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.

ACTION for board: Approve and support board commitment to speaking up (Appendix A)

3.2 UHD staff awards – 2023 "Open and Honest"

The UHD Awards is an important way to recognise each-other. In 2023, over 800 nominations were received.

One of the awards was the "Open and Honest" category, recognising an individual or team that works hard to promote an open and safe culture.

This year's worthy recipient was Catherine Bishop, one of our FTSU Ambassadors. The award celebrated the work that Catherine does to help others speak up, support their wellbeing and at times speaking truth to power. She is relentless in this work and a credit to our FTSU team.

3.3. Speaking up Month – October 2023 Breaking Barriers

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 will be celebrating the sixth Speak Up Month and the theme this year is Breaking Barriers. This topic will recognise that there are many barriers which can silence people and that there are some groups which can face more barriers than others. Throughout the month we will promote the importance of speaking up through different ways. Wear Green Wednesdays will also return when it is encouraged that we all visibly support this work by wearing green every Wednesday of October.

3.4 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.

3.4.1 UHD FTSU Network: Our FTSU network at UHD 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 our FTSU model going forward. We have planned a programme of work for 2023 including some personal development in September.

3.4.2 South-west regional Network: UHD stepped down as co-chair for the south west region in June after 3 $^{1}/_{2}$years. The National Guardian, Jayne Chidgey-Clark was present at the step-down meeting to show her appreciation of the work by the co-chairs. UHD will continue to maintain strong links and share good practice.

3.4.3 Dorset and Somerset FTSU Network: UHD set up this network in 2018 and chairs it. The vision of this group was agreed to share best practice and act as mentors for difficult cases. The membership has expanded over time, and now has representation across healthcare system.

3.5 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 1000 FTSUG in NHS, independent and third sector organisations and national bodies (June 2023). The office provides challenge and learning to the healthcare system as a whole, and conducts speaking up reviews to identify learning and support improvement.

3.5.1 National NGO Key Documents over 2023/4

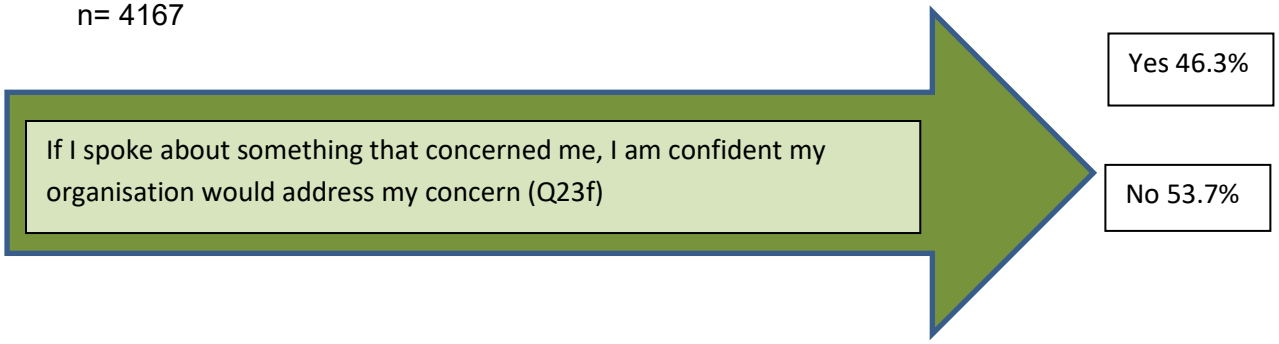
- **NGO Annual Report (July 2023)– Data from 2022/23**
- **Fear and Futility; What does the Staff Survey tell us about Speaking up? (June 2023)**

National Data (2022/23)	UHD data (2022/23)	
Over 25000 cases were raised with the FTSU in 2022/23; an increase of 25%	At UHD there was an increase of 20% from previous 12months; 2021/22 232 cases and 2022/23 raised to 279 cases	
The % of cases which were raised anonymously has fallen to 9.3%	This maintained at 5%	
The average number of cases raised by medium sized NHS trusts were 36 per quarter.	At UHD this was 70 cases.	
The FTSU sub-score calculated from the staff survey can be used as a benchmark for speaking up. The national average FSTU score declined from 6.5 in 2021 to 6.4 in 2022.	At UHD, we also see a decline from 6.59 to 6.41 in 2022.	
Detriment for speaking up was 3.9% of cases.	At UHD this is 6%	
The main national themes are inappropriate behaviours (30%) and then a further 22% of cases raised as bullying and harassment	Inappropriate behaviours accounted for 32% of cases and an additional 6% were raised as bullying and harassment.	
Patient safety and quality increased to 19.3% of cases	This remained at 3%	
One in every four cases (27.4%) involved an element of worker safety or wellbeing	This was 24%	

A number of important points for UHD were raised in these reports.

- The number of cases continue to increase year on year nationally mirrored also at UHD, reflecting that this route to raise concerns is being embedded.
- The number of these which are anonymous is lower at UHD compared to national figures which may suggest that culturally people are comfortable to use the FTSU route.
- The average number of cases raised by medium sized NHS trusts were 36 per quarter. At UHD this was 70 cases (2022/23 data). National data correlates FTSUGs in lower rated NHS Trusts receive more speaking up cases each quarter. These observations do however need careful evaluation and monitoring as numbers can represent a number of things. High numbers do not necessarily indicate that UHD has a poor speaking up culture but may mean we have a more invested FTSU route. At UHD we have recently invested in our FTSU team and ringfence time to promote and hear cases.
- The FTSU sub-score calculated from the staff survey can be used as a benchmark for speaking up. The national average FSTU score declined from 6.5 in 2021 to 6.4 in 2022. At UHD, we also see a decline from 6.59 to 6.41 in 2022. The FTSU sub-score correlates with Care Quality Commission ratings. Such results could suggest 2 things: Firstly staff are feeling a fear of detriment, that speaking up is a risky thing to do (q19a and 23e) and secondly the belief that speaking up is futile – that nothing will happen as a result (q19b and 23f).

At UHD, we know when we triangulate our data from our staff survey, all questions relating to raising concerns have deteriorated (questions 19a, 19b, 23e, 23f). It is question 23f however 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.

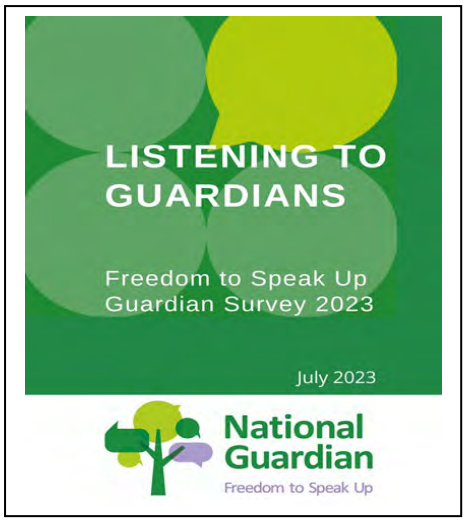


- UHD has a higher number of cases raised to them where staff feel detriment. At UHD this is 6% and needs urgent review to ensure that we are confident of what detriment for speaking up looks and feels like, that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment and that we are offering the right support if detriment is being felt. It is an area for focus in 2023 and also identified in our NHSI/E Board; A Guide for Leaders.
- The national averages for themes are similar in terms of behaviours and worker safety. A theme that continues to be prominent at UHD are cases involving policy and procedure whereas cases relating to patient safety remain lower than national average. This could suggest that

staff use the FTSU channel more for workplace and relational issues and issues relating to patient safety use other channels such as LERNs. This needs to be monitored to ensure that we are not at risk that staff are not reporting at all.

3.5.2 FTSUG Survey – July 2023

NGO – Freedom to Speak up Guardian Survey 2023 (July 2023)



This report – listening to FTSUG – outlines the experience of FTSUG and how speaking up arrangements are being implemented. The report highlighted warning signs where nearly two-thirds of respondents felt "nothing will be done" was a key barrier to workers speaking up. This is an 8% increased and now puts feelings of futility on a par with the fear of detriment as the main barrier to speaking up.

Dr Jayne Chidgey-Clark, National Guardian for the NHS reminds us that the responsibility of creating a positive speaking up culture falls on everyone, requiring each conversation and action to contribute to fostering an environment where speaking up is highly valued and heard. This is more than a FTSUG but about all of us making speaking up business as usual. The report also points out the impact on the wellbeing of FTSUG, who as a result are feeling that they are not always meeting the needs of the workforce due to more cases involving complex mental health issues and systemic barriers such as burnout, stress and anxiety. At UHD we have a strong network of support for our FTSU team including emotional support to allow them to do the work as best they can.

In light of the findings of this report the following recommendations for leaders include:

Table 2: Key findings of the Freedom to Speak up Guardian Survey (July 2023)	**RAG rated**	**UHD comments**
Mandate Speak up training for all workers, prioritising those responsible for responding to colleague concerns.		This is currently not mandated. E-learning is accessed on BEAT but update remains poor (refer to section 3.7)
Working with FTSUG, identify and initiate a plan to address barriers to speaking up particularly the perception of futility and fear of retaliation.		Triangulate work with HR, OH and Risk and Governance, education and Staff Networks.
Discussing the findings of this report with FTSUG and include an evaluation of resources, including protected time, provided to the role. This will be a focus for future regulatory and supervisory reviews,		Findings in this report discussed at 1:1 meeting with exec leads. Recent investment in time and resource.
FTSUG responding to workers speaking up must receive effective training to listen with curiosity, empathy and be conscious of barriers to speaking up and their impact on marginalised groups		Participate and complete NGO training including lunchtime lunch and learn, Supporting an Inclusive Speak Up Culture for Black and Minority Ethnic People (Nov 2022). Co-chair/chair Networks and member of Staff Networks. NGO mentor
Workers should have a variety of routes available for them to voice their concerns. Offering multiple		UHD has a rich number of avenues to speak up and messages triangulated.

avenues increases the likelihood of workers finding a suitable channel for them to speak up to.		
Ensure a fair and open recruitment processes for FTSUG posts and thereby address any systemic discrimination and discriminatory hiring practices.		Recent FTSUG deputy post had a diverse interview panel and networks encouraged to apply.
Annual Refresher training is now mandatory		Completed (July 2023)

3.5.3 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 hope to be addressed soon in a board development session.

3.6 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 3 below shows how staff at UHD use this service as compared to surrounding healthcare.

Table 3: 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	28	**57**
Dorset Healthcare	Medium	27	26	43	53	**149**
Salisbury	Small	31	31	42	30	**134**
Solent	Medium	7	24	25	22	**78**
University Hospitals Dorset	Medium	55	65	93	66	**279**
University Hospitals Southampton	Large	15	x	x	26	**41**

Table 3 does create some questions. Why do our staff use the FTSU route when raising concerns more than neighbouring trusts? An initial hypothesis was a product of significant staff changes in merger and re-organisational processes, resulting in staff being unaware of whom to escalate issues to. This hypothesis continues not to be the case and instead our data since April to end of August 2023 shows us;

- 40% of staff whom come to the FTSU team is because their line manager is the issue or that they are not addressing it.
- Eighteen per-cent staff reported that the reason they came to the FTSU team was because they felt insecure in raising concerns with line managers. This data is significantly higher from that collected during 2022/23 (12%) and needs urgent attention as a culture of speaking up needs a strong foundation of psychological safety.
- A continuing increasing trend is staff are using the FTSU route for advice prior to escalating themselves via the correct route. Thirty-eight percent (↑ 12% from 2022/23) of staff knew what they needed to do but wanted a confidential, impartial viewpoint to draft their thoughts.

These points all suggest that we need to continue to train our line managers to create working environments which are psychologically safe to speak up, and when staff do, that we listen and act.

3.7 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.

Over the last 12 months (June 22-June 23) there have been only 136 people who has accessed the training, approximately 2% of the Trust. This is disappointing. Focused communications campaign happened in spring 2023, it has been implemented into core induction programmes such as Trust induction, preceptorship, medical and international educated programmes and 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 and more recently it has been recommended in national guidance (see section 3.5.2). We also need to be mindful that following recent NGO Speak Up review with the Ambulance Trusts these packages were mandated for all staff.

3.8 Freedom to Speak Up Strategy at UHD

In January 2023, UHD board approved of our clear, robust and ambitious FTSU improvement strategy. The strategy was built on national and local drivers, based on a diagnosis of speaking up issues within UHD and known areas for improvement. A detailed workplan sits beneath this strategy and its progress continues to be updated.

3.9 NHS People Pulse

Listening and responding to our NHS people is as important as ever. The People Pulse is a national online pulse survey, developed for all provider and commissioner organisations, to support local listening and engagement activities. Results provide a regular and national, regional and local view of employee experience and wellbeing. The People Pulse runs at a monthly frequently until Qtr 3 when a larger and more detailed staff survey takes place. Data relating to “a voice that counts; raising concerns” occurs each year in September as part of the People Pulse and results will be presented at the next report.

3.10 Integrated Care Board (ICB) and Freedom to Speak Up guidance – June 2023

NHS England and the NGO published guidance in June for ICBs to ensure speaking up routes are available for their own staff and their primary care workers across the Integrated Care System (ICS). The guidance also outlines that they should consider how they will gain assurance that all NHS organisations across the ICS have accessible speaking up arrangements, in line with Freedom to Speak Up guidance and policy. ICBs will need to demonstrate a consideration of the different barriers that workers face when speaking up, as well as any actions that can be taken to reduce those barriers. This document will be discussed at our next Dorset and Somerset Network (see section 3.4.3).

3.11 NHSE Response to Lucy Letby Case

Following the recent trial and verdict of Lucy Letby, a catalogue of tragic failures have been uncovered including the importance that staff have avenues to speaking up but also when they do speak up they are listened to and actioned. NHSE wrote to all trusts the week the verdict was made and their initial thoughts and actions outlined for us. Those relating to speaking up have been assessed by the team. FTSU is one avenue to speaking up and needs careful consideration and as leaders we must demonstrate that we welcome and encourage speaking up, through

actions, not just words. That means listening to understand and challenging our own biases; remaining impartial and investigating the matter raised, not the person raising it.

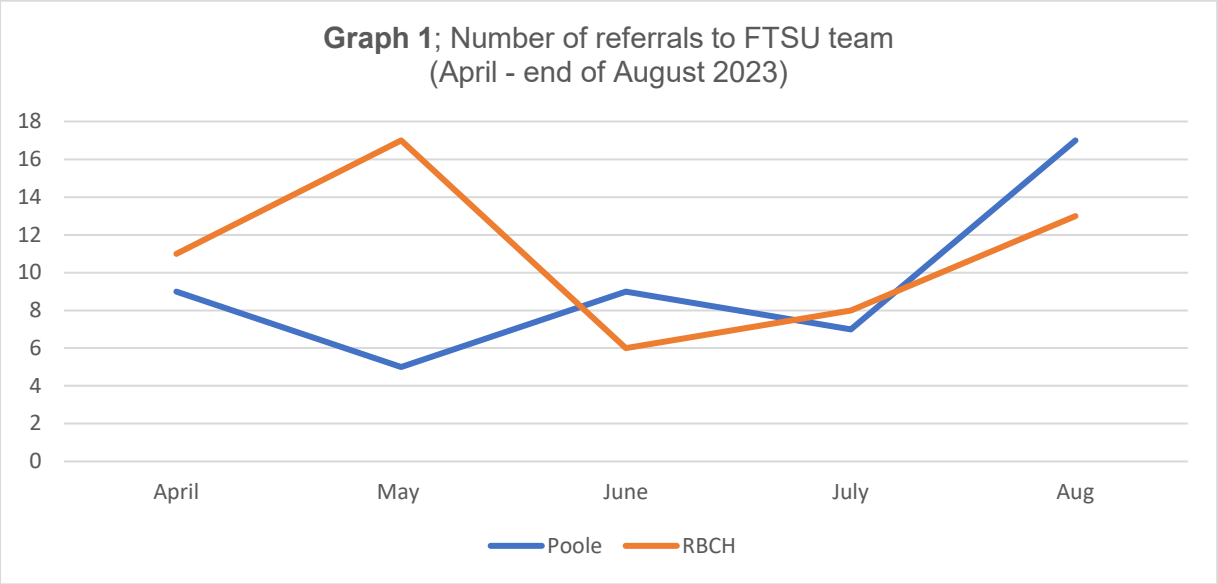
Speaking up Action	**Comment**
Freedom to Speak Up (FTSU) policy. All organisations providing NHS services are expected to adopt the updated national policy by January 2024 at the latest.	Completed May 2023
NHS leaders need to listen to the concerns of patients, families and staff, and following whistleblowing procedures, alongside good governance, particularly at trust level.	Need to Improve Listen up/follow up module completion Management and leadership training in place with speaking up elements. But data from April 2023; • 40% of staff whom come to the FTSU team is because their line manager is the issue or that they are not addressing it. • 18% staff reported that the reason they came to the FTSU team was because they felt insecure in raising concerns with line managers. This data is significantly higher from that collected during 2022/23 (12%) and needs urgent attention as a culture of speaking up needs a strong foundation of psychological safety.
All staff have easy access to information on how to speak up	FTSU established since 2017. Nearly 300 staff used this route last year to escalate concerns. Year on year increases. FTSU is only one route for speaking up. Never complacent and always reviewing. #breakingboundardies annual FTSU month
Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.	FTSUG - Yes. Recent attendance at NGO/NHSE update
Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.	FTSU data since April 2023 to end August 2023 – Of the 102 staff whom raised a FTSU concern, 26% of staff (27 staff) are from an ethnic minority. Strong presence with Networks and EDI group. #breakingboundaries FTSU month
Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.	FTSU evaluations. 100% would speak up again

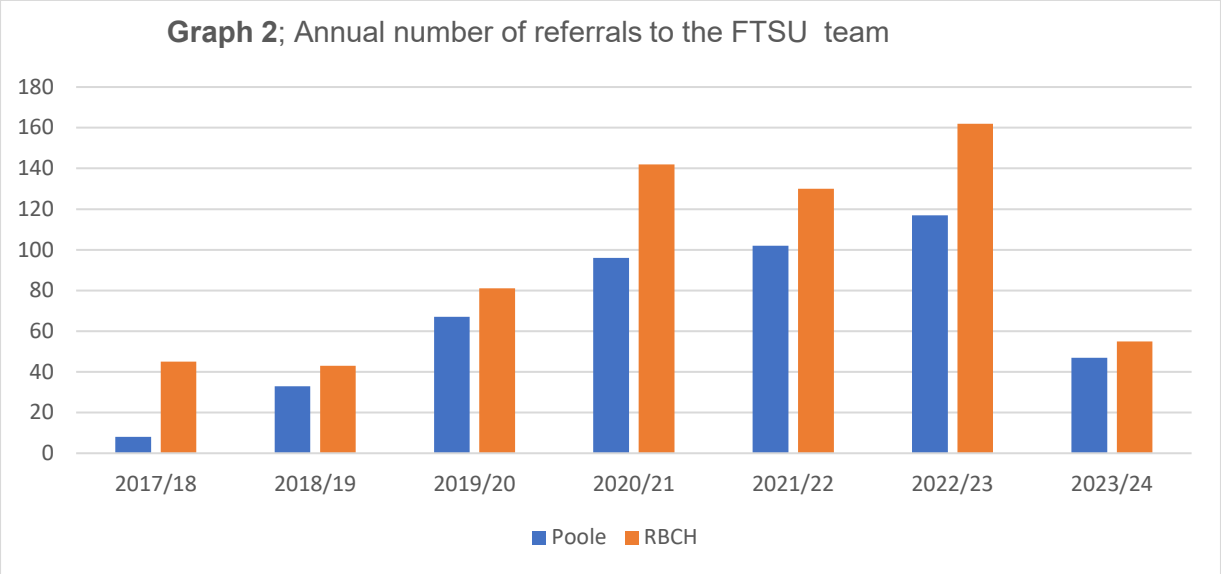
Boards are regularly reporting, reviewing and acting upon available data.	Bi- annual speak up at board and other governance meetings Board needs to complete Board reflection from NHSE. Planning development session.

4.0 Case Referrals – the Headlines since April 2023 (end August 2023)

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 1 highlights the number of referrals received on a monthly basis to the FTSU team since April 2023 to end of August. Forty-seven referrals came from Poole site and fifty-five from Bournemouth and Christchurch (46:54% respectively). It is anticipated that if the number of referrals continue at this rate, the activity for 2023/4 will be that similar to the previous 12months (Graph 2).

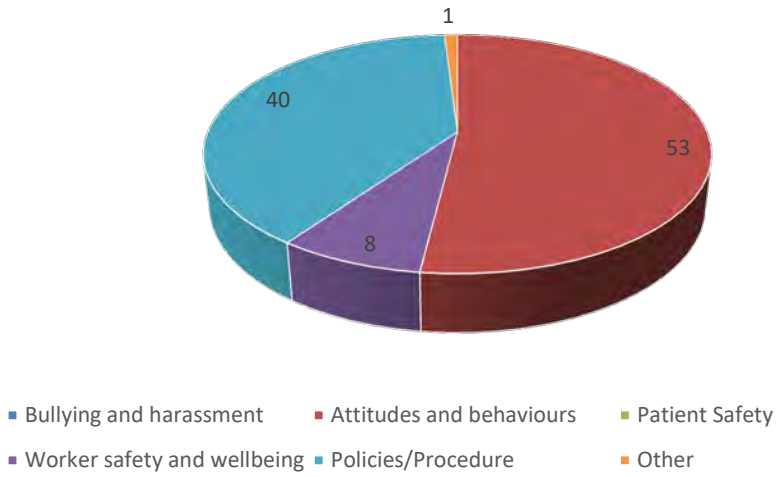




4.1 Key Themes of concerns

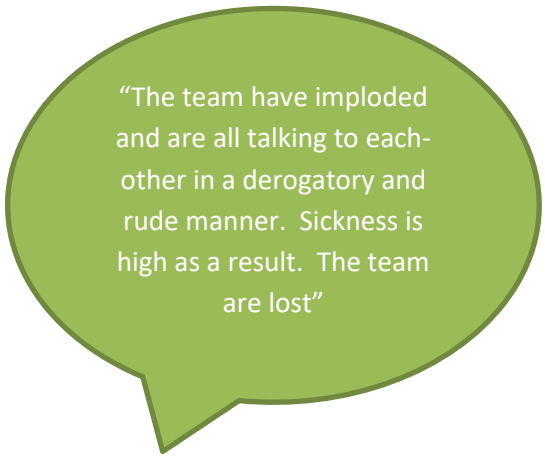
Staff approach the FTSU team for a number of reasons. Graph 3 illustrates the greatest theme had an element of behaviours (53 staff; 52%). This is followed by process and procedures (40 staff; 39%) and then worker safety and wellbeing (8 staff; 8%). Speaking up via the FTSU team continues to be used predominantly for concerns relating to our working environment or relationships rather than patient safety issues and may be a product of our strong LERN culture in capturing our patient safety issues. This needs monitoring and assurance that issues or concerns are not being lost or not reported.

Graph 3; FTSU Themes (April - End August 2023)



4.1.1 Behaviours and Attitudes (incivility)

Attitudes and behaviours are a recurring theme that the FTSU team hear. Staff report a range of behaviours including disrespectful attitudes, lack of compassion, gossiping, micro-aggressions, micromanagement, aggressive communication styles, rudeness and unprofessional behaviour. Sometimes this behaviour is well known within a team, and deeply intractable but never addressed, or addressed but not resulting in a change. Whatever the behaviour, the impact is always far reaching and long-lasting. It often results in staff sickness and always makes the member of staff feel frustrated and under-valued. At UHD, we promote civility and have information available for staff to refer to including ways to calling it out, mediation and formal policies. Despite this, it frequently places the pressure on the member receiving the behaviour to address the behaviour which in many cases requires them to speak truth to power. Having a clearer infrastructure and programme of work to address this issue is the most important piece of work for UHD. We hear that staff choose not to speak up as it is futile and creates little change or action (refer to section 3.5.1) and this issue is one of the clearest frustrations heard year on year through the FTSU team at UHD. The way an organisation handles issues like these says a lot about the culture and if UHD



wants to be an organisation that values staff, makes speaking up worthwhile, and a working environment which is psychologically safe, we need to do this better.

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. Part of this is due to issues relating to process or procedure. (NHSE, 2022). Thirty-nine per cent of referrals at UHD 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.

Table 4: Process and Procedure (April- end Aug 2023)	Poole	RBCH	UHD TOTAL
Organisation Change	3	0	**3**
Guideline/pathway (clinical)	0	0	**0**
HR related issues (regrading, re-deployment, HR policy)	8	12	**20**
Recruitment and selection	3	0	**3**
Parking	1	0	**1**
Education/training	1	0	**1**
Non-clinical guideline/pathway	6	6	**12**
Health and Safety	0	0	**0**
TOTAL	**22**	**18**	**40**

Fifty per cent of referrals with an element of policy and procedure, 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. Nationally, this is also seen, and it has been postulated whether a clarity of HR policies and processes may help to reduce the volume of HR issues being raised with Freedom to Speak Up team.

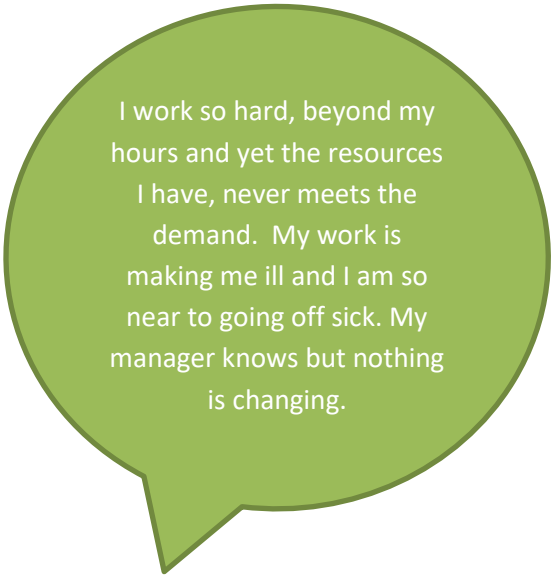
Other issues relating to process and procedure often arise from a conversation or miscommunication. Data since April to end of August 2023 shows that when asking staff as to why they are choosing to raise concerns to the FTSU team rather than their line manager, 40% stated that their line manager was the issue of the concern or knew about the issue but not addressing it. A further 18% 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.

4.1.3 Worker safety and wellbeing

In response to concerns being raised during the pandemic, the NGO introduced worker safety and wellbeing as a new reporting category. This theme relates to cases with a risk on worker safety or wellbeing and can include issues such as lone working arrangements, insufficient access to equipment and stress at work. At UHD, eight per cent who accessed the FTSU team described this theme and predominantly as a result of excessive workload. This mirrors the national trend (refer to section 3.5.1) which tells us that staffing levels and increased workloads as the two most common reasons. It is well documented that there are considerable system pressures across the healthcare sector alongside the cost-of-living crisis; both having an impact on worker wellbeing.



4.2 Outcome of referrals

Table 5 illustrates the outcome of referrals once they were made to the FTSU team. Of those referrals, 40% of cases were escalated to the line manager to investigate and action. In 41% 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.

Table 5: Outcome of referrals received by FTSU team

April- end August, 2023		Poole	RBCH	Total UHD
Line manager		19	22	**41**
FTSU advice		8	9	**17**
Escalate to Chief/Director		1	1	**2**
Signpost	HR	8	11	**19**
	OH	0	1	**1**
	Other	11	11	**22**
TOTAL		**47**	**55**	**102**

Following the Lucy Letby case there were a number of questions raised about how concerns were not listening to or that appropriate and timely action was not taken when concerns were raised. All 57 cases raised to the FTSU team in quarter 1 were all closed with no outstanding action.

4.3 Who are raising concerns?

Table 6: Staff who are raising concerns to the FTSU team

April – End August 2023	Poole	RBCH	Total UHD	No of staff (as of May 23)
Additional Clinical services*	6	5	11	2129
Additional Professional#	0	0	0	350
Admin and clerical	7	17	24	2147
AHP	6	1	7	809
Estates and Ancillary	1	3	4	710
Healthcare scientists	0	2	2	189
Medical and Dental	3	9	12	1519
Nursing/Midwife	19	12	31	3044
Students	2	1	3	101
Other	1	0	1	
Anon	2	5	7	
TOTAL	**47**	**55**	**102**	**10 998**
BAME	10	17	27	

*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 nurses and midwives accounted for the biggest portion (30%) of speaking up cases raised with FTSU team, followed by our administrative staff (24%) and medical workforce (12%; ↑4% from data 2022/23). The increase in number of referrals from our doctor workforce is likely to be as a result of the special attention made to engage with our medical workforce through our increased presence at junior doctor meetings, jointly presenting with our GMC team, presenting at our core induction and working with Acting Chief Medical Officer, Guardian of working times and lead Medical Educator.

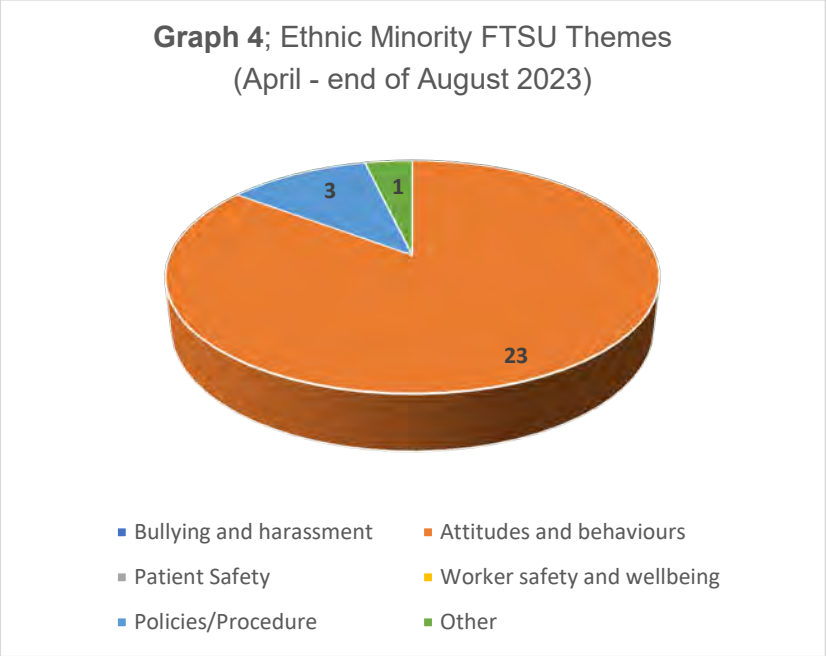
Seven staff felt necessary to remain anonymous, of which 5 are from staff based at RBCH site. This figure remains lower than the national figure of 9.3% (NGO annual report, 2023; refer to section 3.5.1).

The Francis Freedom to Speak Up review recognised back in 2015, that 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. Since then, the NGO has carried out a number of case reviews at different Trusts across the country which has repeatedly validated this observation and therefore encourages every Trust and FTUSG to ensure that work reaches this group of staff and that their voice is also being heard.

Of the 102 staff whom raised a FTSU concern, 26% (27 staff) were from an ethnic minority background. Our most recent data using WRES mapping template, shows the percentage of overall workforce at UHD which is ethnic minority is now 21.5% (March 2023). Using the same

calculation for the Bournemouth, Poole and Christchurch area the percentage of ethnic minority staff is 8.67%. This data suggests that our staff are highly represented from ethnic minority groups at UHD and that FTSU is making good progress to reaching and hearing the issues from this staff group.

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 4 show the predominant theme from our ethnic minority staff is attitudes and behaviours (23 staff; 85%). Concerns with elements of process and procedure then followed (3 staff; 11%).

"I have never experienced such unprofessional and rude behaviour as an International Medical Dr. It was undignified and made me feel isolated and not want to work at UHD".

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 allows 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

April – End August 2023					23f
Care Group	**Directorate**	**PHT**	**RBCH**	**Total**	
Medical (32)	Emergency and Urgent	1	1	**2**	37.9%
	Acute and Ambulatory Medicine	2	2	**4**	47.4%
	Cardiology and Renal	1	0	**1**	43.2%
	Medical specialities	5	6	**11**	46.6%
	Older Persons and Neurosciences	6	8	**14**	48.1%
Surgical (10)	Surgery	0	2	**2**	37.9%

	Anaesthetics	4	1	**5**	39.3%
	Head and Neck	1	1	**2**	44.1%
	Trauma and Orthopaedics	0	1	**1**	50%
	Private	0	0	**0**	
WCCSS (27)	Cancer Care	1	1	**2**	53.3%
	Child Health	2	0	**2**	50.4%
	Women's Health	6	2	**8**	51%
	Radiology and Pharmacy	4	3	**7**	43.9%
	Clinical Support	3	1	**4**	50.1%
	Pathology	0	4	**4**	39.6%
Operations (5)	Clinical Site	0	0	0	43.2%
	Facilities	2	3	**5**	45.5.%
	Partnership, integration and discharge	0	0	0	
	Emergency Planning	0	0	0	
	Operational Performance	0	0	0	50%
Corporate (21)		7	14	**21**	
Anon (7)		2	5	**7**	
TOTAL		**47**	**55**	**102**	

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 concern are those staff whom are not using the FTSU route and have low confidence in raising concerns such as emergency, cardiology, surgery and anaesthetics. 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:

- An urgent call for action to develop an invested and accountable civil and respectful cultural programme– looking at a clearer message, its infrastructure and tools to help staff and managers address poor behaviour.
- Merger is starting to feel real. Frustrations are being cited as final decisions to where/when moves are happening are often late, making practical life arrangements more difficult and stressful.
- Differences between Bournemouth and Poole sites; differences in work, policy and structure. This makes it difficult to feel #TeamUHD.
- Long and painful organisational restructures resulting in prolonged periods of stress for staff. Do we invest time at the beginning of any re-structure or organisational change to explain the process and ensure staff wellbeing is in the forefront of minds? Do we share the learning from each department or make the same mistakes?
- Not belonging at our workplace –our overseas workforce feel that their work place is not interested in them as people with little time invested in getting to know them, their skills and journey. This makes forming safe relationships, navigating the work, the NHS way and British culture really difficult. Strong feelings of being mis-understood and judged.

- Struggles with cost of living and financial challenges. Moving to cashless systems and cost of food at hospital is making this more difficult.
- Being proud of our working environment and yet we have overflowing cigarette butts and litter.
- Do we have robust processes in place to prevent staff feeling at detriment when speaking up and in those circumstances when a worker feels they have suffered detriment do we address this and offer the right support?
- The number of cases which have an element of patient safety is lower at UHD than the national average. Are we confident that we are capturing patient safety concerns or are staff not reporting?
- We hear staff say that they cannot go to their line manager as either they are the issue, or they are not addressing the issue; we need to 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. There is a national steer to mandate these (speak up module).
- More staff are telling us that they use alternative channels to speak up as they are insecure of raising issues with their line managers. We need to upskill our leaders on how to create psychological safe working environments to speaking up.
- More clinical staff are engaged in raising concerns through the FTSU channel.
- Contribute, embrace and be involved in our Patient first programme. Patient First will help us all by improving the way we work. Speaking up is integral to this work and we look forward to supporting this moving forward.

6.0 Summary and Next Steps

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. It is both futile and results in fear.

At UHD, it is everyone's business to encourage speaking up and to do this we need leaders to create psychologically safe working environments where every voice is heard, celebrated and action occurs.

We are #TeamUHD and collectively we need to Speak Up, Listen Up and Follow Up so to continually improve our culture of safety.

Appendix 1

UHD Board of Directors' Statement of Commitment to the principles of the Freedom to Speak up

Sir Robert Francis set out his vision for creating an open and honest reporting culture in the NHS in his 2015 publication Freedom to Speak Up. The Board of Directors is committed to fostering a culture of safety and learning in which all staff feel safe to raise a concern across the Trust.

Speaking up is essential in any sector where safety is an issue. Speaking up should be something that everyone does and is encouraged to do. There needs to be a shared belief at all levels of the organisation that raising concerns is a positive, not a troublesome activity, and a shared commitment to support and encourage all those who raise honestly held concerns about safety. Without a shared culture of openness and honesty in which the raising of concerns is welcomed, and the staff who raise them are valued, the barriers to speaking up will persist.

The Board supports the key principles of speaking up and is committed to leading the actions required to implement them. The Board will receive support from the Freedom to Speak up Guardian (FTSUG) who is sponsored by the Chief Executive.

The key principles the Board is committed to include:

	Principle	Action
1	Culture of safety	Every organisation involved in providing NHS healthcare, should actively foster a culture of safety and learning, in which all staff feel safe to raise concerns.
2	Culture of raising concerns	Raising concerns should be part of the normal routine business of any well led NHS organisation.
3	Culture free from bullying	Freedom to speak up about concerns depends on staff being able to work in a culture which is free from bullying and other oppressive behaviours.
4	Culture of visible leadership	All employers of NHS staff should demonstrate, through visible leadership at all levels in the organisation, that they welcome and encourage the raising of concerns by staff.
5	Culture of valuing staff	Employers should show that they value staff who raise concerns, and celebrate the benefits for patients and the public from the improvements made in response to the issues identified.
6	Culture of reflective practice	There should be opportunities for all staff to engage in regular reflection of concerns in their work.
7	Raising and reporting concerns	All NHS organisations should have structures to facilitate both informal and formal raising and resolution of concerns.
8	Investigations	When a formal concern has been raised, there should be prompt, swift, proportionate, fair and blame-free investigations to establish the facts.
9	Mediation and dispute resolution	Consideration should be given at an early stage to the use of expert interventions to resolve conflicts, rebuild trust or support staff who have raised concerns.

10	Training	Every member of staff should receive training in their organisation's approach to raising concerns and in receiving and acting on them.
11	Support	All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and without formality.
12	Support to find alternative employment in the NHS	Where a NHS worker who has raised a concern cannot, as a result, continue in their current employment, the NHS should fulfil its moral obligation to offer support.
13	Transparency	All NHS organisations should be transparent in the way they exercise their responsibilities in relation to the raising of concerns, including the use of settlement agreements.
14	Accountability	Everyone should expect to be held accountable for adopting fair, honest and open behaviours and practices when raising or receiving and handling concerns.
15	External Review	There should be an Independent National Officer (INO) resourced jointly by national systems regulators and oversight bodies and authorised by them to carry out the functions described in this report
16	Coordinated Regulatory Action	There should be coordinated action by national systems and professional regulators to enhance the protection of NHS workers making protected disclosures and of the public interest in the proper handling of concerns
17	Recognition of organisations	CQC should recognise NHS organisations which show they have adopted and apply good practice in the support and protection of workers who raise concerns.
18	Students and Trainees	All principles in this report should be applied with necessary adaptations to education and training settings for students and trainees working towards a career in healthcare.
19	Primary Care	All principles in this report should apply with necessary adaptations in primary care.
20	Legal protection	Should be enhanced to those who make protected disclosures.

Speaking up ANNUAL DECLARATION

This declaration is to be signed annually alongside our statement of commitment to the Sir Robert Francis recommendations

Declaration

Please tick the statements below to confirm that you remain.

☐ I recognise that I have a responsibility for creating a safe culture and an environment which workers are able to highlight problems and make suggestions for improvement.

☐ I understand the importance of workers feeling able to speak up and the trusts vision to achieve this

☐ I recognise the impact of my own behaviour on the trust's culture. I will therefore reflect on my own behaviour regularly so that it does not inhibit someone speaking up*.

☐ I have insight into how my power could silence truth

☐ I will welcome approaches from workers and thank them for speaking up. I will ensure that I will provide feedback

☐ I will speak up, listen and constructively challenge one another during board meetings

☐ I will seek feedback from peers and workers and reflect on how effectively they demonstrate the trust's values and behaviours

☐ I will accept challenging feedback constructively, publicly acknowledge mistakes and make improvements.

☐ I will be open and transparent and see speaking up as an opportunity to learn.

*It is good practice to test your behaviour with direct and incidental feedback from staff surveys, pulse surveys, social media comments, reverse mentoring, 360 feedback and appraisals.

Signed: _____ Date: _____

Name in block letters: _____

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 27 September 2023

Agenda item: 7.2

Subject:	Workforce Race Equality Standards and Action Plan 2023 / 2024
Prepared by:	Jon Harding, Head of Organisational Development
Presented by:	Karen Allman, Chief People Officer Deb Matthews, Director of Organisational Development

Strategic themes that this item supports/impacts:	Systems working and partnership ☐ Our people ☒ Patient experience ☐ Quality: outcomes and safety ☐ Sustainable services ☐ Patient First programme ☐ One Team: patient ready for reconfiguration ☐
BAF/Corporate Risk Register: (if applicable)	BAF 3 and BAF 8
Purpose of paper:	Assurance
Executive Summary:	The NHS Workforce Race Equality Standard (WRES) was introduced in 2016 to address the inequalities and less positive lived experience of our ethnically diverse workforce. This is the seventh year of reporting on the WRES and the third year for University Hospitals Dorset (UHD). • The overall workforce sample has increased to over 9700. • The number of ethnically diverse staff has increased to 2089 (21.5% of the total workforce). • Ethnicity declarations remain high and above 97%. • The white ethnicity staff group (WME) has decreased slightly to 692 (7.2%). • The relative likelihood of ethnic diverse staff being appointed from shortlisting across all posts has improved to 1:1.90. This means for every member of staff from an ethnic background approximately 2 members of white candidates are appointed. • The relative likelihood of staff accessing non-mandatory training and Continuing Professional Development has improved to 0.9. • The bullying and harassment metrics show some worsening and stagnation.

	• Indicator 7 shows a significant drop in staff believing the trust provides equal opportunities for both ethnic diverse and white staff. This is in line with the trend nationally of a decrease in positive results for this metric. • The Board membership continues to show an under-representation at the most senior level. To note: for WRES 2024, a second non-executive director was appointed from a Black and Minority Ethnic (BME) background (1 April 2023). • Our workforce from an ethnic background continue to report fewer positive experiences in our staff survey and this is also reflected in data from our Freedom to Speak Up Guardian (Appendix C). • Our disparity ratios (Appendix D) show a continuing trend of inequity in progression for our ethnically diverse staff from the lower to upper bandings in both clinical and non-clinical roles. (The data doesn't take account of targeted workforce solutions and recruitment)
Background:	It is evident from successive reports that there has been improvement, however this has not been at pace or consistent with the changing demographic of our workforce. This year's reporting also includes the disparity data, which shows how our staff are represented in progression. Interventions to ensure improvement in our WRES indicators are embedded within our Equality Diversity and Inclusion (EDI) workplan priorities for UHD. Our Equality, Diversity and Inclusion group (EDIG) is chaired by Pete Papworth (Chief Finance Officer). The group includes representatives from across the organisation, including staff network leads, Governors and patient representatives. This report was presented at the People and Culture Committee (9 August 2023) and EDIG (10 August 2023). Its purpose is to provide the governance and assurance to the Trust Board on compliance with statutes and national standards and makes recommendations on specific interventions.
Key Recommendations:	• Publish this report externally from 01 October 2023. • Update the EDI Priority Action Plan and report progress at the Equality, Diversity and Inclusion group. Review actions and progress aligned to the NHS EDI Improvement Plan. • Include named Executive Sponsors and Operational Leads with accountability in the action plan working documents and increase participation from Care Groups.

	• Embed a culture of Anti-Racism through the Board statement, plan and See ME First. • Continue to integrate EDI into all leader, manager and personal development training including Patient First. • Work with our Dorset Integrated Care System partners to ensure this report and actions are integrated into all workstreams and share good practice across our systems.
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
People and Culture Committee	09/08/2023	Noted.
Equality Diversity and Inclusion Group	10/08/2023	Approved.

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

University Hospitals Dorset
NHS Foundation Trust

NHS Workforce Race Equality Standard (WRES)

Annual Report and Action Plan 2023/24

University Hospitals Dorset NHS Foundation Trust

We are caring one team listening to understand open and honest always improving inclusive

Contents

Some useful abbreviations:

- BAME - Black, Asian and Minority Ethnic
- BME - Black Minority Ethnic
- EDI - Equality Diversity and inclusion
- EDIG - Equality Diversity and Inclusion Group
- FTSU: Freedom to Speak Up (Guardian)
- HR: Human Resources
- OD: Organisational Development
- PCC: People and Culture Committee
- WRES - Workforce Race Equality Standards
- WDES - Workforce Disability Equality Standards
- ICS – Integrated Care System
- IEN – Internationally Educated Nurse

UHD anti-racism statement

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

27 July 2023

1 Introduction

The NHS Workforce Race Equality Standard (WRES) was introduced in 2016 to address the inequalities and less positive lived experience of our ethnically diverse workforce. This is the seventh year of reporting on the WRES and the third year for University Hospitals Dorset (UHD).

It is evident from the national, regional and local data that that there has been improvement, however this has not been at pace or consistent across the NHS systems. This year's reporting also includes the disparity data, which shows how our staff are represented in progression through the seniority ranks.

NHS England have introduced a new 'NHS equality, diversity, and inclusion improvement plan' that sets out six high impact actions targeted to address prejudice and discrimination that exists through behaviour, policies, practices and cultures against certain groups and individuals.

Co-produced through engagement with staff networks and senior leaders from across the NHS. The plan sets out the case for change and explains the actions required to make the changes that NHS staff and patients expect and deserve, and who is accountable and responsible for their delivery. It describes how NHS England will support implementation and provides a framework for integrated care boards to produce their own local plans. (Link)

This is in line with the NHS Race and Health Observatory report, The Power of Language. As a result of a consultation process in 2021 they have developed five key principles when writing and talking about race and ethnicity:

- Be Specific
- No acronyms or initialisms
- Context
- Transparency
- Adaptability

At the equality, diversity and inclusion group meeting on the 20 January 2022 it was agreed to adopt these principles in our reporting.

Throughout this report, we have used the phrases ethnically diverse or ethnic background when referring to our Black, Asian and Minority Ethnic staff. The data label of BAME is used to reflect all ethnic minority categories and only in the context of data. The use of the word minority reinforces the disparities and we have reduced its use to within the data labels only.

Additionally, the term BME, Black and Minority Ethnic is often used in reporting templates with NHS England, the interchangeability of these terms is not undertaken to cause offence. It should be recognised that people sit behind the data and we are aware that staff experience varies in our organisation.

2 Executive summary

University Hospitals Dorset NHS Foundation Trust aspires to embed an inclusive culture where diversity is valued and championed at all levels of the organisation. Through our Trust objectives, values and the EDI Strategy we aim to promote and deliver equality of opportunity, dignity and respect for all our patients, service users, their families' carers and our people. We aim to eliminate discrimination and harassment and reduce health inequalities. Our National NHS Staff Survey and workforce data reflects the lived experience of our staff and across the NHS demonstrating that we have more to do.

Research shows that organisations with diverse leadership are more successful and innovative. People who feel valued are more likely to be engaged with their work, and diversity at senior levels increases productivity and efficiency in the workplace. When the opportunity arises our board representation will reflect the local demographic of our staff and community as we have a commitment for our board to be representative and matched to our staff ethnicity.

The Messenger Review into Leadership in Health and Social Care by NHS Confederation in June 2022 reinforced the EDI vision for all NHS organisations: -

"EDI embedded and mainstreamed as the responsibility of all regardless of role and especially leaders and managers from front line to board. This must include the practice of zero tolerance of discrimination, but also greater awareness of the realities in the workplace for those with protected characteristics."

UHD has over 9700 staff serving a population base of 400,300 and in 2011, 84.8% were White British that has now reduced to 82.4% White British [*Census: 2021 ONS*]. We will continue to monitor our data alongside the lived experiences of all our staff. It is worth noting that using the WRES Mapping tool and local data obtained from Bournemouth, Poole and Christchurch Council that 8.67% of the local population identified at BME.

We continue our commitment to understanding staff experience and to engage with staff in a way which respects and advances our commitment to the trust Value of 'Listening to understand'. There is a valuable richness in the lived experience of members of staff across our hospitals and bringing human stories to the fore and sharing these to the benefit of others remains an important dimension of EDI work.

Our staff network groups have been instrumental in providing increased feedback to inform the Trust of the need for change to reduce potential organisational barriers. They are more mature in their development and progress compared to

many others in the region; evidenced by invitations to speak with other trusts and the recognition at a national level.

See ME First, is a staff-led initiative aimed at supporting and educating staff towards ending discrimination in the workplace. Through, See ME First staff will be individually asked to pledge to **challenge** discrimination when we see it and **support** any staff that experience discrimination by **listening** and encouraging them to **speak up** through the appropriate channels.

By calling out racist behaviour or contextually adopting **'anti-racism'** and educating ourselves we will be working towards improving staff experience for all our staff.

To be a Model employer, UHD needs to be inclusive - embodying a diverse workforce at all levels and bringing the wealth of experience and perspective for delivering the best outcomes for the community we serve. We aim to make real change to the culture of our organisation by creating a more inclusive, open and non-judgemental work environment in which all staff are treated with dignity and respect.

3.0 Equality Diversity and Inclusion [EDI] Strategy & Group

Our equality, diversity and inclusion group (EDIG) is chaired by Pete Papworth (chief finance officer) The group includes representatives from across the organisation, including staff network leads, Governors and patient representatives.

Its purpose is to provide the governance and assurance to the People and Culture Committee and Trust Board on compliance with statutes and national standards and makes recommendations on specific interventions.

Membership comprises multi-disciplinary staff occupations and patient representative/s, external key stakeholders and partners are invited to join group meetings.

Our Strategy for equality, diversity and inclusion is published on our external website. It contains our strategic objectives with measurable outcomes and goals, aligned to our organisational vision, mission and values.

4.0 Voice of our Networks - BAME Network

BAME Network Chair: Judith Dube and Monica Chigborogu

Executive Sponsors: Peter Gill, Chief Informatics and IT Officer, Paula Shobbrook, Chief Nursing Officer

Our BAME staff network has gone from strength to strength over the last year and continues to provide pastoral and peer support to colleagues across the whole organisation. We have a network aim of tackling concerns with the aim to improve the work experience for all. Our network values, alongside the Trust values, are UNITED:

Unity
Nurture
Inclusive
Teamwork
Empower
Diversity

The BAME network has become increasingly more strategic in its approach to Trust issues and holds monthly network meetings that continue to listen and act on the experiences of staff. As a result of the WRES in 2022 and the reported lived experiences of staff, the BAME network has raised the need for an organisational increase in focus on anti-racism.

The network worked alongside the EDI Leads to develop an Anti-Racism strategic plan. This was inspired by a visit from Yvonne Coghill, Director of Workforce Race Equality at NHSI leading a discussion on some of the challenges and opportunities for improvement.

The network was instrumental in supporting the Cultural Day in July 2023 and have initiated engagement conversations in relation to the adoption of See Me First.

Personal Objectives for all staff and managers will include an EDI objective and this is supported at the most senior level of the organisation. The network also supports grievances cases and signposting to other services.

Other work we have undertaken includes:

- Supporting our Internationally Educated Nurses, with pastoral support, welcome introductions and ongoing peer support and guidance. This work has been recognised in the NHS Employers International Recruitment toolkit as best practice, working in partnership with recruitment and education teams.
- Providing expert advice for the development of Beyond Difference and Reverse Mentoring programmes, actively promoting and using coaching conversations to support applicants to access these programmes and self- development opportunities.
- Peer support for colleagues from all Staff Networks

- Expert review of documents and strategies from the Race and Health Observatory and recommendations on language and terminology used when referring to ethnically diverse staff.
- UHD representation on South West Expert Reference Group for Nursing/Midwifery staff from an ethnic background. This group is to inform and advise the regional NHSE/I team of what priorities should be focused on to make a difference.
- Providing information to national teams and linking to webinars, workshops and online forums

There is a strong correlation reported by NHS England that staff networks are instrumental to the improvement of patient care. As a network we are proud of the rich diversity and wealth of experience the staff we represent bring to UHD.

See Me First...

Don't let assumptions budge
Look beyond the surface, before you judge
I am more than what you see
A complex soul, just like thee

My flaws and quirks make me whole
A unique being, with a story to unfold
Don't let my appearance deceive
Or the labels you may perceive

I am more than just a name
A person with feelings, not a game
See me first, with an open heart
Let our differences set us apart

In our diversity, we can learn
And in acceptance, we can truly earn
A world where we all can thrive
Appreciating the beauty in our differences, before it's too late.

See Me First ...

A poem by Zainab Sobanke -UHD ITU staff

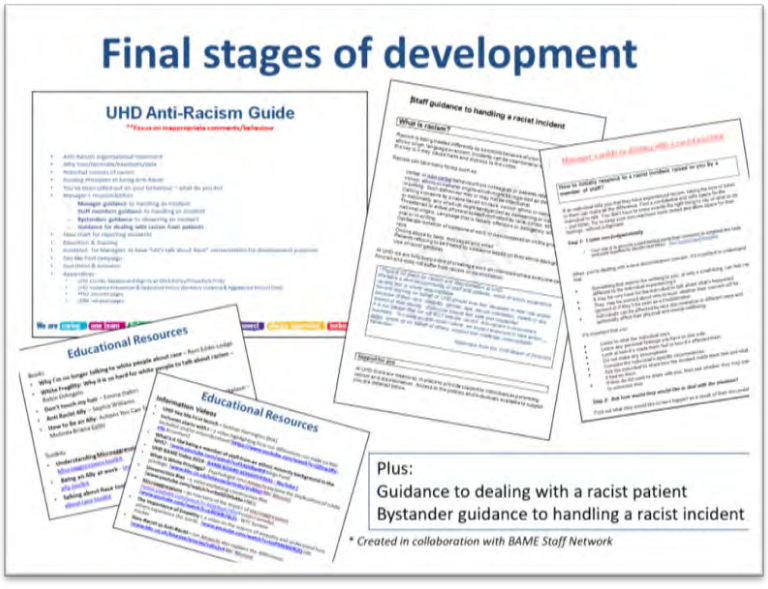
5.0 Anti-Racism Campaign

UHD Anti-Racism and See ME First

The Anti-Racism Plan was discussed at Executive Board on 23rd August 2023, the plan will introduce a Trust Board Anti-Racism statement (page 3) as the catalyst to a multi-layered and staged campaign that is envisaged will drive a culture of speaking up and challenging inappropriate behaviour notably, racism. Without challenge, racism can sit quietly behind structures, damaging everyone affected including the negative impact on our patient care. See ME First was launched in June 2023.

The target operating model is aimed at building momentum and taking everyone with us on the journey.

The guidance and workshops are in the final stages of development.



See ME First

What is See ME First?

See ME First is a staff-led initiative to promote equality, diversity and inclusivity. It requires colleagues to challenge and work together towards ending racism and discrimination in the workplace.

The aim is to make real change to our culture, creating a more inclusive, open, and non-judgemental work environment in which all staff are treated with dignity and respect.

Will you pledge to support any colleagues that experience discrimination? Fill out this form and pledge to encourage colleagues to speak up and safely challenge discriminatory behaviour through the appropriate channels. You will receive a See Me First badge to signify you have made this commitment and ensure your support is visible to colleagues.

Why is it important?

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

Why wear a See ME First badge?

- You are making a visible commitment to actively create an open, non-judgemental and inclusive culture at UHD by ensuring your BAME colleagues are treated with dignity and respect
- You are signifying that you uphold UHD's values of being inclusive, caring, one team, listening to understand, open and honest, and always improving.
- You are signifying that colleagues can come to you for support and advice on how to safely challenge discriminatory behaviour.

What can you do to make a positive difference?

Make yourself visible as a member of staff who will **listen** to colleagues who have been subjected to discrimination or need advice and information.

Encourage your colleagues to **speak up** safely through the appropriate channels if they have experienced discrimination. Direct them to the pink LERN form, Freedom To Speak Up, their line manager or UHD's equality, diversity and inclusion lead (**deepa.pappu@uhd.nhs.uk**).

Listen **Speak up** **Support** **Challenge**

Signpost colleagues to the **support** available to them (BAME network, Human Resources and Trade Union representatives) as well as wellbeing support including Psychological Support and Counselling service, Mental Health First Aiders and Trauma Risk Management.

Be a visible and active ally; if you see racism, **challenge** it.

Make your pledge here:

NHS

See ME First

6.0 Conclusion and Next Steps

- The overall workforce sample has increased to over 9700
- The number of ethnically diverse staff has increased to 2089, 21.5% of the total workforce.
- Ethnicity declarations remain high and above 97%
- The white ethnicity staff group (WME) has decreased slightly to 692, 7.2%
- The relative likelihood of ethnic diverse staff being appointed from shortlisting across all posts has improved to 1:1.90 This means for every member of staff from an ethnic background approximately 2 members of white candidates are appointed.
- The relative likelihood of staff accessing non-mandatory training and CPD has improved to 0.9
- The bullying and harassment metrics show some worsening and stagnation.
- Indicator 7 shows a significant drop in staff believing the trust provides equal opportunities for both ethnic diverse and white staff. This is in line with the trend nationally of a decrease in positive results for this metric.
- The Board membership shows a very small improvement in representation of the overall workforce, but still being a large under-representation at the most senior level. To note for 2024, two non-executive directors were appointed from BME backgrounds 1 April 2023.
- Our workforce from an ethnic background continue to report fewer positive experiences in our staff survey and this is also reflected in data from our Freedom to Speak Up Guardian (appendix C).
- Our disparity ratios (appendix D) show a continuing trend of inequity in progression for our ethnically diverse staff from the lower to upper bandings in both clinical and non-clinical roles. (The data doesn't take account of targeted workforce solutions and recruitment.).

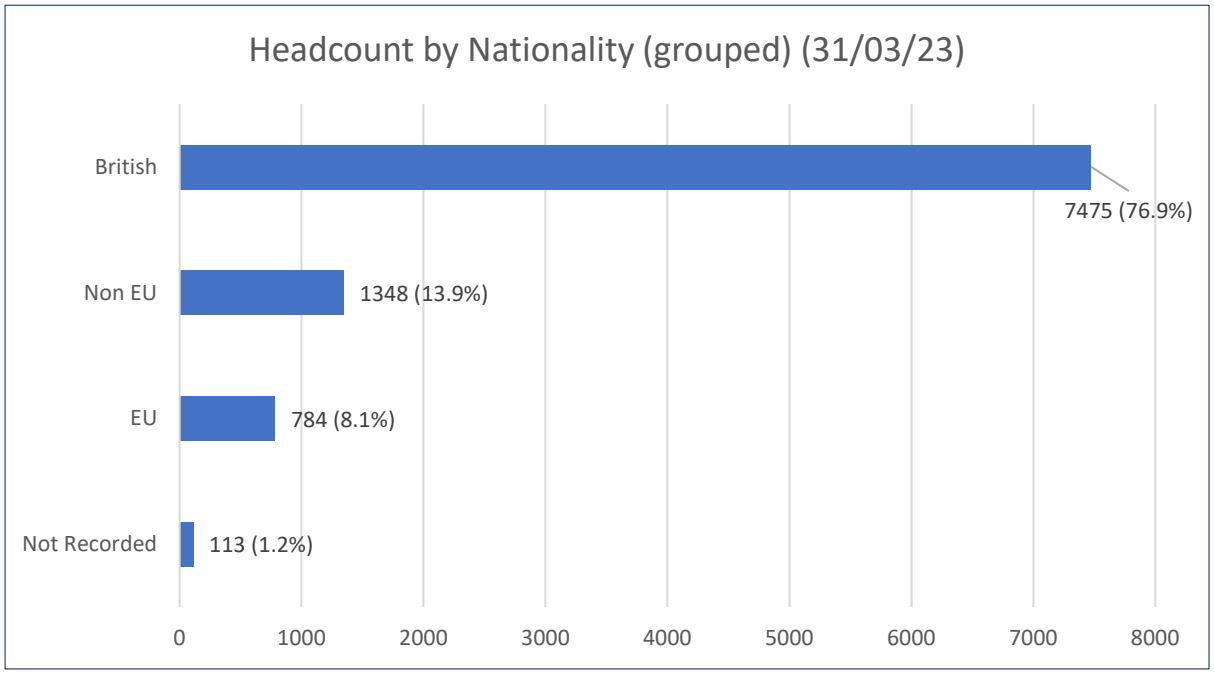
Next Steps

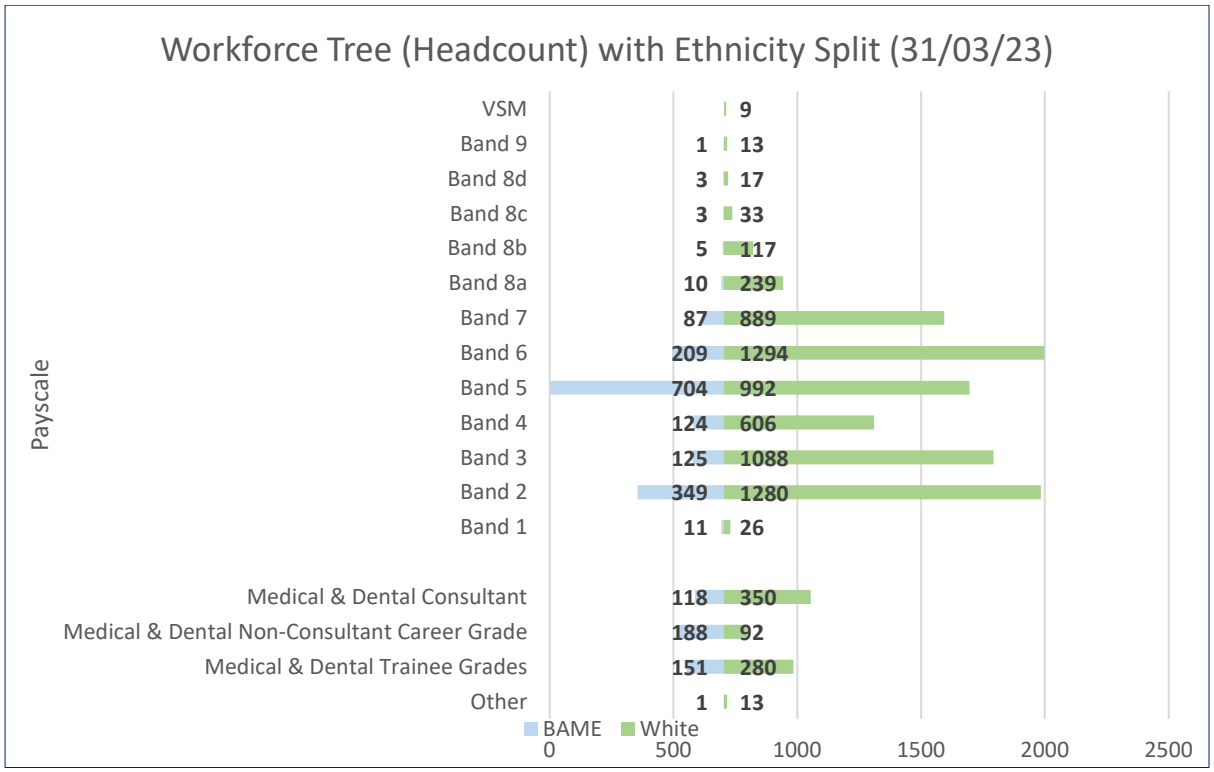
- Present the report to EDIG and the People and Culture Committee
- Present the Report to the Board and publish final document externally
- Update the EDI Priority Action Plan and report progress at the Equality, Diversity and Inclusion group
- Review actions and progress aligned to the NHS EDI Improvement Plan
- Include named Executive Sponsors and Operational Leads with accountability in the action plan working documents
- Embed a culture of Anti-Racism through the Board statement, plan and See ME First
- Continue to integrate EDI into all leader, manager and personal development training
- Working with our Dorset Integrated Care System partners to ensure this report and actions are integrated into all workstreams and share good practice across our systems

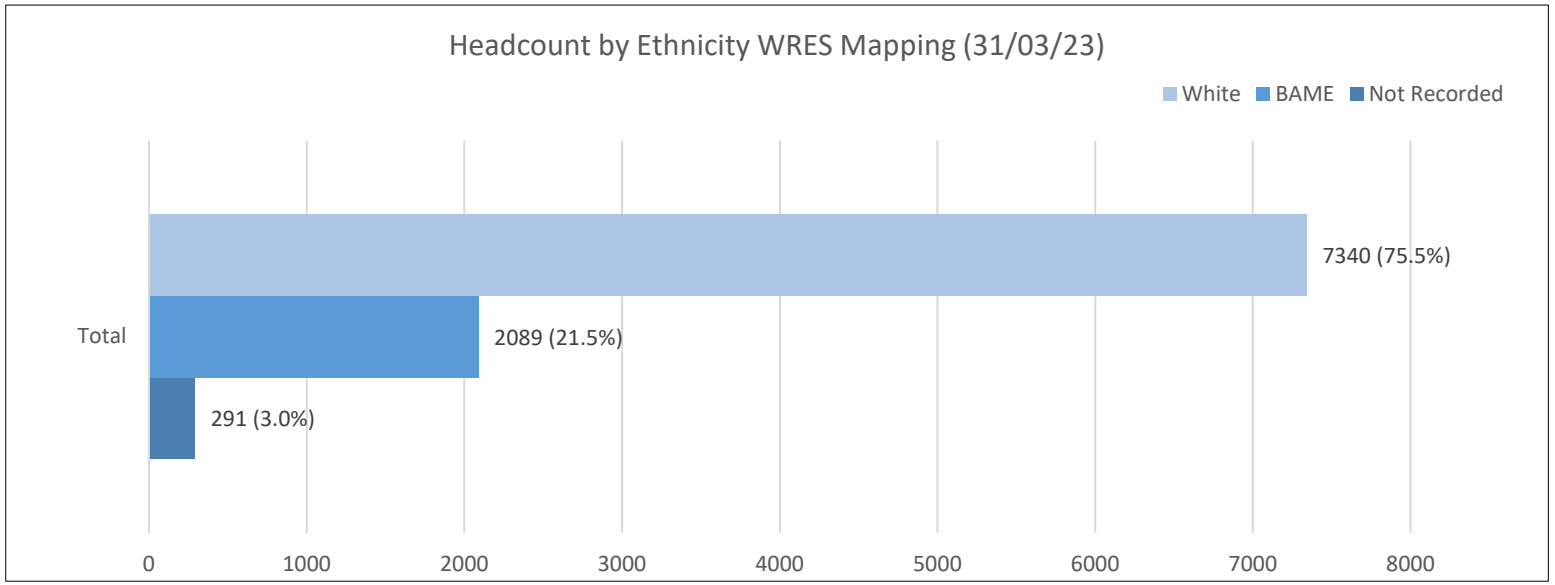
7.0 Workforce Race Equality Standard Indicators 2023

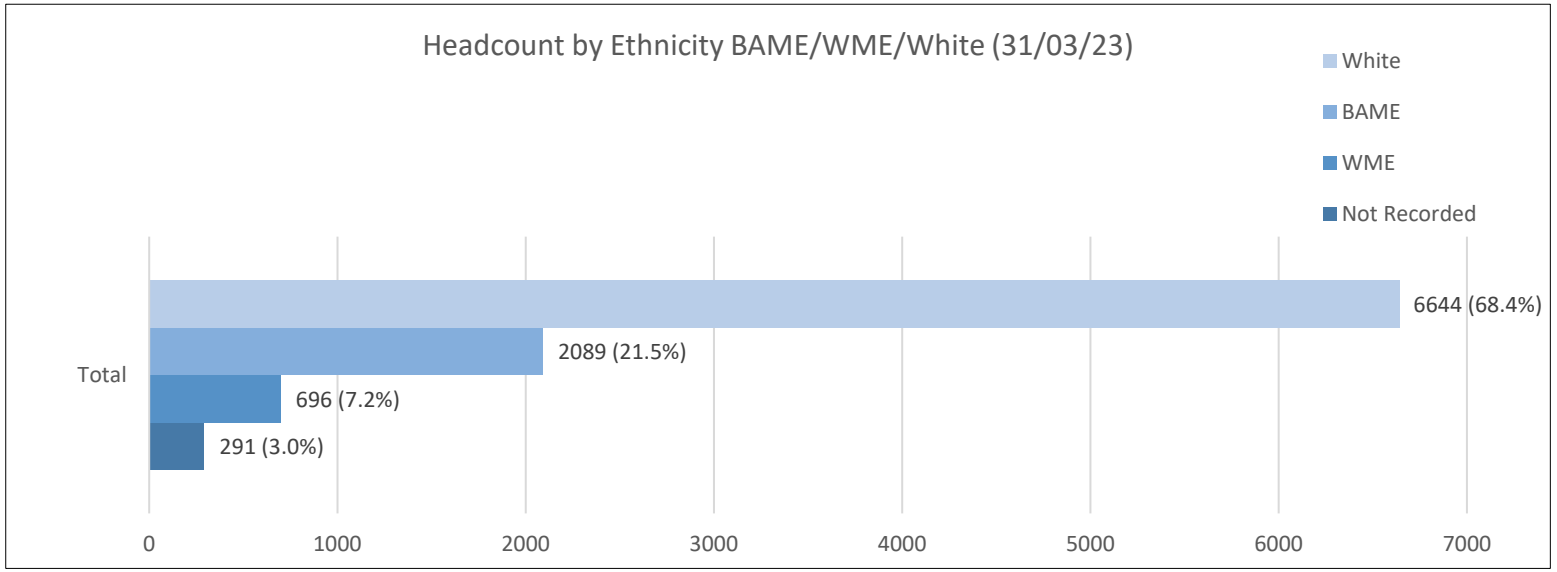
WRES 1 - UHD's shows presents a rapid fall off in BME staff progression through higher pay bands and to greater seniority within the organisation, disparity calculations can be found in appendix C.

Workforce profile charts






Headcount by Ethnicity WRES Mapping (31/03/23)
White
BAME
Not Recorded
Total
7340 (75.5%)
2089 (21.5%)
291 (3.0%)
0
1000
2000
3000
4000
5000
6000
7000
8000


Headcount by Ethnicity BAME/WME/White (31/03/23)
White
BAME
WME
Not Recorded
Total
6644 (68.4%)
2089 (21.5%)
696 (7.2%)
291 (3.0%)
0
1000
2000
3000
4000
5000
6000
7000

WRES Indicators 2 – 9

Workforce Race Equality Standard metrics	2021	2022	2023
	University Hospitals Dorset		
Indicator 2: relatively likelihood of staff being appointed from shortlisting across all posts	1.26	2.09 ↑	1.90 ↓
Indicator 3. relatively likelihood of staff entering the formal disciplinary process as measured by entry into a formal disciplinary investigation	1.17	1.22 ↑	1.0 ↓
Indicator 4. relatively likelihood of staff accessing non-mandatory training and CPD	1.11	0.79 ↓	0.9 ↔
Indicator 5. % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	BME: 27%	BME: 30% ↑	BME: 34.1% ↑
	White: 25%	White: 26.3% ↑	White: 27.9% ↑
Indicator 6. **%** of staff experiencing harassment, bullying or abuse from staff in the last 12 months	BME: 29%	BME: 31.1% ↑	BME: 31.7% ↑
	White: 22%	White: 23.9% ↑	White: 22.5% ↔
Indicator 7. % percentage believing that trust provides equal opportunities for career progression or promotion	BME: 78%	BME: 44.5% ↓	BME: 45.7% ↑
	White: 90%	White: 60% ↓	White: 60.1% ↔
Indicator 8. In the last 12 months have you personally experienced discrimination at work from any of the following: Manager/team leader or other colleagues	BME: 17%	BME: 16.8% ↔	BME: 20.3% ↑
	White: 6%	White: 7.4% ↔	White: 5.4% ↓
Indicator 9. % difference between the organisations Board voting membership and its overall workforce*	-13.7%	-12.2% ↓	-15.0% ↑

*To note: for indicator 9 the % of overall workforce BME increased to 21.5% and the % of BME voting Board membership using the WRES mapping tool was 6.7% at 31.03.23 hence the reported % above. Two non-executive directors were appointed as on 1.04.23, therefore the trajectory for 2024 will be more positive.

Appendix A Workforce Race Equality Standard Action Plan 2023/24

WRES indicator	Action/s 21/22 & 22/23	Progress and Update	Actions 23/24	Reviews/ Monitored	Impact Measure
Indicator 2 Likelihood of being appointed from shortlisting across all posts	Develop and launch Values proposition for employee life cycle, support trust objective "a great place to work" Adoption of values-based shortlisting and interview approach Values based recruitment Diverse talent panels Statement on all job adverts welcoming applications from under- represented groups, linked to inclusion networks Continue to promote targeted opportunities available through NHS South West Leadership Academy, including Stepping Up and WRES Expert programme Continue to support improvement in recruitment and promotion practices to ensure an inclusive approach from application to appointment. Improve diverse panel compositions and interview questions and feedback panels monitor candidate profiles at all stages of recruitment Refresh recruiting Managers selection training, knowledge of reasonable adjustments Commitment to balanced shortlisting review job description and person	Values based recruitment and interview approach embedded. Visible statements on all job adverts linked to inclusion networks. All Programmes for development and positive actions for underrepresented groups are shared trust wide and through staff inclusion networks. The networks have provided peer support and guidance on applications and encouraged diverse representation on courses and leadership programmes by positive role modelling. Network members becoming involved in senior panel interviews/carousels EDI team providing coaching for applications	Name Executive and Strategic /Operational Accountable Leads to Adopt principles of anti-racism and live our UHD values Review and support improvement to recruitment and promotion practices to ensure an inclusive approach from application to appointment. Mandate the introduction of diverse panel compositions and interview questions and feedback panels consider sharing examples of reasonable adjustments. • monitor candidate profiles at all stages of recruitment • explore less traditional recruitment practices to attract and appoint candidates who are Disabled • Refresh recruiting Managers selection training, knowledge of reasonable adjustments • Commitment to balanced	EDIG, PCC And Trust Board	Improvement in shortlisting ratio (1:1 or lower)

WRES indicator	Action/s 21/22 & 22/23	Progress and Update	Actions 23/24	Reviews/ Monitored	Impact Measure
	specifications Review advertising and shortlisting processes, including Board appointments		shortlisting • Review job description and person specifications • Review advertising and shortlisting processes, including Board appointments Promotion of Health & Wellbeing Check-In Conversations Introduce guidance on how to complete application forms Align with the NHS EDI Improvement Plan		
Indicator 3 Staff entering formal disciplinary process	Civility Toolkit/Dignity at work policy updated and published. Adoption of a just and learning culture, using a restorative justice, civility and respectful approach. Reverse Mentoring programme Wellbeing conversations Coaching conversations Freedom to Speak Up support for mediated discussions Engaging through the BAME staff network for more diverse representation in investigation team.	Civility toolkit now published. - Schwartz rounds have continued during the Covid pandemic, virtual and small face to face groups, focusing on behaviours. Reverse Mentoring programme has given underrepresented staff the confidence to question and raise concerns. Cultural differences referenced in new HR Policies Manager modules. Draft Staff check in/wellbeing conversations will provide additional opportunities to raise causes for concern by manager	Name Executive and Strategic /Operational Accountable Leads Adopt principles of anti-racism and live our UHD values Continue to embed previous actions and evaluate Align with the NHS EDI Improvement Plan	EDIG and PCC FTSU	FTSU reporting index Improvement in ratio to 1:1 or below

WRES indicator	Action/s 21/22 & 22/23	Progress and Update	Actions 23/24	Reviews/ Monitored	Impact Measure
	Launch awareness campaign for a Just and Learning Culture Use of national decision trees checklist for Managers, post action audits on disciplinary decisions and pre-forma action checks Year on year reduction in number of BAME staff involved in disciplinary grievance procedures	or staff member.			
Indicator 4. Staff accessing non-mandatory training and CPD	Beyond Difference Leadership programme for BAME staff, in partnership with Dorset ICS. 9 Places for 2020, evaluation and development for further cohorts in 2021 with additional spaces. Appraisal process and documentation updated, reflection and review stages to review career pathway and self-development needed to achieve career goals Coaching and wellbeing conversations linked to career development and progression. Further rollout of Reverse Mentoring programme Further rollout of positive action programmes (Beyond Difference) in partnership with Dorset Integrated Care System Embed career conversations as part of the annual performance appraisal process Scope for Growth career conversation framework	Next programme in development. 10 candidates attend for UHD, feedback used for next development. 2 promotions achieved during programme Career conversations still under development. To be tested via our Staff Network groups. Draft Staff check in/wellbeing conversations will provide Additional opportunities to discuss development and progression. Leadership training now tracking ethnicity demographics for data evaluation.	Name Executive and Strategic /Operational Accountable Leads Adopt principles of anti-racism and live our UHD values Continue to embed previous actions and evaluate Demonstrate diversity within decision making for CPD and Leadership opportunities Align with the NHS EDI Improvement Plan	EDIG and PCC	Reduction in disparity between white and BME staff statistics Improvement in equal opportunities metric 7 Visible diverse representation throughout the workforce structure

WRES indicator	Action/s 21/22 & 22/23	Progress and Update	Actions 23/24	Reviews/ Monitored	Impact Measure
Indicator 5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	Continue to raise awareness of the FTSU Guardians, how to speak up and support available for all staff to report incidents. Regular reporting through assurance committees and highlighting themes and trends and hotspots in the organisation Civility/Dignity at Work policy and toolkit updated Hate Crime Charter is in place, organisation is an active member of Prejudice Free Dorset with access to resources and support for all staff to report incidents safely. Zero tolerance approach to reduce bullying, harassment, discrimination and violence (BHDV) to ensure staff feel save to come to work. Identify themes and hotspots for colleague-on-colleague BHDV Promote a transparent escalation pathway building on our values-based behaviours Further promote the NHSI Civility and Respect Toolkit Bystander training, equip leaders to actively address inappropriate behaviours	FTSU Guardian and Ambassador continue to provide support to all staff. (Reference to their work and report is in appendix C) Civility toolkit now published and referenced within Manager Induction Modules EDI now linked with UHD Violence at work standard.	Name Executive and Strategic /Operational Accountable Leads Adopt principles of anti-racism and live our UHD values Continue to embed previous actions and evaluate Align with the NHS EDI Improvement Plan	EDIG and PCC	Improvement in staff survey results, narrowing the gap between white/BME staff and improving experience for all Recruitment and retention statistics (reasons for leaving) FTSU reporting index

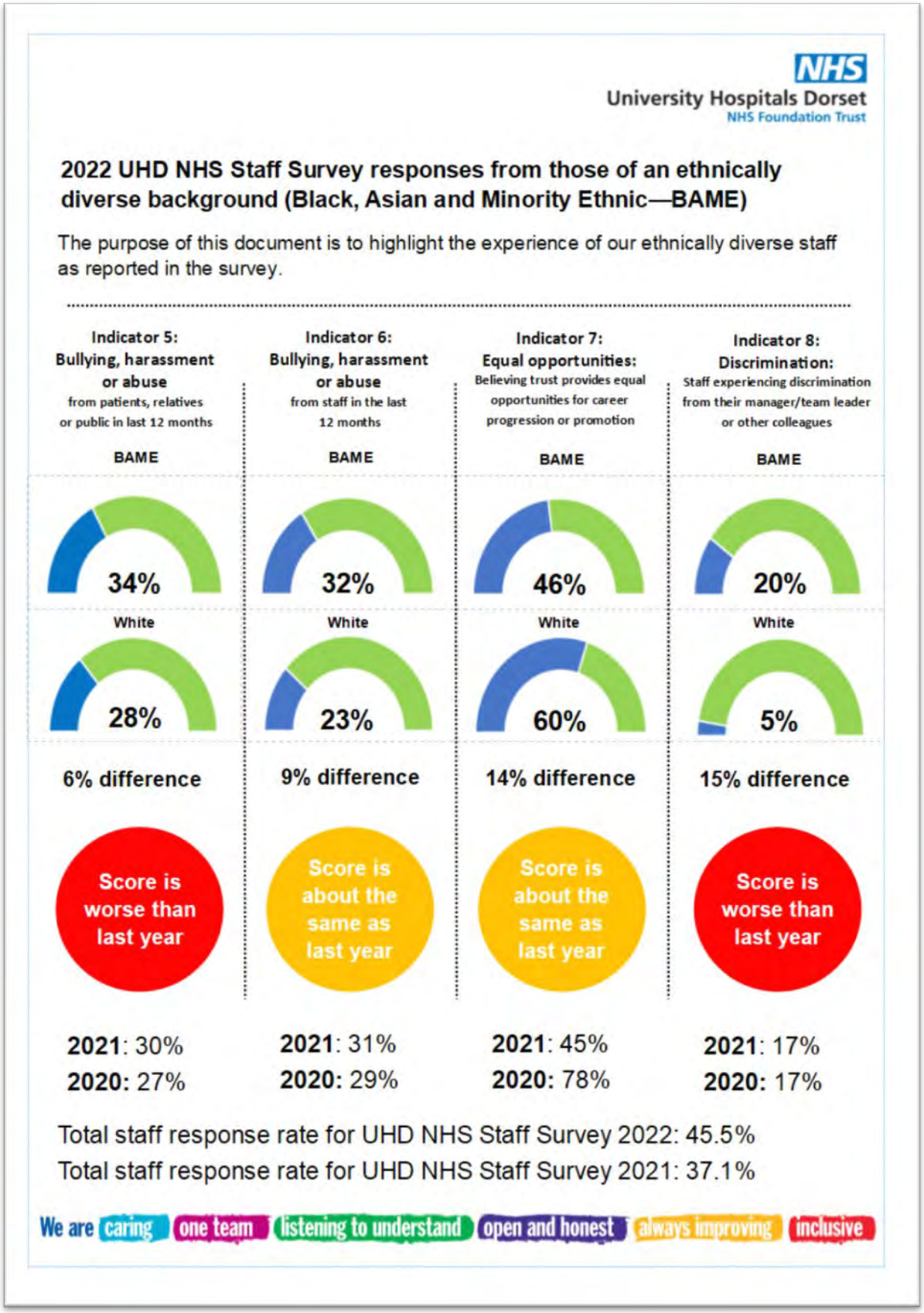
WRES indicator	Action/s 21/22 & 22/23	Progress and Update	Actions 23/24	Reviews/ Monitored	Impact Measure
	(recommended output from Reverse Mentoring)				
Indicator 6. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	Civility/Dignity at Work policy and toolkit updated. Progression of process and policies to support a just and learning culture Second Reverse mentoring programme due to start October 2021 Staff networks included in partnership working, providing expert by experience advice and guidance. Wellbeing Conversations FTSU and staff network support for mediated discussions Zero tolerance approach to reduce bullying, harassment, discrimination and violence (BHDV) to ensure staff feel save to come to work. Identify themes and hotspots for colleague-on-colleague BHDV Promote a transparent escalation pathway building on our values-based behaviours	FTSU Guardian and Ambassador continue to provide support to all staff. (Reference to their work and report is in appendix C) Second cohort of Reverse Mentoring nearing completion with 22 mentoring partnerships Sharing of personal stories and call to organisational action where required. Draft Staff check in/wellbeing conversations will provide additional opportunities to discuss development and progression.	Name Executive and Strategic /Operational Accountable Leads Adopt principles of anti-racism and live our UHD values Continue to embed previous actions and evaluate Align with the NHS EDI Improvement Plan	EDIG and PCC FTSU	Improvement in staff survey results, narrowing the gap between white/BME staff and improving experience for all Recruitment and retention statistics (reasons for leaving) FTSU reporting index

WRES indicator	Action/s 21/22 & 22/23	Progress and Update	Actions 23/24	Reviews/ Monitored	Impact Measure
	Further promote the NHSI Civility and Respect Toolkit Bystander training, equip leaders to actively address inappropriate behaviours (recommended output from Reverse Mentoring				
Indicator 7. Percentage believing that trust provides equal opportunities for career progression or promotion.	Positive action development programme: Beyond Difference. In partnership with Dorset ICS. Launches Sept 2021, further cohorts to develop on evaluation. Introduction of a system of constructive and critical challenge to ensure fairness during interviews. Including values-based shortlisting, diverse interview panels, presence of an equality representative (staff networks), values-based interview questions and specific equality and inclusion questions for band 8A and above. Values based shortlisting and interview approach Further rollout of Reverse Mentoring programme Further rollout of positive action programmes (Beyond Difference) in partnership with Dorset Integrated Care System Embed career conversations as part of the annual performance appraisal process Scope for Growth career conversation framework	Nine UHD delegates for ICS Beyond Difference Programme with 2 being promoted as a result. Unsuccessful candidates also followed up with informal career discussion by EDI team. Development opportunities shared with Staff Network groups. Review of progress with recruitment approach and consideration of constructive challenge process required.	Name Executive and Strategic /Operational Accountable Leads Adopt principles of anti-racism and live our UHD values Continue to embed previous actions and evaluate Align with the NHS EDI Improvement Plan	EDIG and PCC	Improvement in access to learning and development opportunities for all protected groups Improvement in the metric 7, narrowing the gap between white/BME staff and improving equal opportunities for all FTSU reporting index

WRES indicator	Action/s 21/22 & 22/23	Progress and Update	Actions 23/24	Reviews/ Monitored	Impact Measure
Indicator 8. In the last 12 months have you personally experienced discrimination at work from any of the following: Manager/team leader or other colleagues	Second cohort of Reverse Mentoring programme to commence October 2021. Actively promoted through staff networks, encourage under- represented groups to participate as Mentors with supported training and coaching. Continuing collaboration with BAME staff network and our Freedom to Speak Up Guardian/Ambassadors Unconscious Bias workshops Inclusive modules on all leadership programmes Reverse Mentoring programme Wellbeing conversations Coaching conversations FTSU support for mediated discussions, raising awareness Include an EDI objective to ensure every leader can demonstrate their commitment to inclusion and fairness Further rollout of Reverse Mentoring programme, including Managers at all levels Bystander training	Second cohort of Reverse Mentoring nearing completion with 22 mentoring partnerships. Sharing of personal stories and call to organisational action where required. BAME staff network & FTSU leads joined together on National Staff Networks Day in May and continue to work closely. Unconscious Bias now included in mainstream new Manager Induction module training.	Name Executive and Strategic /Operational Accountable Leads Adopt principles of anti-racism and live our UHD values Continue to embed previous actions and evaluate Align with the NHS EDI Improvement Plan	EDIG and PCC	Year on year improvement on this metric, narrowing the gap between white/BME and improving the experience for all staff FTSU reporting index

WRES indicator	Action/s 21/22 & 22/23	Progress and Update	Actions 23/24	Reviews/ Monitored	Impact Measure
Indicator 9. Percentage difference between the organisations ' board voting membership and its overall workforce.	Action plan aligned to Model Employer goals, increase BAME representation at Board/VSM level to reflect workforce diversity by 2025 (appendix b) Regular reporting against key metrics in the context of the broader performance frameworks Increase in staffing levels more reflective of diversity of local communication and regional/national labour markets. Significant annual improvement towards 18.7% BAME composition target to improve leadership diversity by 2025 (Model Employer goals)	This action is included in the recruitment and retention review action plan and is an ongoing commitment to improve the representation in line with the recommended Model Employer goal of relative representation (UHD 19%	Name Executive and Strategic /Operational Accountable Leads Adopt principles of anti-racism and live our UHD values Continue to embed previous actions and evaluate Align with the NHS EDI Improvement Plan	EDIG and PCC Trust Board	Model Employer Goals/ Benchmarks Increased representation through the senior leadership structures

Appendix B


NHS
University Hospitals Dorset
NHS Foundation Trust
2022 UHD NHS Staff Survey responses from those of an ethnically diverse background (Black, Asian and Minority Ethnic—BAME)
The purpose of this document is to highlight the experience of our ethnically diverse staff as reported in the survey.
Indicator 5: Bullying, harassment or abuse from patients, relatives or public in last 12 months
Indicator 6: Bullying, harassment or abuse from staff in the last 12 months
Indicator 7: Equal opportunities: Believing trust provides equal opportunities for career progression or promotion
Indicator 8: Discrimination: Staff experiencing discrimination from their manager/team leader or other colleagues
BAME
34%
32%
46%
20%
White
28%
23%
60%
5%
6% difference
9% difference
14% difference
15% difference
Score is worse than last year
Score is about the same as last year
Score is about the same as last year
Score is worse than last year
2021: 30%
2020: 27%
2021: 31%
2020: 29%
2021: 45%
2020: 78%
2021: 17%
2020: 17%
Total staff response rate for UHD NHS Staff Survey 2022: 45.5%
Total staff response rate for UHD NHS Staff Survey 2021: 37.1%
We are caring one team listening to understand open and honest always improving inclusive

Appendix C

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.

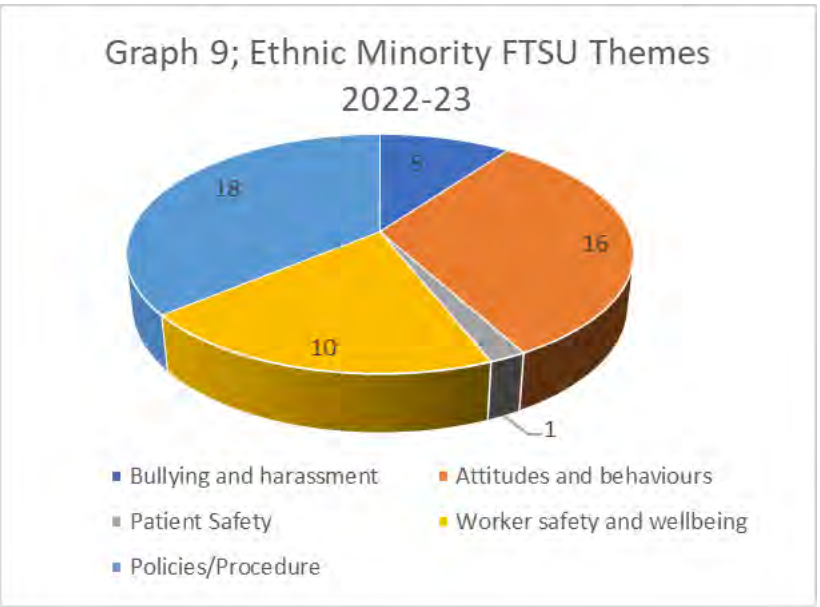
Such an increase of cases reflects how trusted FTSUG are as additional channel for speaking up.

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.

In the period leading to the report, 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.



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 5.1 below shows how staff at UHD use this service as compared to surrounding healthcare.

Table 5.1: 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 1 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 National NHS 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.

- 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.

Appendix D Disparity Ratios

Whole Organisation

Bands	White - Current Year	BME - Current Year	Unknown - Current Year
Under Band 1	0	0	0
Band 1	26	11	2
Band 2	1,280	349	58
Band 3	1,088	125	26
Band 4	606	124	12
Band 5	992	704	39
Band 6	1,294	209	41
Band 7	889	87	12
Band 8a	239	10	4
Band 8B	117	5	3
Band 8C	33	3	2
Band 8D	17	3	1
Band 9	13	1	0
VSM	16	1	0
Grand Total	**6,610**	**1,632**	**200**

Bandings	White - Current Year	BME - Current Year	Unknown - Current Year
1 to 5	3,992	1,313	137
6 and 7	2,183	296	53
Band 8a+	435	23	10
Grand Total	**6,610**	**1,632**	**200**

	White	BME
Lower to middle	**1.83**	**4.44**
Middle to upper	**5.02**	**12.87**
lower to upper	**9.18**	**57.09**

Disparity ratio - lower to middle	**2.43**
Disparity ratio - middle to upper	**2.56**
Disparity ratio - lower to upper	**6.22**

Total No of Staff	BME representation at trust
8,442	**19.3%**

*Note: the total number of staff differs from the total headcount. This is due to staff that did not have the required information recorded on ESR to attribute them to a banding or clinical/non-clinical grouping. This includes blank or 'not recorded' ethnicity on ESR.

Clinical Staff

Bands	White - Current Year	BME - Current Year	Unknown - Current Year
Under Band 1	0	0	0
Band 1	11	1	1
Band 2	825	232	32
Band 3	498	68	15
Band 4	166	92	3
Band 5	795	682	33
Band 6	1,173	192	36
Band 7	764	77	12
Band 8a	165	8	3
Band 8B	69	3	0
Band 8C	10	2	1
Band 8D	7	1	1
Band 9	2	0	0
VSM	7	1	0
Grand Total	**4,492**	**1,359**	**137**

Bandings	White - Current Year	BME - Current Year	Unknown - Current Year
1 to 5	2,295	1,075	84
6 and 7	1,937	269	48
Band 8a+	260	15	5
Grand Total	**4,492**	**1,359**	**137**

	White	BME
Lower to middle	**1.18**	**4.00**
Middle to upper	**7.45**	**17.93**
lower to upper	**8.83**	**71.67**

Disparity ratio - lower to middle	**3.37**
Disparity ratio - middle to upper	**2.41**
Disparity ratio - lower to upper	**8.12**

Total No of Staff	Clinical BME representation at trust
5,988	**22.7%**

Non - Clinical Staff

Bands	White - Current Year	BME - Current Year	Unknown - Current Year
Under Band 1	0	0	0
Band 1	15	10	1
Band 2	455	117	26
Band 3	590	57	11
Band 4	440	32	9
Band 5	197	22	6
Band 6	121	17	5
Band 7	125	10	0
Band 8a	74	2	1
Band 8B	48	2	3
Band 8C	23	1	1
Band 8D	10	2	0
Band 9	11	1	0
VSM	9	0	0
Grand Total	**2,118**	**273**	**63**

Bandings	White - Current Year	BME - Current Year	Unknown - Current Year
1 to 5	1,697	238	53
6 and 7	246	27	5
Band 8a+	175	8	5
Grand Total	**2,118**	**273**	**63**

	White	BME
Lower to middle	**6.90**	**8.81**
Middle to upper	**1.41**	**3.38**
lower to upper	**9.70**	**29.75**

Disparity ratio - lower to middle	**1.28**
Disparity ratio - middle to upper	**2.40**
Disparity ratio - lower to upper	**3.07**

Total No of Staff	Non- Clinical BME representation at trust
2,454	**11.1%**

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 27 September 2023

Agenda item: 7.3

Subject:	Workforce Disability Equality Standard Annual Report and Action Plan
Prepared by:	Jon Harding, Head of Organisational Development
Presented by:	Karen Allman, Chief People Officer Deb Matthews, Director of Organisational Development

Strategic themes that this item supports/impacts:	Systems working and partnership ☐ Our people ☒ Patient experience ☐ Quality: outcomes and safety ☐ Sustainable services ☐ Patient First programme ☐ One Team: patient ready for reconfiguration ☐
BAF/Corporate Risk Register: (if applicable)	BAF 3 and BAF 8
Purpose of paper:	Assurance
Executive Summary:	The Workforce Disability Equality Standard (WDES) was launched in 2019 and aims to improve the workplace and career experiences of Disabled colleagues in the NHS. • The data shows a small improvement on our declaration rate to 5.6% (national target by NHS England is 4%). • A gap exists of 15.72% between our staff record declaration and the National NHS staff survey responses of 21.3%. • The likelihood of Disabled staff being appointed from shortlisting has improved to 1.24. This means a higher percentage of non-Disabled staff are appointed from shortlisting at a ratio of 1:1.24. • The reports of bullying and harassment by Disabled staff show an increase for metrics 4b, 4c and 4d and a small reduction for 4a. • There is a small decrease in Disabled staff believing the Trust offers equal opportunities and this is also reflected as a decrease for non-Disabled staff. • The presenteeism experience for Disabled staff has worsened, with a 9.2% in the disparity in their experience compared to non-Disabled staff.

	• The percentage of Disabled staff saying that their employer has made adequate adjustments remains at 78%. • The relative likelihood of Disabled staff entering the formal capability process compared to non-Disabled staff is showing at 3.03. This means for every member of non-Disabled staff 3 Disabled staff enter the formal capability process. Of note is the fact that no capability processes were on the grounds of ill health.
Background:	It is evident from successive reports that there has been an improvement, however this has not been at pace or consistent with the changing demographic of our workforce. Our Equality, Diversity and Inclusion group (EDIG) is chaired by Pete Papworth (Chief Finance Officer). The group includes representatives from across the organisation, including staff network leads, Governors and patient representatives. This report was presented at the People and Culture Committee on the 9 August 2023 and presented and approved at EDIG on the 10 August 2023. Its purpose is to provide assurance to the Trust Board with compliance on statutes and national standards and makes recommendations on specific interventions. The national report on Disabled staff experience during Covid-19 report contained key recommendations: • all NHS organisations have a Disabled staff network • programmes and initiatives need to be introduced to inspire talented Disabled staff to become NHS leaders of the future • line managers need to be better equipped and skilled to have meaningful health and wellbeing conversations with Disabled staff NHS England lead work to improve the NHS Electronic Staff Record (ESR) disability declaration rate to at least 4 per cent in England.
Key Recommendations:	• Publish final document externally 1 October 2023. • Review actions and progress aligned to the NHS Equality Diversity and Inclusion (EDI) Improvement Plan. • Update the UHD EDI Priority Action Plan and report progress at the EDIG. • Include named Executive Sponsors and Operational Leads with accountability in the action plan working documents and increased participation from Care Groups.

	• Continue to integrate EDI into all leader, manager and personal development training including Patient First. • Work with our Dorset Integrated Care System partners to ensure this report and actions are integrated into all workstreams and share good practice across our systems.
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**
People & Culture Committee	09/08/2023	Noted.
EDIG	10/08/2023	Approved

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

University Hospitals Dorset
NHS Foundation Trust

NHS Workforce Disability Equality Standard (WDES)

Annual Report and Action Plan 2023/24

University Hospitals Dorset NHS Foundation Trust

We are caring one team listening to understand open and honest always improving inclusive

Contents

Some useful abbreviations:

- BAME - Black, Asian and Minority Ethnic
- BME - Black Minority Ethnic
- EDI - Equality Diversity and inclusion
- EDIG - Equality Diversity and Inclusion Group
- FTSU: Freedom to Speak Up (Guardian)
- HR: Human Resources
- OD: Organisational Development
- PCC: People and Culture Committee
- WRES - Workforce Race Equality Standards
- WDES - Workforce Disability Equality Standards
- ICS – Integrated Care System
- IEN – Internationally Educated Nurse

1 Introduction

The Workforce Disability Equality Standard (WDES) was launched in 2019 and aims to improve the workplace and career experiences of Disabled colleagues in the NHS.

[1] *The NHS People Promise recognises and celebrates the diversity of the NHS, setting out seven themes that are fundamental to creating an open and inclusive environment; one in which our people can thrive in their teams, workplaces and careers. The fundamental principles set out in the People Promise provide the grounds for an inclusive environment for all our staff, in which the voices of Disabled staff are heard and listened to, in which Disabled staff feel recognised and valued, and will be supported to achieve their full potential*

The Workforce Disability Equality Standard (WDES) remains the only example in the UK where employers are mandated to report and publish annual data on the workplace and career experiences of Disabled staff. Our ambition is to increase the representation of Disabled people in the NHS workforce and see the disparities between Disabled and non-disabled staff reduce year on year; supported by an inclusive culture through the realisation of the vision set out in the People Promise.

We use the term 'Disability' as it is defined in the Equality Act 2010 recognising that the Act's intention is both positive and protective for Disabled people. However, we recognise that 'Disability' is a dynamic term, within which terms such as 'neurodivergence' and 'neurodiversity' are emerging and changing, including the relationship between neurodivergence and definitions of Disability.

This report for University Hospitals Dorset (UHD) and the data submission will be reviewed and ratified by the Equality, Diversity and Inclusion Group (EDIG), the People and Culture Committee and the Trust Board.

EDIG serves to provide assurance that the Trust has an effective framework within which it overseas the implementation of the national Standards, including WDES.

Throughout this report, we have used a capital 'D' when referring to Disabled staff. This is a conscious decision, made to emphasise that barriers continue to exist for people with long-term conditions. The capital 'D' also signifies that Disabled people have a shared identity and are part of a community that continues to fight for equality.

1.1 Equality Diversity and Inclusion [EDI] Strategy & Group

Our Equality, Diversity and Inclusion group (EDIG) is chaired by Pete Papworth (chief finance officer) The group includes representatives from across the organisation, including staff network leads, Governors and patient representatives.

Its purpose is to provide the governance and assurance to the People and Culture Committee and Trust Board on compliance with statutes and national standards and makes recommendations on specific interventions.

Membership comprises multi-disciplinary staff occupations and patient representatives, external key stakeholders and partners are invited to join group meetings.

Our strategy for equality, diversity and inclusion is published on our external website. It contains our strategic objectives with measurable outcomes and goals, aligned to our organisational vision, mission and values.

1Extract from the national Workforce Disability Equality Standard report 2021, published in March 2022, by Professor Em Wilkinson-Brice, Acting Chief People Officer.

2 Executive Summary

University Hospitals Dorset NHS Foundation Trust (UHD) aspires to embed an inclusive culture where diversity is valued and championed at all levels of the organisation. Through our Trust objectives, values and the EDI Strategy we aim to promote and deliver equality of opportunity, dignity and respect for all our patients, service users, their families, carers and our people. We aim to eliminate discrimination and harassment and reduce health inequalities.

The Messenger Review into Leadership in Health and Social Care by NHS Confederation in June 2022 reinforced the EDI vision for all NHS organisations: -

'EDI embedded and mainstreamed as the responsibility of all regardless of role and especially leaders and managers from front line to board. This must include the

practice of zero tolerance of discrimination, but also greater awareness of the realities in the workplace for those with protected characteristics.'

UHD has over 9700 staff serving a population base of 400,300 [*Census: 2021 ONS*]. Our staff group shows 5.58% declare a Disability with 10.28% not wishing to disclose. This compares to our local population of 20% reporting poor or bad health (BCP Council statistics 2021). We will continue to monitor our data alongside the lived experiences of all our staff.

We continue our commitment to understanding staff experience and to engage with staff in a way which respects and advances our commitment to the trust Value of 'Listening to understand'. There is a valuable richness in the lived experience of members of staff across our hospitals and bringing human stories to the fore and sharing these to the benefit of others remains an important dimension of EDI work.

Our staff network groups have been instrumental in providing increased feedback to inform the Trust of the need for change to reduce potential organisational barriers. They are more mature in their development and progress compared to many others in the region; evidenced by invitations to speak with other trusts and the recognition at a national level.

The UHD commitment to staff wellbeing has continued to develop and is accessible by all staff. UHD staff have a broad range of wellbeing offers available in house and through the Dorset ICS. These are shared through the trust communications and via a set of intranet wellbeing pages across many subject areas.

The UHD *Building Healthy Working Lives* strategic framework outlines the intention for UHD to be the best place to work and provide high quality care by the health and wellbeing of our people becoming a part of our everyday operations and a key part of our workplace culture; promoting positive behaviour and challenging those which may be detrimental to the wellbeing of UHD people.

The UHD *Healthy Working Lives* Group, chaired by the UHD Wellbeing Guardian, has a role to implement and deliver activity on the UHD Health and Wellbeing Strategy. The group comprises staff with high engagement and enthusiasm in this area with practical skills and ability to apply this. Serving to guide and direct health and wellbeing focus and activity, it also represents our commitment to the 'We are safe and healthy' People Promise and UHD Values and culture.

The Group shares staff members with the Pro-Ability Staff Network and serves to widen an understanding of ability as an area of inclusion. It enables good practice, including the UHD Health Passport, to be shared across the trust and developed for the benefit of all staff groups. Governance in this key inclusion area is by the Group reporting to the People and culture Committee.

To be a Model Employer, UHD needs to be inclusive - embodying a diverse workforce at all levels and bringing the wealth of experience and perspective for delivering the best outcomes for the community we serve.

The national report on Disabled staff experience during Covid-19 report contains key recommendations:

- all NHS organisations have a Disabled staff network;
- programmes and initiatives need to be introduced to inspire talented Disabled staff to become NHS leaders of the future;
- line managers need to be better equipped and skilled to have meaningful health and wellbeing conversations with Disabled staff;
- NHS England and NHS Improvement to lead work to improve the NHS Electronic Staff Record (ESR) disability declaration rate to at least 4 per cent in England.

https://www.nhsemployers.org/publications/nhs-Disabled-staff-experiences-during-covid-19-report

3 **Voice of our Network - ProAbility** (supporting staff with long term medical conditions / Disability)

Co-leads, ProAbility network: Elayne Goulding/Diane Potter, Jo Olsen & Jo Pritchard

Executive sponsors: Peter Gill, Chief Informatics and IT Officer, Karen Allman, Chief People Officer

The ProAbility Network continues to support the recruitment, training, career development and promotion of Disabled persons / employees. The Trust holds 'Disability Confident' accreditation. It takes positive and proactive steps to maintain continued employment, provide training, and foster career development and promotion for disabled members of staff.

The Trust reports on the 'Workforce Disability Equality Standard' (WDES) on an annual basis. This national reporting standard includes providing statistics which demonstrate a proportionate comparison between disabled and non-disabled members of staff in relation to their experience at work and opportunities. This data will enable a gap analysis to be conducted and the development of a targeted action plan in conjunction with the ProAbility staff network.

This network aims to listen, understand and support people living and working with physical Disabilities and long-term health conditions holding regular listening events. The network is working closely with the HR department to understand the reasons for low declaration rates of disabilities and how this can be improved.

The Trust recognises there is a strong business case for adopting a positive approach to supporting and developing Disabled staff both in terms of acquiring and maintaining valuable workplace skills. Developing a culture where both our staff and patients can flourish is simply the right thing to do. It is the responsibility of the People Directorate team to maintain up-to-date policies, taking into consideration revised employment law.

The network has recognised the need to support employees with neurodiversity in the workplace and the services of Lexxic experts in psychological support were sought to provide introductory training and support the development of a suggested action plan in 2022 and the recommendations are being introduced into our workstreams.

Deaf Awareness week in May was celebrated together with the ongoing promotion of British Sign Language training. In addition, the Network championed red hearing aid boxes for use by patients to safeguard against loss of their devices with associated distress and cost.

In December, Purple Light Up Day was celebrated by the Network and colleagues within UHD to recognise the contributions of Disabled employees.

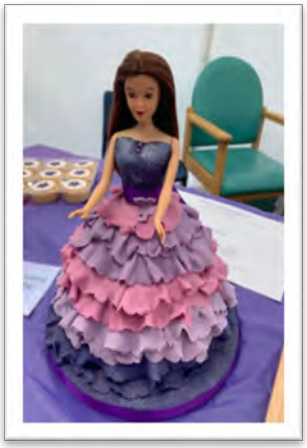
ProAbility activity

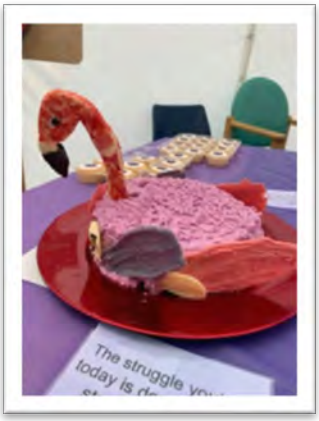
- December celebration – Purple Light Up – we held a 'Purple Pro Ability Bake off' competition in the Marquee on Friday 2 December – we also invited lots of health and wellbeing contacts with fantastic competition entries. We started the day with a special 'Friday Five Mins of Fun.' A colourful array of photographs are included on page 7;
- Promotion of Neurodiversity – invited guest speaker Rachel Noes 'The Pink Vicar';
- Network leads engaged in regional and national Disability networks and NHS Employers Disability Pioneer group;
- One of the Co Leads, attended first national NHS Employers meeting for deaf NHS staff in Leeds;
- Continuous promotion of Trust Health Passports for employees;
- Network members invited to speak about network at various department meetings and Inductions;
- Supported other regional Trusts and ICS to set up their own Disability staff networks;
- Involved in deaf awareness presentations to various department;
- Involved in interview panel for non-Exec Director and other senior posts;
- Gave Hospital Radio interview about deaf awareness;
- HR personnel was involved to discuss 'uploading Disability onto ESR'.

This report shows the continuing gap in the experience of our Disabled and non-Disabled staff. The work to address these disparities requires positive actions, words are not enough.

In trusts that have improved their declaration rates and experience of Disabled staff it is evident the tone from the top and representation of Disability at the highest level creates a psychologically safe place to bring your whole self to work and seek the adjustments and support to be the best you can be every day. We will work with our senior leaders and Executive Board members to champion visibility and openness, as role models and positive leaders.

We will continue to work in partnership with the Trust to elevate the voices of the staff group we represent and ensure the support continues for colleagues still working from home, who still need on-going support, inclusion and value as our hidden workforce.





Purple Light Up 2022

4 Conclusion

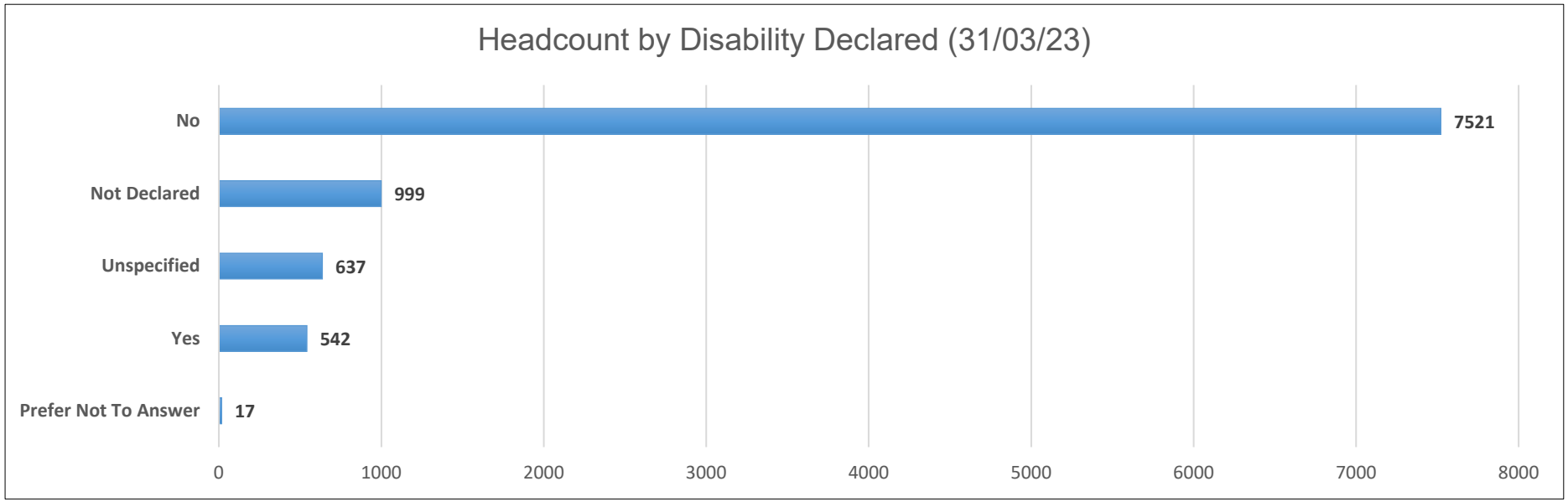
- The data shows a small improvement on our declaration rate to 5.6% (national target by NHSE is 4%);
- The honesty gap is 15.72% between our staff records declaration and the staff survey responses of 21.3%;
- The likelihood of Disabled staff being appointed from shortlisting has improved to 1.24. This means a higher percentage of non-Disabled staff are appointed from shortlisting at a ratio of 1:1.24;
- The reports of bullying and harassment by Disabled staff show an increase for metrics 4b, 4c and 4d and a small reduction for 4a;
- There is a small decrease in Disabled staff believing the trust offers equal opportunities and this is also reflected as a decrease for non-Disabled staff;
- The presenteeism experience for Disabled staff has worsened, with a 9.2% in the disparity in their experience compared to Non-Disabled staff;
- The percentage of Disabled staff saying that their employer has made adequate adjustments remains at 78%;
- The relative likelihood of Disabled staff entering the formal capability process compared to non-Disabled staff is showing at 3.03. This means for every member of non-Disabled staff 3 Disabled staff enter the formal capability process. Of note is the fact that no capability processes were on the grounds of ill health;
- This report contains information and action that highlights the need to improve recruitment for Disabled people. A simple act of keep asking the question: "*How can we make this process better for you?"* can make all the difference in an interview and beyond (Paul Deemer, Head of D&I, NHS Employers).

5 Next Steps

- Present the report to EDIG and the People and Culture Committee;
- Present the Report to the Board and publish final document externally;
- Update the EDI Priority Action Plan and report progress at the Equality, Diversity and Inclusion Group;
- Review actions and progress with the new NHS EDI Improvement Plan;
- Include named Executive Sponsors and Operational Leads with accountability in the action plan working documents;
- Evaluate options that will remove cost bias from appointments during recruitment. This could include the introduction of a centralised budget to support workplace adjustments or assurance of support for departments to make the adjustments.

APPENDIX A: WDES Data (31 March 23)

Metric 1: Workforce



	31/03/2022		31/03/2023	
Disability	Headcount	%	Headcount	%
No	6856	71.72%	7521	77.41%
Not Declared	1552	16.24%	999	10.28%
Prefer Not to Answer	17	0.18%	17	0.17%
Unspecified	680	7.11%	637	6.56%
Yes	454	4.75%	542	**5.58%**
Grand Total	**9559**	**100.00%**	**9716**	**100.00%**

The 2023 National WDES data submission was 5.6% using the official reference period 1.04.22 – 31.3.23 with data uploaded in May 2023.

The 5.58% was produced from additional data produced in June 2023.

	Disabled Staff	% Disabled Staff	Non-Disabled staff	% Non-Disabled Staff	Disability unknown or null	Disability Unknown/null %
NON-CLINICAL						
Cluster 1 (under band 1, bands 1-4)	100	5.7%	1302	73.9%	361	20.5%
Cluster 2 (bands 5-7)	36	7.2%	402	79.9%	65	12.9%
Cluster 3 (bands 8a-8b)	7	5.4%	90	69.2%	33	25.4%
Cluster 4 (bands 8c – 9 & VSM)	1	1.7%	45	77.6%	12	20.7%
CLINICAL						
Cluster 1 (under band 1, bands 1-4)	121	6.2%	1521	78.2%	302	15.5%
Cluster 2 (bands 5-7)	197	5.2%	2969	78.9%	598	15.9%
Cluster 3 (bands 8a-8b)	15	6.0%	192	77.4%	41	16.5%
Cluster 4 (bands 8c – 9 & VSM)	1	3.8%	21	80.8%	4	15.4%
Cluster 5 (Medical & Dental Staff Consultants)	3	0.60%	333	66.87%	162	32.53%
Cluster 6 (Medical & Dental Staff, non-Consultants career grade)	4	1.32%	233	76.90%	66	21.78%
Cluster 7 (Medical & Dental staff, Medical and dental trainees)	43	9.17%	379	80.81%	47	10.02%
Total declaration	529					

Table 1.1 declaration by pay bands, re-validated data for actual WDES data submission shows variation in ESR data

Metric 2 – Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts

(Data source: Trust's recruitment data)

	Relative likelihood in 2021	Relative likelihood in 2022	Relative likelihood in 2023 (A figure below 1 indicates more likelihood of Disabled staff being appointed)
Relative likelihood of non-Disabled staff being appointed from shortlisting compared to Disabled staff	**0.96**	**1.20**	**1.24**

Metric 3 - Relative likelihood of Disabled staff entering formal capability process compared to non-Disabled staff

(Data source: Trust's HR data)

	Relative likelihood in 2021	Relative likelihood in 2022	Relative likelihood in 2023
Relative likelihood of Disabled staff entering formal capability process compared to non-Disabled staff	**3.18**	**4.12**	**3.03**

Metric 4

(Data source: Question 13, NHS Staff Survey)

	% Disabled staff responses to 2021 NHS Staff Survey	% Non-Disabled staff responses to 2021 NHS Staff Survey	% points difference (+/-) between Disabled staff and non-Disabled staff responses 2021	% Disabled staff responses to 2022 NHS Staff Survey	% Non-Disabled staff responses to 2022 NHS Staff Survey	% points difference (+/-) between Disabled staff and non-Disabled staff responses 2022	National Average % points difference (+/-) between Disabled staff and non-Disabled staff responses 2022
4a) Staff experiencing harassment, bullying or abuse from patients/ service users, their relatives or other members of the public in the last 12 months	**32.4%**	**25%**	**+7.4%**	**32.5%**	**27.8%**	**+4.7%**	**+6.8%**
4b) Staff experiencing harassment, bullying or abuse from managers in the last 12 months	**15.3%**	**9.1%**	**+6.2%**	**15.3%**	**8.6%**	**+6.7%**	**+7.2%**
4c) Staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	**25.4%**	**19.2%**	**+6.2%**	**26.6%**	**17.8%**	**+8.8%**	**+9.11%**
4d) Staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months	**45.8%**	**46.1%**	**-0.3%**	**47.8%**	**42.8%**	**+5.0%**	**+1.1%**

Metrics 5 – 8

(Data source: Questions 14, 11, 5, 28b, NHS Staff Survey)

	% points difference (+/-) between Disabled staff and non-Disabled staff responses 2021	Disabled staff responses to 2022 NHS Staff Survey	Non-Disabled staff responses to 2022 NHS Staff Survey	% points difference (+/-) between Disabled staff and non-Disabled staff responses 2022	National Average 2022
	Percentage (%)	Percentage (%)	Percentage (%)	Percentage (%)	Percentage (%)
Metric 5 - Percentage of Disabled staff compared to non-Disabled staff believing that the trust provides equal opportunities for career progression or promotion.	**-4.8%**	**55.3%**	**58.5%**	**-3.2%**	**-5.9%**
Metric 6 - Percentage of Disabled staff compared to non-Disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	**+8.1%**	**28.8%**	**19.6%**	**+9.2%**	**+9.2%**
Metric 7 - Percentage of Disabled staff compared to non-Disabled staff saying that they are satisfied with the extent to which their organisation values their work.	**-8.0%**	**31.4%**	**40.8%**	**-9.4**	**-11.1**
Metric 8 - Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.		**78.0%**			**71.8%**

Metric 9 – Disabled staff engagement

(Data source: NHS Staff Survey)

	Difference (+/-) between Disabled staff and non-	Disabled staff engagement score for	Non-Disabled staff engagement score for	Difference (+/-) between Disabled staff and non-	National Average
b) Has your trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No)					
	2021 (UHD)			**2022 (UHD)**	
a) The staff engagement score for Disabled staff compared to	0.4	6.5	6.9	0.4	0.5

Yes

Please provide at least one practical example of action taken in the last 12 months to engage with Disabled staff.

- Listening Events and expert speakers
- Monthly staff network meetings
- Inclusion of the staff networks in the governance framework for the equality, diversity and inclusion group meetings.
- Reverse Mentoring programme, positive work on deaf awareness and positive action of developing and procuring hearing aid boxes for patients to reduce loss whilst inpatients and cost to trust of £35k+ a year.
- Continued peer to peer support through the ProAbility network.

Metric 10 – Percentage difference between the organisation's board voting membership and its organisation's overall workforce

(Data source: NHS ESR and/or trust's local data)

	Disabled Board members in 2021 (UHD)	Disabled Board members in 2022 (UHD)	Disabled Board members in 2023 (UHD)	Non-Disabled Board members in 2023 (UHD)	Board members with Disability status unknown in 2023 (UHD)	% points difference (+/-) between Disabled Board members and Disabled staff in overall workforce 2023 (UHD)
	Percentage (%)	Percentage (%)	Percentage (%)			Percentage (%)
Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated by Exec/non-exec and Voting/non-voting.	**0%**	**0%**	**0%**	**16**	**0**	**Total Board = 0%** **Overall workforce = 5.58%** **Difference -5.58%**

APPENDIX B: Workforce Disability Equality Action Plan 2023/24

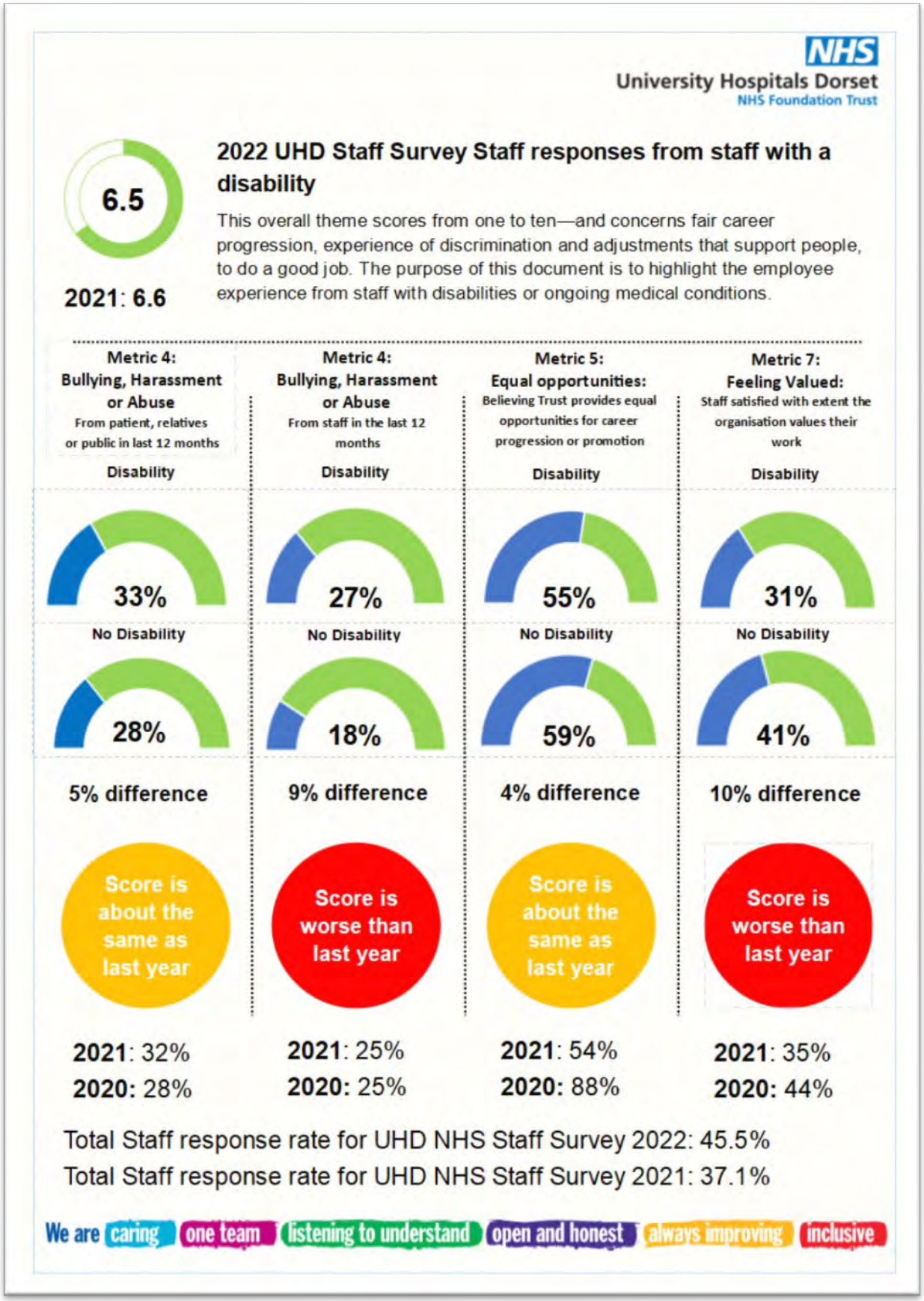
Objective	Action/s 21/22 & 22/23	Progress and Update	Actions 23/24	Reviewed /Monitored	Impact Measure
Improve workforce data representation	Increase self-declaration rates and track action plan with targeted interventions against all NHS Standards action plans. Continue to promote through Employee Self Service, updating personal information and why this is needed. Board Development session on declaration and why it matters (evidence of improved declaration when tone from the top is open and honest).	Whole workforce self-declaration rates have continued to improve through ProAbility Network Activity now 5.6%. Work continues to improve this with implementation of ESR dashboards, promotion of updating records and ESR self-service now available trust wide. 100% Board declaration.	Name Executive and Strategic / Operational Accountable Leads • Presentations at Care Group meetings to reinforce need for declaration and why it matters • Clear instructions for staff on the relevant categories on ESR • UHD supports and promotes ProAbility engagement activity	EDIG and PCC	Increase in declaration rates (4%). Close the gap on ESR/NHS National Staff Survey Long term conditions and Disability.
Recruitment and selection	Values Based shortlisting and interview questions Statement on all job adverts welcoming applications from under-represented groups and links to staff networks. Diverse representation on interview panels, including staff networks. Raise awareness of reasonable adjustments. Disability Confident and Armed Forces Covenant guaranteed interviews.	Values based shortlisting and interview templates implanted June 2021. All adverts contain statement and links to the staff networks. Interview panel for new CEO included diverse representation from the staff networks. Disability Confident and Armed Forces Covenant guaranteed interviews continue to be provided and HR processes ensure applicants who meet minimum criteria are offered an interview to meet these accreditations	Name Executive and Strategic / Operational Accountable Leads Review and support improvement to recruitment and promotion practices to ensure an inclusive approach from application to appointment. Mandate the introduction of diverse panel compositions and interview questions and feedback panels consider sharing examples of reasonable adjustments: • monitor candidate profiles at all stages of recruitment • continue accreditation practices and implementation of Disability Confident and Armed Forces Covenant • explore Level 3 Disability Confident accreditation	EDIG and PCC	Improvement in metric 2, shortlisting. Improvement in metric 5, equal opportunities. Achieving renewal of accreditation and improving to Level 3 Disability Confident Leader.

Objective	Action/s 21/22 & 22/23	Progress and Update	Actions 23/24	Reviewed /Monitored	Impact Measure
		Staff Network members included in recruitment panels for senior leaders	• explore less traditional recruitment practices to attract and appoint candidates who are Disabled • Refresh recruiting Managers selection training, knowledge of reasonable adjustments • Commitment to balanced shortlisting • Review job description and person specifications Review advertising and shortlisting processes, including Board appointments Promotion of Health & Wellbeing Check-In Conversations		
Staff Experience	Continued development of the staff network leads to work in partnership across the organisation and share their lived experience to inform and raise awareness. Unconscious bias workshops to include disability/long term health conditions in scenarios. Health Passports included in wellbeing conversations.	Network leads develop continues through the Community of Practice. Specialist sessions with Power of Staff Networks and Story Telling workshop to develop profiles. Developing strategic Leadership skills development session for all Staff Networks by Cherron Inko-Tariah MBE in January 2023. Unconscious bias workshops in partnership with Enact Solutions.	Name Executive and Strategic / Operational Accountable Leads. Review Governance arrangements to ensure staff networks: • Be able to contribute to and inform trust decision making processes • Have a programme of work that can be celebrated at the annual staff network event and engages further recruitment to the group • Continue to promote Health Passport and link to sickness	EDIG and PCC	Improvement in metrics 5-8, equal opportunities, value and presenteeism.

Objective	Action/s 21/22 & 22/23	Progress and Update	Actions 23/24	Reviewed /Monitored	Impact Measure
		Health passports and toolkit promoted through ProAbility, Occupational Health, wellbeing pages and linked to sickness absence management policy. Health and Wellbeing check in conversations introduced ProAbility network engaged in UHD Health & Wellbeing Ambassadors launch and engagement. New Sponsors recruited for ProAbility Network – Peter Gill, and Karen Allman. Network championed the sourcing of Lexxic to undertake an assessment and training on the needs of staff with neurodiversity.	absence and presenteeism support mechanisms Ensure equitable representation in all work streams for staff living and working with a Disability, alongside all our equality standards Review the Equality Impact Assessment process in partnership with staff networks Re-visit and progress actions within the Lexxic report alongside HRBP and recruitment. Review reasonable adjustments approach in line with regional South West best practice. Consider how a centralised Workplace Adjustments Budget could improve staff experience.		
Career promotion and progression	Promoting all development opportunities widely and encouraging applications from under-represented groups. Ensure all training and development opportunities are fully accessible. Risk assessment and Equality Impact Assessments completed to ensure barriers and possible reasonable adjustments identified in advance.	Statement on all job adverts welcoming underrepresented groups and links to staff networks. eLearning development in the BEAT team, lead is working with ProAbility to beta test accessibility tools. Risk Management team wishing to be part of the EQIA workshops and develop protocols for widening use across trust for all processes.	Name Executive and Strategic / Operational Accountable Leads • Equality Impact Assessment process and toolkit to be developed and programme of education and implementation • Lexxic Discovery workshop to develop Roadmap of tools and resources to improve the experience of our Neuro Diverse people • Listening events on talent management and career	EDIG and PCC BEAT Education Team and Quality & Risk Management Team	Workforce Disability Equality Standard (WDES) improvement. Improved metric 2, shortlisting, to 1:1 or below. Improved metric 5 equal opportunities.

Objective	Action/s 21/22 & 22/23	Progress and Update	Actions 23/24	Reviewed /Monitored	Impact Measure
		Reasonable adjustment awareness through talks and events with the ProAbility network. Lexxic workshops on Neuro Diversity and further audit workshop to develop roadmap being scoped for September 2022. Continuing work with risk management specialists on risk assessments / adjustments, developing toolkits and flowcharts for accessing support through Access to Work and in-house mechanisms.	pathways, with support of staff network leads • Increase in staffing levels more reflective of diversity of local community and regional/national labour markets - through declaration campaigns and creating a safe space to share health conditions for senior staff as role models • Develop reasonable adjustment toolkit and flowcharts, raising awareness through education and promotion of tools and resources • Scope for Growth career conversation framework promotion with Disabled staff.		
Staff Wellbeing	Continue to promote the Health Passport as a tool to support staff wellbeing and wellbeing conversations Wellbeing conversations Long Covid support programme Professor Clifford Shearman, Non-Executive Director appointed as Wellbeing Guardian to oversee the implementation of the Building Healthy Working Lives Framework, objectives and measures	Health passport continues to be used across the Trust and is updated on feedback from users. Wellbeing coaching/wellbeing ambassadors UHD responders programme, winter planning to support staff redeployed. Health and Wellbeing Check-In Conversations piloted in Cardiology in September 2022 with additional links to other support mechanisms.	Name Executive and Strategic / Operational Accountable Leads • Continue to promote and embed the Health Passport in all sickness review and support mechanisms • Zero tolerance approach to reduce bullying, harassment, discrimination and violence (BHDV) to ensure staff feel save to come to work. • Campaign to introduce Health and Wellbeing Check-In Conversations in UHD and include reference into people development opportunities	EDIG PCC Building Healthy Working Lives Group	Improved metric 4a/b Continue to improve metric 4c/d and increased reporting of incidents.

APPENDIX C: WDES Infographic



University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 27 September 2023

Agenda item: 7.4

Subject:	Equality, Diversity and Inclusion Annual Report and Workforce Profile 2022-2023
Prepared by:	Jon Harding, Head of Organisational Development
Presented by:	Karen Allman, Chief People Officer Deb Matthews, Director of Organisational Development

Strategic themes that this item supports/impacts:	Systems working and partnership ☐ Our people ☒ Patient experience ☐ Quality: outcomes and safety ☐ Sustainable services ☐ Patient First programme ☐ One Team: patient ready for reconfiguration ☐
BAF/Corporate Risk Register: (if applicable)	BAF 3 and BAF 8
Purpose of paper:	Assurance
Executive Summary:	The purpose of this paper is to provide assurance to the Trust Board that University Hospitals Dorset NHS Foundation Trust has met its obligatory Equality, Diversity and Inclusion Public Sector Duty compliance requirements along with NHS national standards. We have made good progress in many areas and our overall NHS Staff Survey result for Compassionate and Inclusion was our best themed score in 2022 (7.3 / 10). Despite this, our workforce profile data and the lived experience of our staff continue to present disparities in career progression, exposure to inappropriate behaviour, less favorable recruitment outcomes for candidates with both visible and non-visible difference at interview. Our Workforce Race Equality Standard (WRES) indicators and Workforce Disability Equality Standard (WDES) metrics also show a mixed picture and our data suggests that Black and Minority Ethnic and Disabled staff are subject to greater levels of discrimination, lower levels of Continuing Professional Development and career progression. University Hospitals Dorset NHS Foundation Trust (UHD) Staff Networks impact staff positively across the

	Trust supporting and leading initiatives. New campaigns are aimed at addressing racism and violence and aggression towards staff from colleagues, managers and patients. UHD now has two non-executives from BME backgrounds and, in the wider organisation, UHD has continued to attract more diversity within the workforce. 21.5% of staff now identify from other ethnic backgrounds and more staff confident to disclose Disability has risen to 5.6%. We are becoming comparably more diverse than the population we serve. **Ethnicity / Race.** The percentage of BME staff has risen to 21.5% [up from 18.7% in 2022]. The local demographic when using comparable data from Bournemouth, Christchurch and Poole Council with the WRES mapping tool is 8.67% BME. **Sex.** The trust reported male and female split representation shows a slight increase in male staff headcount. For agenda for change the gender pay gap is closing. **Disability.** The reported declaration for staff who are 'Disabled' has increased to 5.6% in 2023, an increase from the 4.77% reported in 2022. This is a significant increase and largely attributable to our ProAbility Staff Network's engagement. When considering the NHS Staff Survey our reported Disability / long term condition representation is reported to be much higher at 21.3%. **Age.** UHD now has over 2000 staff aged 55 and over. When considering Band 5, 190 are over 55 and a further 30 are over 65. When comparing the age demographic and ethnicity at Band 5 our BME staff are a comparably younger workforce than white staff, however up to the age of 44 there is more parity. **Religion or Belief.** Staff feel comfortable not to disclose their religion. Our chaplaincy service provides multi faith options and are notably an important source of support for our staff and patients. **Sexual Orientation.** A characteristic along with sexual identity which requires greater consideration in relation to how staff identify and choose not to disclose. **Marriage and Civil Partnership**. There was an increase in married staff in 2023 compared to 2022, and civil partnership has also increased. **Pregnancy + Maternity.** The percentage of staff taking parental leave continues to be statistically significant for workforce planning and ward establishment reviews.

Background:	UHD became an organisation during a period of rapid change and adversity during the COVID-19 pandemic and we have continued to monitor our data alongside the lived experiences of all our staff. It is evident from successive annual reports that there has been improvement, however this has not been at pace or consistent with the changing demographic of our workforce. This year's reporting also includes the disparity data, which shows how our staff are represented in progression. Our Equality, Diversity and Inclusion Group (EDIG) is chaired by Pete Papworth (Chief Finance Officer). The group includes representatives from across the organisation, including staff network leads, Governors and patient representatives. Its purpose is to provide the governance and assurance to the People and Culture Committee [PCC] and Trust Board on compliance with statutes and national standards and makes recommendations on specific interventions. This report was presented at the PCC on 9 August 2023 and EDIG on 10 August 2023.
Key Recommendations:	• Review of all EDI action plans so that they are aligned to the new NHS EDI Improvement Plan. • Include named executive sponsors and operational leads with accountability for delivering the plans. • Develop recruitment champions or similarly trained staff that understand protected characteristics to attend interviews. • Remove cost bias from the recruitment process for Disabled candidates and those requiring adjustments. • Implement, monitor and continually review our Anti-Racism and See ME First campaigns.
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
People and Culture Committee	09/08/2023	Noted
Equality, Diversity and Inclusion Group	10/08/2023	Approved.

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

University Hospitals Dorset
NHS Foundation Trust

Equality, Diversity and Inclusion

Annual Report & Workforce Profile

University Hospitals Dorset NHS Foundation Trust

2022 - 2023

We are caring one team listening to understand open and honest always improving inclusive

Contents

Some useful abbreviations:

- BAME - Black, Asian and Minority Ethnic
- BME - Black Minority Ethnic
- EDI - Equality Diversity and inclusion
- EDIG - Equality Diversity and Inclusion Group
- FTSU: Freedom to Speak Up (Guardian)
- HR: Human Resources
- OD: Organisational Development
- PCC: People and Culture Committee
- WRES - Workforce Race Equality Standards
- WDES - Workforce Disability Equality Standards
- ICS – Integrated Care System
- IEN – Internationally Educated Nurse

UHD anti-racism statement

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

27 July 2023

Foreword

University Hospitals Dorset NHS Foundation Trust aspires to embed an inclusive culture where diversity is valued and championed at all levels of the organisation. Through our Trust objectives, values and the EDI Strategy we aim to promote and deliver equality of opportunity, dignity and respect for all our patients, service users, their families' carers and our people. We aim to eliminate discrimination and harassment and reduce health inequalities.

Research shows that organisations with diverse leadership are more successful and innovative. People who feel valued are more likely to be engaged with their work, and diversity at senior levels increases productivity and efficiency in the workplace. When the opportunity arises our board representation will reflect the demographic of our staff and local community as we have a commitment for our board to be representative and matched to our staff ethnicity.

1.0 Introduction

UHD became an organisation during a period of rapid change and adversity. From the COVID-19 pandemic to the present we have continued to monitor our data alongside the lived experiences of all our staff.

We continue our commitment to understanding staff experience and to engage with staff in a way which respects and advances our commitment to the all the Trust Values notably 'We are Inclusive' and 'We Listen to Understand'. There is a valuable richness in the lived experience of members of staff across our hospitals and bringing human stories to the fore and sharing these to the benefit of others remains an important dimension of our EDI work.

Our staff network groups have been instrumental in providing increased feedback to inform the Trust of the need for change to reduce potential organisational barriers.

The EDI strategy was implemented in March 2021. The key priorities agreed in May 2021 were the subject to reporting through our People and Culture Committee. The initial priorities identified for UHD, together with associated actions, were set in order to achieve the maximum positive benefit for our staff and patients.

Throughout this report, we have started to use the phrases ethnically diverse or ethnic background when referring to our Black, Asian and Minority Ethnic staff.

The data label BAME has been used to reflect all ethnic minority categories and only in the context of data. The use of the word minority reinforces the disparities and where possible we have reduced its use to within the data labels only.

This is in line with the NHS Race and Health Observatory report, The Power of Language. As a result of a consultation process in 2021 they have developed five key principles when writing and talking about race and ethnicity:

- Be Specific
- No acronyms or initialisms
- Context
- Transparency
- Adaptability

Additionally, the term BME, Black and Minority Ethnic is often used in reporting templates with NHS England, the interchangeability of these terms is not undertaken to cause offence. It should be recognised that people sit behind the data and we are aware that staff experience varies in our organisation.

We continue to work alongside our partners in the Dorset Integrated Care System (ICS) to ensure our objectives are aligned and are representative of the needs of our workforce and local community. In addition, the ICS has led on the application of the Equality Delivery Service reporting requirements for 2022 to assist Dorset

organisations in terms of consistency of completion. Other collaboration will include leadership and inclusion initiatives.

We are committed to delivering high standards of corporate governance and a key element of this is managing the Trust in a socially responsible way. We are absolutely committed to preventing slavery and human trafficking in our corporate activities and supply chains. We also expect the same high standards which we set for ourselves from those parties with whom we engage, such as our suppliers and those who use our services.

The purpose of this report is to provide an outline profile of our workforce and to sign post readers to other reports within the requirements of the NHS contract and our Public Sector Equality Duty. The desired outcome is that we strive to provide the same experience of working at UHD for all our staff.

Research shows that organisations with diverse leadership are more successful and innovative. People who feel valued are more likely to be engaged with their work, and diversity at senior levels increases productivity and efficiency in the workplace. When the opportunity arises our board representation will reflect the local demographic of our staff in the same way it now reflects the local community as we have a commitment for our board to be representative and matched to our staff ethnicity.

The Messenger Review into Leadership in Health and Social Care by NHS Confederation in June 2022 reinforced the EDI vision for all NHS organisations: -

"EDI embedded and mainstreamed as the responsibility of all regardless of role and especially leaders and managers from front line to board. This must include the practice of zero tolerance of discrimination, but also greater awareness of the realities in the workplace for those with protected characteristics."

UHD has over 9700 staff serving a population base of 400,300 and in 2011, 84.8% were White British, now reduced to 82.4% [*Census: 2021 ONS*]. We will continue to monitor our data alongside the lived experiences of all our staff. It is worth noting that using the WRES mapping tool and local data obtained from Bournemouth, Poole and Christchurch Council that 8.67% of the local population identified as BME.

We continue our commitment to understanding staff experience and to engage with staff in a way which respects and advances our commitment to the Trust Value of 'We Listening to Understand'.

2.0 Public Sector Duty

The Public Sector Equality Duty (PSED) sets out the main statutory duty that all public authorities must, in the exercise of their functions, have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation
- advance equality of opportunity
- foster good relations.

Specific duties to publish information

Public authorities are required to publish information annually on how they are complying with the equality duty. It is recommended that NHS authorities publish their PSED reports in quarter one of each new financial year, reporting on outcomes from data in the previous financial year. For UHD the reporting period is from 1 April 2022 to 31 March 2023.

Prepare and publish equality objectives

These should be clearly defined, measurable commitments, agreed with the governing body. They should be kept under review and must be updated at least once every four years. Developing an action plan can help map activities to achieve each objective, but there is no requirement to do so. Working in partnership with trade unions to develop and monitor action plans that include clear timescales can support progress towards objectives. It is good practice to publish information on progress towards meeting each equality objective.

The benefits of publishing PSED information

- It provides a focus on what the current issues are, helping organisations to become more attuned to the needs of different groups.

- Determines and demonstrates what organisations are already doing and what it is planning to do.

- Promotes transparency and increases accountability.

- Can be used as a resource for decision making within the organisation.

- In England, all NHS organisations should publish their public sector equality duty information within one year of their last publication, the previous report for UHD was published October 2022 following acceptance at Trust Board.

2.1 Equality Diversity and Inclusion [EDI] Strategy & Group

The Equality, Diversity and Inclusion Group (EDIG) is chaired by Pete Papworth (Chief Finance Officer) and includes representatives from across the organisation, including staff network leads, Governors and patient representatives.

Its purpose is to provide the governance and assurance to the People and Culture Committee and Trust Board on compliance with statutes and national standards and makes recommendations on specific interventions.

Membership comprises multi-disciplinary staff occupations and patient representative/s, external key stakeholders and partners are invited to join group meetings.

The Equality, Diversity and Inclusion Strategy is published on the UHD external website. It contains strategic objectives with measurable outcomes and goals, aligned to the organisational vision, mission and values.

2.1.1 Audit

At the time of writing this report, the EDI workstream was undergoing a follow up audit to determine the maturity and progression of Equality, Diversity and Inclusion at UHD.

2.2 Equality Objectives

To manage and support the progression of this work, an EDI Priorities Action Plan was developed which presented the work streams identified in the strategy aligned to trust objectives. This also included the actions from the NHS People Plan, the Trust Organisational Development (OD) Plan and the March 2021 Audit Report.

The specific targets in place will be re-evaluated following the identification of further areas of activity and all will be data tracked so that improvements made can be noted and advanced further. The equality objectives within the EDI Strategy are:

- Improve employee experience
- Develop inclusive leadership capability
- Increase equal opportunities for career development
- Enhance staff network engagement
- Improve collection and use of all EDI data and compliance against national standards
- Develop patient co-production and engagement to reduce health inequalities

2.3 Equality & Diversity Delivery System 2022

Implementation of the Equality Delivery System (EDS) is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the

implementation of EDS in accordance EDS guidance documents. The documents can be found at: www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/eds/

The EDS is an improvement tool for patients, staff and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement and insight.

The EDS Report is a template which is designed to give an overview of the organisation's most recent EDS implementation and grade. This was undertaken in partnership across the Dorset Integrated Care System. The report was submitted via england.eandhi@nhs.net and has been published on the UHD external website Link

The Domains reported during the transitional period are:

- Domain 1. Commissioned or provided services [maternity]
- Domain 2. Workforce Health and Wellbeing
- Domain 3. Inclusive Leadership

The rating reported as of March 2023 for UHD is developing shown in Table 2.1.

EDS Organisation Rating (overall rating): 17 – Developing
Organisation name(s): University Hospitals Dorset
Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped** Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing** Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving** Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

Table 2.1 EDS Organisation Rating

2.4 Workforce Race Equality Standard (WRES) (reported in 2022)

The NHS Workforce Race Equality Standard (WRES) was introduced in 2016 to address the inequalities and less positive lived experience of our ethnically diverse workforce. This is the seventh year of reporting on the WRES and the second for University Hospitals Dorset (UHD).

It is evident from the national, regional and local data that that there has been some improvement, but this has not been at pace or consistent across the NHS systems. This year's reporting includes the disparity data, which shows how our staff are represented in progression through the seniority ranks.

The workforce sample has increased to over 9,700.

The number of ethnically diverse staff has increased to 21.5% of the total workforce.

All Ethnicity declarations remain high and are now above 97%.

2.4.1 Recruitment

WRES Indicator 2 suggests that the likelihood of BME candidates when compared to white candidates of being appointed from shortlisting is now 1.90, this moved positively from 2.09 in 2022, however it sems a long way from the 1.26 in 2021.

2.4.2 Continuous Professional Development

WRES Indicator 4 suggests that the likelihood of BME staff compared to white staff of accessing non-mandatory training and CPD is now 0.90, this moved positively from 0.79 in 2022 however it remains lower than the reported 1.11 in 2021.

2.4.3 Progression

WRES Indicator 7 shows the percentage of BME staff who consider the trust provides equal opportunities for career progression or promotion in 2023 is 45.7% compared to 60.1% of white staff. This is comparable to 2022 but both groups are significantly lower than in 2021.

- The white ethnicity staff group (WME) has decreased slightly to 692 (7.2%) (Pg. 42);
- The relative likelihood of ethnic diverse staff being appointed from shortlisting across all posts has improved to 1:1.90. This means for every member of staff from an ethnic background approximately 2 members of white candidates are appointed;
- The bullying and harassment metrics show some worsening and stagnation;
- Indicator 7 shows a significant drop in staff believing the trust provides equal opportunities for both ethnic diverse and white staff. This is in line with the trend nationally of a decrease in positive results for this metric;
- The Board membership shows under-representation at the most senior level. This will improve in 2024 with the appointment of a second Non-Executive from a BME background on the 1st April 2023;
- Our workforce from an ethnic background continue to report fewer positive experiences in our staff survey and this is also reflected in data from our Freedom to Speak Up Guardian (Appendix B);

- The disparity ratios presented in the WRES report show a continuing trend of inequity in progression for our ethnically diverse staff from the lower to upper bandings in both clinical and non-clinical roles. (Appendix A).

2.5 Workforce Disability Equality Standard (WDES) reported in 2022

The Workforce Disability Equality Standard (WDES) was launched in 2019:

'The Workforce Disability Equality Standard (WDES) remains the only example in the UK where employers are mandated to report and publish annual data on the workplace and career experiences of Disabled staff. Our ambition is to increase the representation of Disabled people in the NHS workforce and see the disparities between Disabled and non-disabled staff reduce year on year; supported by an inclusive culture through the realisation of the vision set out in the People Promise'.

1 Extract from the national Workforce Disability Equality Standard report 2021, published in March 2022, by Professor Em Wilkinson-Brice, Acting Chief People Officer.

The declaration has increased to 5.6% of the workforce, notably the Executive Team have 100% declaration.

For UHD part of the recommendations in the WDES report will include the need to have an increased focus in this area of understanding and intervention. For an example the workforce profile shows many areas with an ageing demographic, so it is vitally important for the maturity of the EDI agenda at UHD that we raise the profile of this complex area of need.

- The data shows a small improvement on our declaration rate to 5.6% (national target by NHSE is 4%).
- The honesty gap is 15.72% between our staff records declaration and the staff survey responses of 21.3%.
- The likelihood of Disabled staff being appointed from shortlisting has improved to 1.24. This means a higher percentage of non-Disabled staff are appointed from shortlisting at a ratio of 1:1.24.
- The reports of bullying and harassment by Disabled staff show an increase for metrics 4b, 4c and 4d and a small reduction for 4a.
- There is a small decrease in Disabled staff believing the trust offers equal opportunities and this is also reflected as a decrease for non-Disabled staff.
- The reported presenteeism for Disabled staff compared to Non-Disabled staff has worsened, increasing to 9.2% in 2022 compared to 8.1% in 2021.
- The percentage of Disabled staff saying that their employer has made adequate adjustments remains at 78%.
- The relative likelihood of Disabled staff entering the formal capability process compared to non-Disabled staff is showing at 3.03. This means for every

member of non-Disabled staff 3 Disabled staff enter the formal capability process. Of note is the fact that no capability processes were on the grounds of ill health.

2.6 Gender Pay Report published March 2023

The Trust reported on snapshot data as at 31 March 2022. This data demonstrates that there could be greater female representation in senior clinical roles. Similarly, the Trust acknowledges that there could be greater male representation in less senior clinical and non-clinical roles.

The effectiveness of actions in place to reduce the gender pay gap will not be evident until at least the next gender pay gap publication.
Separating the data for Agenda for Change and the Medical / Dental workforce gives a better understanding of the difference in pay and gender representation.

Comparing the median hourly pay gap, women earn 95p for every £1 that men earn. Their median hourly pay is also 5.33% lower than men's.

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. The median hourly pay for women was reported to be 6.6% lower than men.

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). Link to published report.

Next Steps

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. Recruitment actions include more diverse recruitment panels for senior vacancies.

We will also further develop and raise the profile of the UHD Women's network.

3.0 Leadership Development

The UHD Talent Management strategy is currently being developed with a commitment that invests in our people and is inclusive for our entire workforce. We aspire to develop this approach in line with our UHD values, supporting a culture of continuous improvement.

We will support all staff to have in-depth career development conversations and annual appraisals, supported by our current involvement piloting *Scope for Growth*, a national career conversation framework which is holistic and inclusive, recognising that every individual's career development is different. We want to support our staff in appreciating and valuing difference in attracting, developing and retaining our diverse workforce.

Throughout our approach, we aim to sustain and embed a focus on equality, diversity and inclusion. Leadership development is key to this and we will work to ensure that our staff are equipped with fundamental leadership skills and have the confidence and capability to support and develop the talent of others, while also being able to perform in a leadership role themselves. A systematic talent management approach which unlocks leadership potential among our staff will ensure that we can be more sustainable in the development of leaders at all levels of our organisation.

Our Leadership Way

We have 5 principles that are aligned to our Trust values:

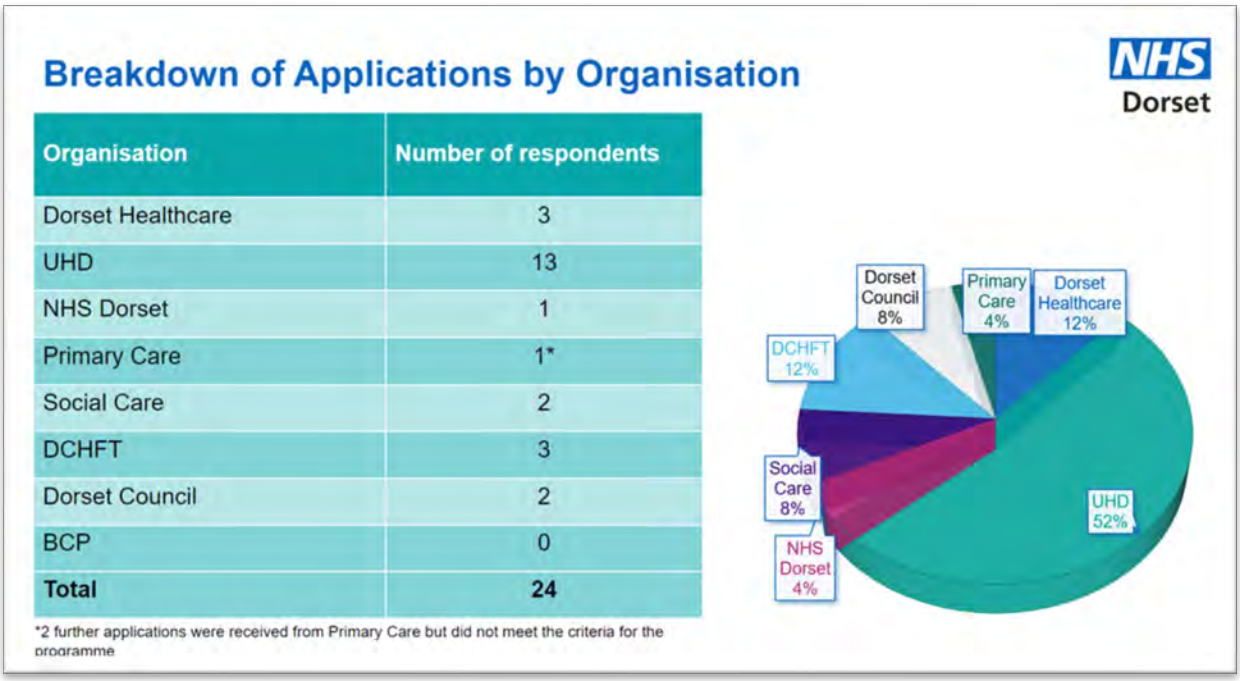
- We will support our staff to be inclusive, compassionate leaders at the heart of UHD
- Our leaders will strive for excellence and look for continuous improvement
- A coaching culture will be part of everything we do.
- We promote lifelong learning
- Our leaders are role models

At UHD, inclusive leadership means our leaders have the courage to take conscious steps to break down barriers for people at risk of being excluded from society.
Inclusive leaders embody a leadership approach that appreciates diversity, invites and welcomes everyone's individual contribution, and encourages full engagement.
Our internal programmes include:

- **Leadership Fundamentals** (across 4 cohorts of 85 delegates) 34.1% BAME / Other / European
- **Leadership in Action** (across 2 cohorts of 32 delegates) 9.4% BAME / Other / European

Beyond Difference: Dorset Integrated Care System [ICS]

The *Beyond Difference* Leadership Programme was developed with our Dorset ICS colleagues to provide minority ethnic staff an opportunity and the confidence to actively participate in mainstream leadership programmes. UHD represented 13 of the 24 places available, this was in part due to the support provided through our Organisational Development EDI leads.



Breakdown of Applications by Organisation

NHS Dorset

Organisation	Number of respondents
Dorset Healthcare	3
UHD	13
NHS Dorset	1
Primary Care	1*
Social Care	2
DCHFT	3
Dorset Council	2
BCP	0
Total	**24**

*2 further applications were received from Primary Care but did not meet the criteria for the programme

4.0 University Dorset NHS Foundation Trust Membership

As a Foundation Trust, we are accountable to NHS England. As the regulator for health services in England it oversees the governance and performance of the organisation, providing support where required, and ensures the Trust operates in line with the conditions of its provider licence.

We are also accountable to local people through our Council of Governors and members. In addition, there is a large range of inspection and other regulatory bodies which govern the activities of the Trust, including the Care Quality Commission (CQC). The Council of Governors, which represents around 15,000 members, is made up of members of the public, staff and appointed governors. They ensure members' views are heard and are fed back to our Board of Directors, and members of the public are kept up to date with developments within the hospitals.

Our Board of Directors is made up of full-time executives, who are responsible for the day-to-day running of the organisation, and part-time non-executive Directors. The Executive Directors work closely with the clinical leaders and managers throughout the hospitals in running the services. The Board also works closely with the Council of Governors. The Trust is organised under three clinical care groups and departments providing support services.

We also work closely with a range of key health and social care partners to develop and deliver our services, such as clinical commissioning groups (CCGs) and social services. We are also part of the Dorset Integrated Care System (ICS).

Public constituency	**Number of members**	**Eligible membership**
Age (years):		
0-16	17	112,132
17-21	66	34,607
22+	14,393	488,573
Ethnicity:		
White	13,390	579,773
Mixed	106	22,452
Asian or Asian British	203	12,709
Black or Black British	40	6,823
Other	34	11,058
Socio-economic groupings*:		
AB	4,624	62,934
C1	4,306	89,392
C2	2,826	65,065
DE	2,722	66,241
Gender analysis		
Male	5,314	315,075
Female	8,986	320,236

The membership data presented excludes:

- 27 public members with no dates of birth, 730 members with no stated ethnicity and 203 members with no gender
- 0 patient members with no dates of birth

Public constituency	**2022/2023**
At year start (April 1)	14,810
New members	155
Members leaving	462
At year end (March 31)	14,503

At the time of collating the data for this report there were 14640 members at 31/3/2022.

5.0 Freedom to Speak Up

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.

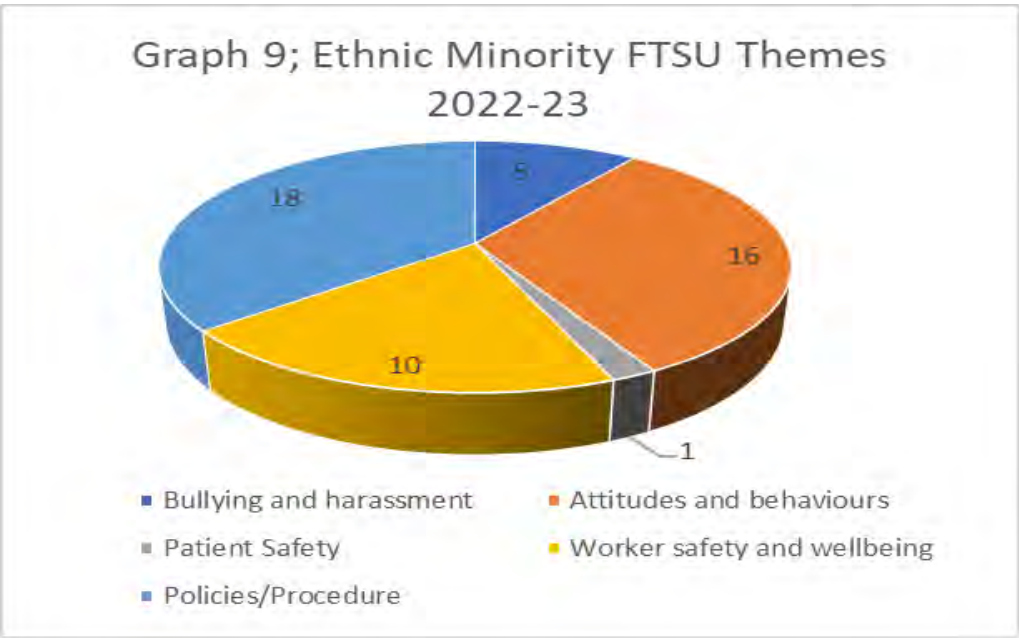
Speaking up benefits everyone. Building a more open culture in which leadership encourages learning and improvement, leads to safer care and improved patient experience. At UHD, we have many routes that our people can use to speak up including our line managers, occupational health, staff governors, 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.

In the period leading to the report, eighteen per cent of staff (50 staff) raised a concern from an ethnic minority background. All staff were signposted to our BAME network who was also able to support and advise. The FTSUG is an integral member of the Equality, Diversity and Inclusion Group 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.



UHD continues to be an active contributor to the work from the National Guardians Office. 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 5.1 below shows how staff at UHD use this service as compared to surrounding healthcare.

Table 5.1: 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.

- 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 National NHS 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.

- 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.

6.0 Voice of our Staff Networks

Our Staff Networks are recognised at a national level and have been used as case study for other organisations. Throughout 2022/23 there have been development training sessions and Community of Practice meetings for the network leads on a regular basis. Staff Network members are invited to attend as an Equality Diversity and Inclusion expert person during interviews for senior leaders and board members.

Staff Networks in the NHS foster a sense of belonging, promote diversity and create supportive communities for employees with shared identities and experiences. These networks facilitate peer support, mentoring and knowledge exchange, contributing to a more inclusive, engaged and empowered workforce ultimately enhancing patient care.

The UHD Staff Networks have agreed Terms of Reference, board level sponsorship and leads have 15 hours paid work hours to facilitate the smooth run of Network activities. The staff network groups have been instrumental in providing increased feedback to inform the Trust of the need for change to reduce potential organisational barriers.

6.1 The Armed Forces Support Group

Sponsor: Abigail Daughters, Care Group Leader

The Armed Forces Support Group (AFSG) continues to meet monthly and is a great place for support for the Armed Forces Community within UHD.

The Armed Forces Community Advocate is Rob Hornby, over the last 12 months he has received some very positive feedback from stake holders, patients, staff and Family members of the Armed Forces Community (AFC). A very good foundation has been put in place to deliver a successful service for the Armed Forces Community within UHD.

The AFCA has made regular referrals to numerous supporting agencies, both locally and nationally as well as assisting members of the AFC with such matters as homelessness, welfare support, home de-cluttering and substance misuse. There have been requests from staff who are members of the AFC around what support is available for serving personnel's spouse whilst they are on tour.

Spreading the word

The AFCA has given a number of presentations over the last few months to a number of different organisation including, 'We Are With you' (Substance misuse) and to The Dorset Armed Forces network meeting which was held at Hamworthy Camp and included representatives from a number of local military units, local supporting agencies.

This was a very well supported event and it is hoped that there will be more of them in the future. Along with this, the AFA is an active member of the Dorset Armed Forces Covenant programs who have a 5 year strategic plan to improve the care and support the local Armed Forces Community and was able to attend the resent Dorset Armed Forces Covenant Conference at the Bovington Tank Museum.

Introduction of Welfare and Information Packs

The introduction of the UHD veteran's welfare pack was well received and appreciated by all who received them. The need for this project became apparent when several of the older generation of veterans were being admitted without any basic commodities.

Reservist Recruitment

243 Field Hospital continue to hold their regular recruitment days at two of UHD locations, Poole and Royal Bournemouth Hospitals. Both locations are getting plenty of encouraging enquiries and paternal recruits, keeping Sgt Eastman busy.

UHD actively supported Armed Forces Week; Being present at the two recruitment days held across the Trust as well as having a stand Royal Bournemouth Hospital Atrium raising the profile of the Armed Forces within the trust as well as reminding all staff of the Armed Forces Support Group.

UHD Reservist Policy

The AFCA has now ensured that the Trust has in place a new UHD Reservist Policy. This policy outlines the procedure for managing reservist staff members as well as Cadet Force Adult Volunteers.

6.2 Women's Network

Executive sponsor: Siobhan Harrington, Chief Executive

The Women's network was launched in June 2022 with terms of reference in place. Samantha Murray and Jasmine Sharland are co-leads. The Women's Network have done significant works to create awareness and improve women's health issues and their impact in workplace.

In October 2022 the network held its first event to promote baby loss awareness week with various local women wellbeing stands.

The network is introducing the Employer with heart policy with Human Resources. A Period poverty project provides free sanitary products to staff in all unisex and female facilities. Sanitary waste facilities have been audited, and work has begun to install more bins.

In March 2023 we celebrated International Women's Day 2023. The network hosted an in-person event to celebrate with a line-up of inspirational women speakers.

6.3 European Network

Executive Sponsor: Richard Renaut, Chief Strategy and Transformation Officer

The network has continued to offer support to European nationals following Brexit and the EU Settlement Scheme. The network has raised the profile of the European workforce as a significant number in the workforce.

The network would welcome an increase membership from across the Trust as we move forward following Brexit, our European colleagues are vital to the sustainability of the hospital.

6.4 BAME Network

Executive Sponsors: Peter Gill, Chief Informatics and IT Officer, Paula Shobbrook, Chief Nursing Officer

The BAME network has become increasingly more strategic in its approach to Trust issues and holds monthly network meetings that continue to listen and act on the experiences of staff. As a result of the WRES in 2022 and the reported lived experiences of staff, the BAME network has raised the need for an organisational increase in focus on anti-racism.

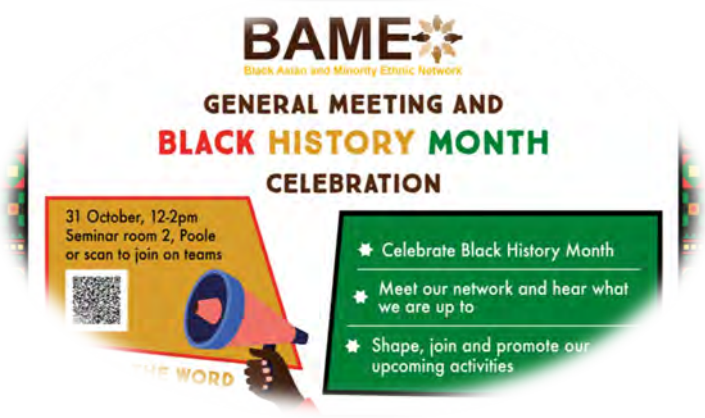
During Black History Month in 2022 the network supported a visit from Yvonne Coghill, Director of Workforce Race Equality at NHSI who led a discussion on some of the challenges and opportunities for improvement. A summary of the feedback from the focus group can be found in appendix 2 on page 62, many points raised by the staff are being taken forward.

The network was instrumental in supporting the Cultural Day on 7th July 2023 and have initiated engagement conversations in relation to the adoption of See ME First.

Personal Objectives for all staff and managers should now include an EDI objective a step supported at the most senior level of the organisation. The network also supports grievances cases and signposting to other services.

The BAME network are currently involved in the Lived Expert by Experience group for the South West where we have contributed to the South West action plan for Global Majority staff. This has now been submitted to NHS England.

There is a strong correlation reported by NHS England that staff networks are instrumental to the improvement of patient care.



Additional photos: Appendix 2

6.5 International Doctors Network

Lead: Dr Muhammad Asad

At present almost one in four postgraduate doctors in training working at UHD are international medical graduates. The International Doctors staff network was created in 2022 after introducing a survey considering racism in medicine that showed there was not enough support available for international medical graduates.

Since its creation the network has worked with the other staff networks. Postgraduate doctors in training are now able to discuss their concerns with full confidentiality to either the staff network lead or they are signposted to the Freedom to Speak Up Guardian.

The network has introduced regular education and training sessions – 'New to NHS and UHD,' with the help of the education department team, which are attended by the international medical graduate doctors, and we have excellent feedback.

The network promoted the use of LERN forms to report incidents like racial discrimination, incivility and behaviour related issues that are unfortunately experienced by some of the international medical graduates.

The network worked with the EDI Lead and other staff networks during antibullying week and race equality week this year. They aspire to influence a safe, inclusive and fair work environment at UHD.

6.6 Pride Network (Formerly Lesbian, Gay, Bisexual, Transgender, Questioning+)

Executive sponsor: Peter Papworth, Chief Finance Officer

The LGBTQ+ Network is now the UHD Pride Network with a new logo. A co-lead, Alice Girling and a deputy co-lead, Reuben Smith have been appointed. They have produced updated PRIDE lanyards and pronoun badges which have been designed and ordered to include the intersex progress flag elements.

UHD was awarded the Bronze award through the Rainbow project for support for both LGBTQ+ staff and patients. An action plan is underway including further work on policies and procedures. In addition, the PRIDE network group is partnering with Estates to review the inclusiveness of the toilets at UHD, including in the BEACH building. In July, the UHD Pride Network partner with other local NHS organisations to celebrate the NHS at the Bournemouth PRIDE event in July.

The UHD Pride Network has published a three-year strategy with the mission to become the most inclusive Trust in England.

The PRIDE network is focusing on three pillars of excellence; Governance, Patients and People, and it aligns with the recommendations from the Rainbow Badge Phase 2 assessment. The work has been awarded Bronze accreditation for the Trust and are in the process of creating a clear action plan for achieving Silver accreditation. A key achievement in Quarter 1 is the updated Gender Reassignment Policy.

The Network created a strategic working group and launched the newly improved lanyards and Pride Pledges in July, with a Trust wide event planned for Quarter 3. The Trust's library service had agreed to be the central point for making pledges and collecting new lanyards.

The Pride Magazine continues to receive positive feedback and is reaching people across the organisation. Pride are looking at updating their intranet presence and creating a Pride Network Padlet.

Pride have joined forces with other NHS partners across Dorset and have a prominent position in the Bourne Free Pride Parade on 8th July. They had an open top bus and a new walking banner inscribed with the slogan: Safe to be me at UHD.

6.7 ProAbility (supporting staff with long term medical conditions / Disability)

Executive sponsors: Peter Gill, Chief Informatics and IT Officer, Karen Allman, Chief People Officer

The ProAbility Network continues to support the recruitment, training, career development and promotion of disabled persons/employees.

The Trust holds ‘Disability Confident’ accreditation. It takes positive and proactive steps to maintain continued employment, provide training, and foster career development and promotion for disabled members of staff.

The Trust reports on the ’Workforce Disability Equality Standard’ (WDES on an annual basis. This national reporting standard includes providing statistics which demonstrate a proportionate comparison between disabled and non-disabled members of staff in relation to their experience at work and opportunities. This data will enable a gap analysis to be conducted and the development of a targeted action plan in conjunction with the ProAbility staff network.

The network aims to listen, understand and support people living and working with physical disabilities and long-term health conditions holding regular listening events. The network is working closely with the HR department to understand the reasons for low declaration rates of disabilities and how this can be improved.

The Trust recognises there is a strong business case for adopting a positive approach to supporting and developing disabled staff both in terms of acquiring and maintaining valuable workplace skills. Developing a culture where both staff and patients can flourish is simply the right thing to do. It is the responsibility of the People Directorate team to maintain up-to-date policies, taking into consideration revised employment law.

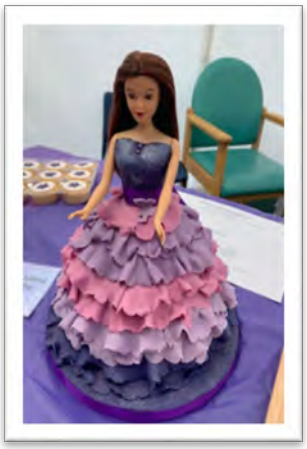
The network has recognised the need to support employees with neurodiversity in the workplace and the services of Lexxic experts in psychological support were sought to provide introductory training and support the development of a suggested action plan and the recommendations are being introduced into our workstreams.

Deaf Awareness week in May was celebrated together with the ongoing promotion of British Sign Language training. In addition, the Network championed red hearing aid boxes for use by patients to safeguard against loss of their devices with associated distress and cost.

ProAbility at a glance

- 3 December celebration – Purple Light Up – we held a ‘Purple Pro Ability Bake off’ competition in the Marquee on Friday 2 December – we also invited lots of health and wellbeing contacts. Fantastic competition entries. We started the day with a special ‘Friday Five Mins of Fun’
- Promotion of Neurodiversity – invited guest speaker Rachel Noes ‘The Pink Vicar’
- Network leads engaged in regional and national Disability networks and NHS employers Disability Pioneer group

- One of the Co Leads, attended first national NHS Employers meeting for deaf NHS staff in Leeds
- Continuous promotion of Trust Health Passports for employees
- Network members invited to speak about network at various department meetings and Inductions
- Supported other regional Trusts and ICS to set up their own Disability staff networks
- Involved in deaf awareness presentations to various department
- Involved in interview panel for non-Exec Director and other senior posts
- Gave Hospital Radio interview about deaf awareness
- HR personnel was involved to discuss ‘uploading Disability onto ESR’



Purple Light Up 2022

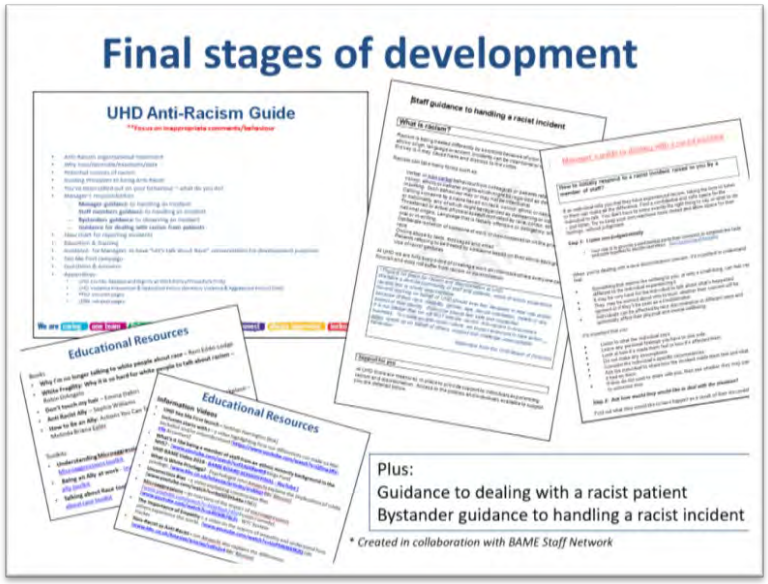
In December, Purple Light Up Day was celebrated by the Network within UHD to recognise the contributions of disabled employees.

7.0 UHD Anti-Racism and See ME First

The Anti-Racism Plan was discussed at Executive Board on 23rd August 2023, the plan will introduce a Trust Board Anti-Racism statement (page 3) as the catalyst to a multi-layered and staged campaign that is envisaged will drive a culture of speaking up and challenging inappropriate behaviour notably, racism. Without challenge, racism can sit quietly behind structures, damaging everyone affected including the negative impact on patient care. See ME First was launched in June 2023.

The target operating model is aimed at building momentum and taking everyone with us on the journey.

The guidance and workshops are in the final stages of development.



See ME First

What is See ME First?

See ME First is a staff-led initiative to promote equality, diversity and inclusivity. It requires colleagues to challenge and work together towards ending racism and discrimination in the workplace.

The aim is to make real change to our culture, creating a more inclusive, open, and non-judgemental work environment in which all staff are treated with dignity and respect.

Will you pledge to support any colleagues that experience discrimination? Fill out this form and pledge to encourage colleagues to speak up and safely challenge discriminatory behaviour through the appropriate channels. You will receive a See Me First badge to signify you have made this commitment and ensure your support is visible to colleagues.

Why is it important?

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

Why wear a See ME First badge?

- You are making a visible commitment to actively create an open, non-judgemental and inclusive culture at UHD by ensuring your BAME colleagues are treated with dignity and respect
- You are signifying that you uphold UHD's values of being inclusive, caring, one team, listening to understand, open and honest, and always improving.
- You are signifying that colleagues can come to you for support and advice on how to safely challenge discriminatory behaviour.

What can you do to make a positive difference?

Make yourself visible as a member of staff who will listen to colleagues who have been subjected to discrimination or need advice and information.

Encourage your colleagues to speak up safely through the appropriate channels if they have experienced discrimination. Direct them to the pink LERN form, Freedom To Speak Up, their line manager or UHD's equality, diversity and inclusion lead (**deepa.pappu@uhd.nhs.uk**).

Listen **Speak up** **Support** **Challenge**

Signpost colleagues to the support available to them (BAME network, Human Resources and Trade Union representatives) as well as wellbeing support including Psychological Support and Counselling service, Mental Health First Aiders and Trauma Risk Management.

Be a visible and active ally; if you see racism, challenge it.

Make your pledge here:

See ME First

8.0 Charters and Partners

UHD champions many charters and agreements with external organisations, we want UHD to be seen to be a safe and inclusive place to work and receive care, some of our charters include:

Armed Forces Covenant

The Armed Forces Covenant is a pledge to acknowledge and understand the needs of the Armed Forces community and aims to build a more open and honest relationship between employers, the Ministry of Defence and reservists. UHD has recently been awarded the Gold Award – demonstrating Rob Hornby's impact!!!

Veteran Aware – silver status

Veteran Aware trusts are leading the way in improving veterans' care within the NHS, as part of the Veterans Covenant Healthcare Alliance (VCHA).

Hate Crime Charter

There is no place, excuse or reason for hate crime in UHD. A hate crime is subjecting people to harassment, victimisation, intimidation or abuse because of their ethnicity, faith, religion, Disability or because they are lesbian, gay, bisexual or transgender this includes "Any incident, which constitutes a criminal offence, which is perceived by the victim or any other person as being motivated by prejudice or hate."

Disability Confident Employer

Disability Confident is creating a movement of change, encouraging employers to think differently about Disability and take action to improve how they recruit, retain and develop Disabled people. Being Disability Confident is a unique opportunity to lead the way in your community, and you might just discover someone your business cannot do without.

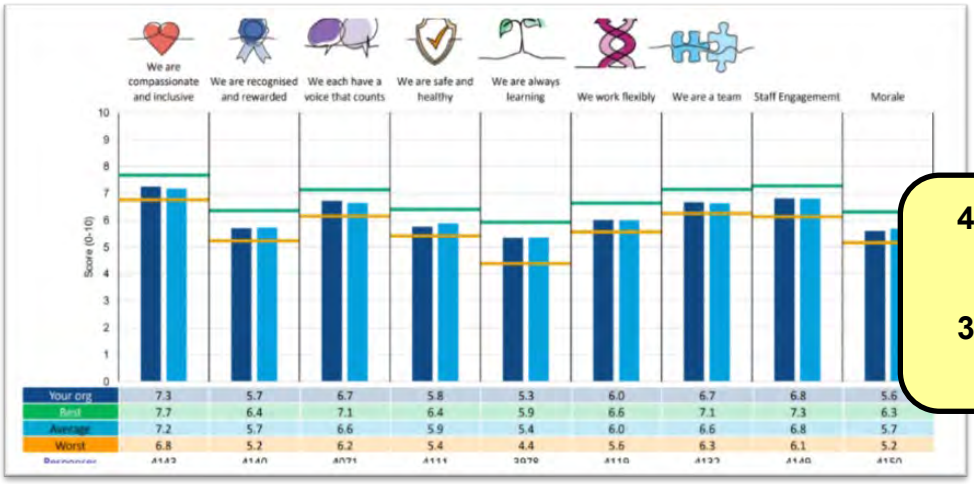
Stonewall Diversity Champion

UHD aims to ensure all staff and patients feel welcome, notably our staff should feel respected and represented at work. Inclusion drives better individual, business and patient outcomes. When LGBTQ+ staff feel free to be themselves, everybody benefits.

Mindful Employer

Being a mindful employer demonstrates the UHD commitment to working toward achieving better mental health at work.

9.0 NHS Staff Survey 2022



4167 responses in 2022 compared to 3393 responses in 2021

The National Staff Survey 2022 is UHD's second year of comparative data, structured around the 7 NHS People Promise pledges and 2 Themes [Staff Engagement and Morale].

The 2022 key findings include:

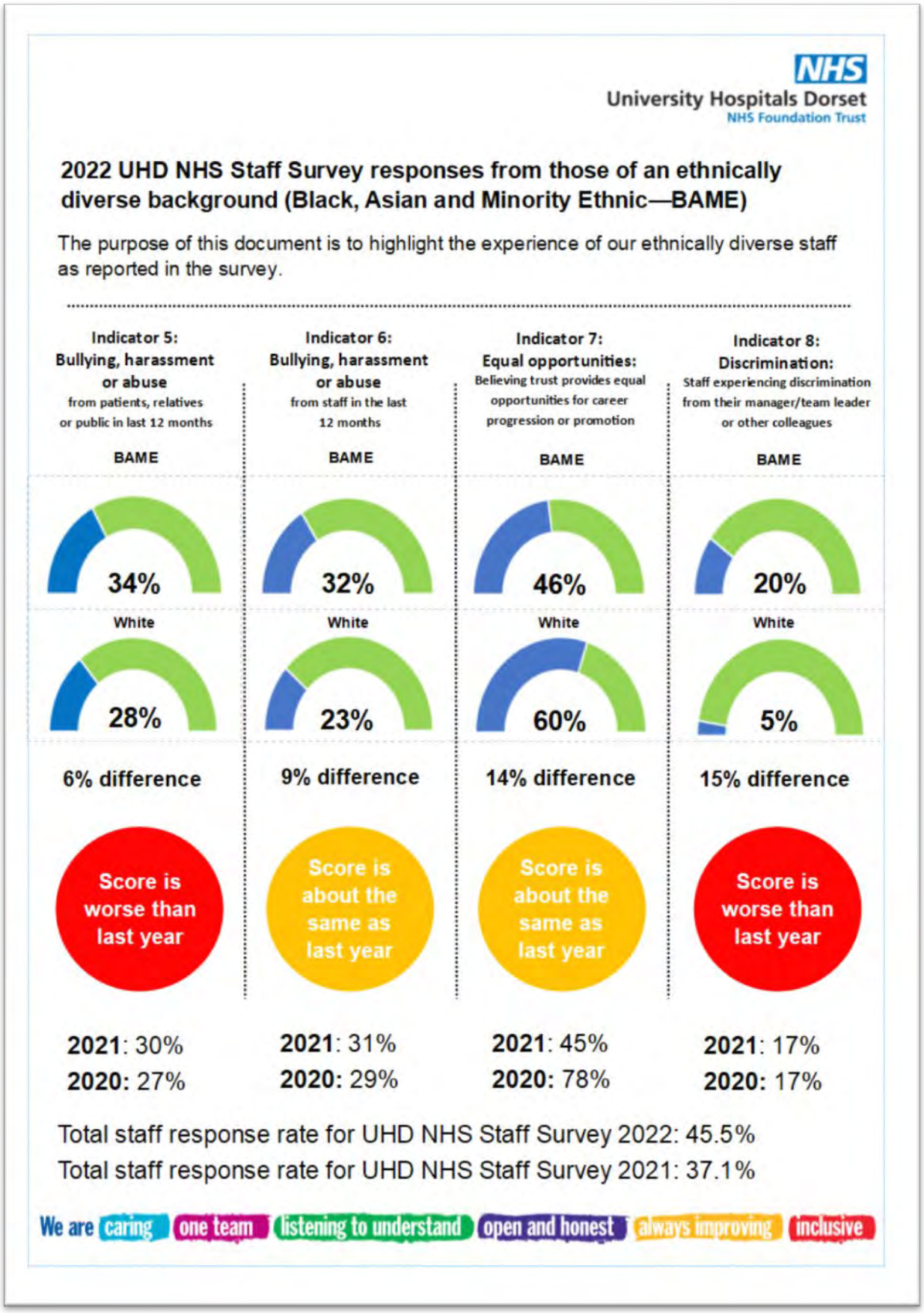
- highest response rate to date of 45.5% (up from 37.1% in 2021 and above the national average)
- Engagement score is 6.8 out of 10 and Morale 5.6 out of 10. This is in line with the sector comparator and stable compared to last year
- a key finding is that there is great variation at team level in the questions that make up the Engagement score
- staff have told us we need to prioritise safe staffing, call out and report incidents of harassment and bullying, be mindful of people experiencing work related stress and support colleagues who may be feeling burnt out.
- score for inclusion and compassionate leadership was 7.3 our best score in relation to the People Plan Pledges.

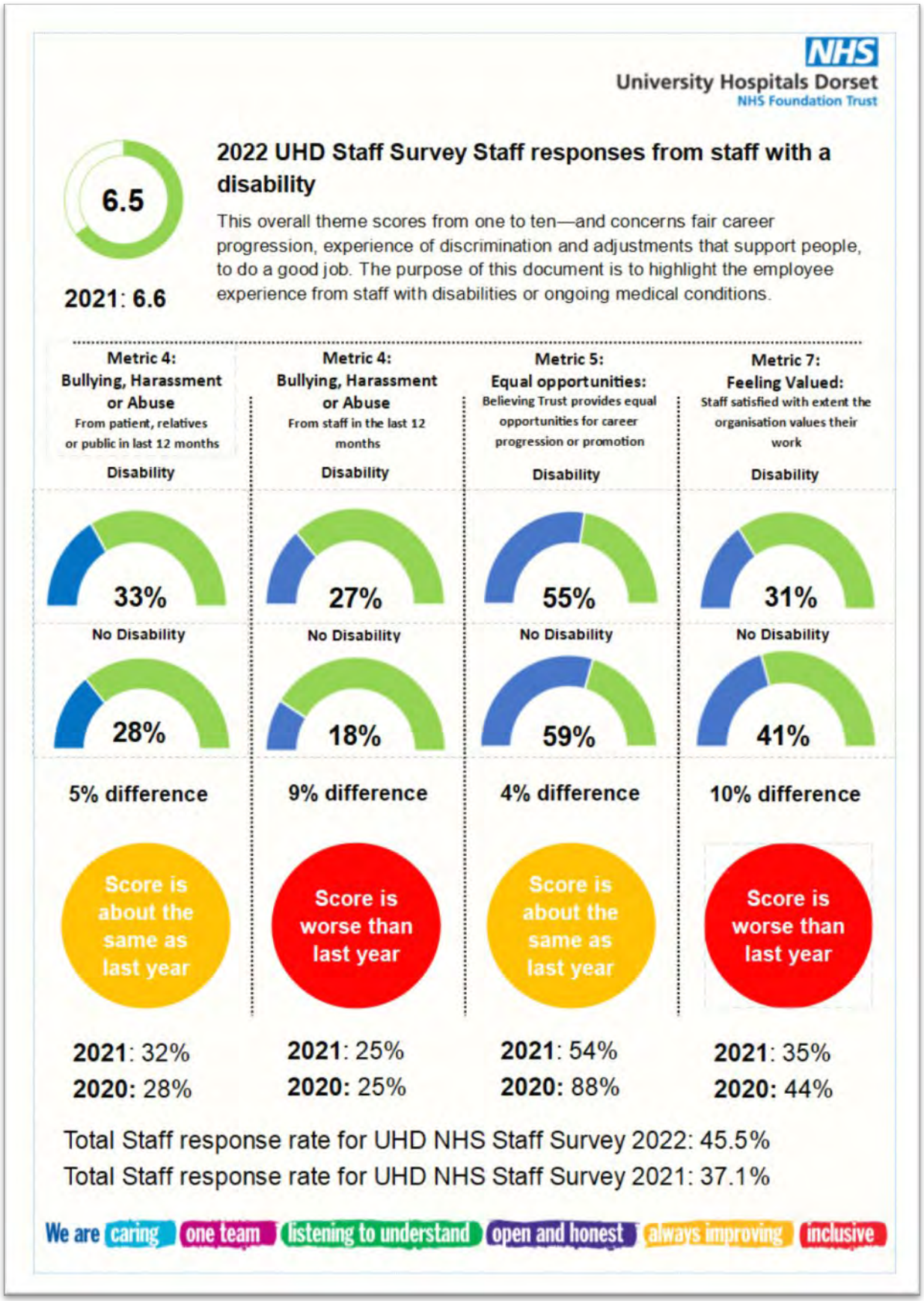
Participation is an important element not only for the wider organisation but specifically in the WRES and WDES reporting, the position remains challenging as staff experience working in UHD differently.

The local information for teams now includes 127 teams that have individual heatmaps to aid local action planning this included 48 wards.

The full reports are available through the NHS Staff Survey Internet page, https://www.nhsstaffsurveys.com/.

The WRES and WDES infographics on page 33 and 34 show we have a lot to do to improve the lived experience of all our staff.


NHS
University Hospitals Dorset
NHS Foundation Trust
2022 UHD NHS Staff Survey responses from those of an ethnically diverse background (Black, Asian and Minority Ethnic—BAME)
The purpose of this document is to highlight the experience of our ethnically diverse staff as reported in the survey.
Indicator 5: Bullying, harassment or abuse from patients, relatives or public in last 12 months
Indicator 6: Bullying, harassment or abuse from staff in the last 12 months
Indicator 7: Equal opportunities: Believing trust provides equal opportunities for career progression or promotion
Indicator 8: Discrimination: Staff experiencing discrimination from their manager/team leader or other colleagues
BAME
34%
32%
46%
20%
White
28%
23%
60%
5%
6% difference
9% difference
14% difference
15% difference
Score is worse than last year
Score is about the same as last year
Score is about the same as last year
Score is worse than last year
2021: 30%
2020: 27%
2021: 31%
2020: 29%
2021: 45%
2020: 78%
2021: 17%
2020: 17%
Total staff response rate for UHD NHS Staff Survey 2022: 45.5%
Total staff response rate for UHD NHS Staff Survey 2021: 37.1%
We are caring one team listening to understand open and honest always improving inclusive


NHS
University Hospitals Dorset
NHS Foundation Trust
6.5
2021: 6.6
2022 UHD Staff Survey Staff responses from staff with a disability
This overall theme scores from one to ten—and concerns fair career progression, experience of discrimination and adjustments that support people, to do a good job. The purpose of this document is to highlight the employee experience from staff with disabilities or ongoing medical conditions.
Metric 4: Bullying, Harassment or Abuse From patient, relatives or public in last 12 months
Metric 4: Bullying, Harassment or Abuse From staff in the last 12 months
Metric 5: Equal opportunities: Believing Trust provides equal opportunities for career progression or promotion
Metric 7: Feeling Valued: Staff satisfied with extent the organisation values their work
Disability
33%
27%
55%
31%
No Disability
28%
18%
59%
41%
5% difference
9% difference
4% difference
10% difference
Score is about the same as last year
Score is worse than last year
Score is about the same as last year
Score is worse than last year
2021: 32%
2020: 28%
2021: 25%
2020: 25%
2021: 54%
2020: 88%
2021: 35%
2020: 44%
Total Staff response rate for UHD NHS Staff Survey 2022: 45.5%
Total Staff response rate for UHD NHS Staff Survey 2021: 37.1%
We are caring one team listening to understand open and honest always improving inclusive

10.0 NHS People Pulse Survey

The People Pulse is an opportunity to regularly share our views about our working experience. Our answers will be used to shape a range of support, both locally and nationally, for all our NHS people. The survey should take no longer than 5 minutes to complete and is fully anonymous.

There are a group of demographic questions at the end of the survey. These will allow for the results to be explored for different populations, and this information can help tailor support in the right way.

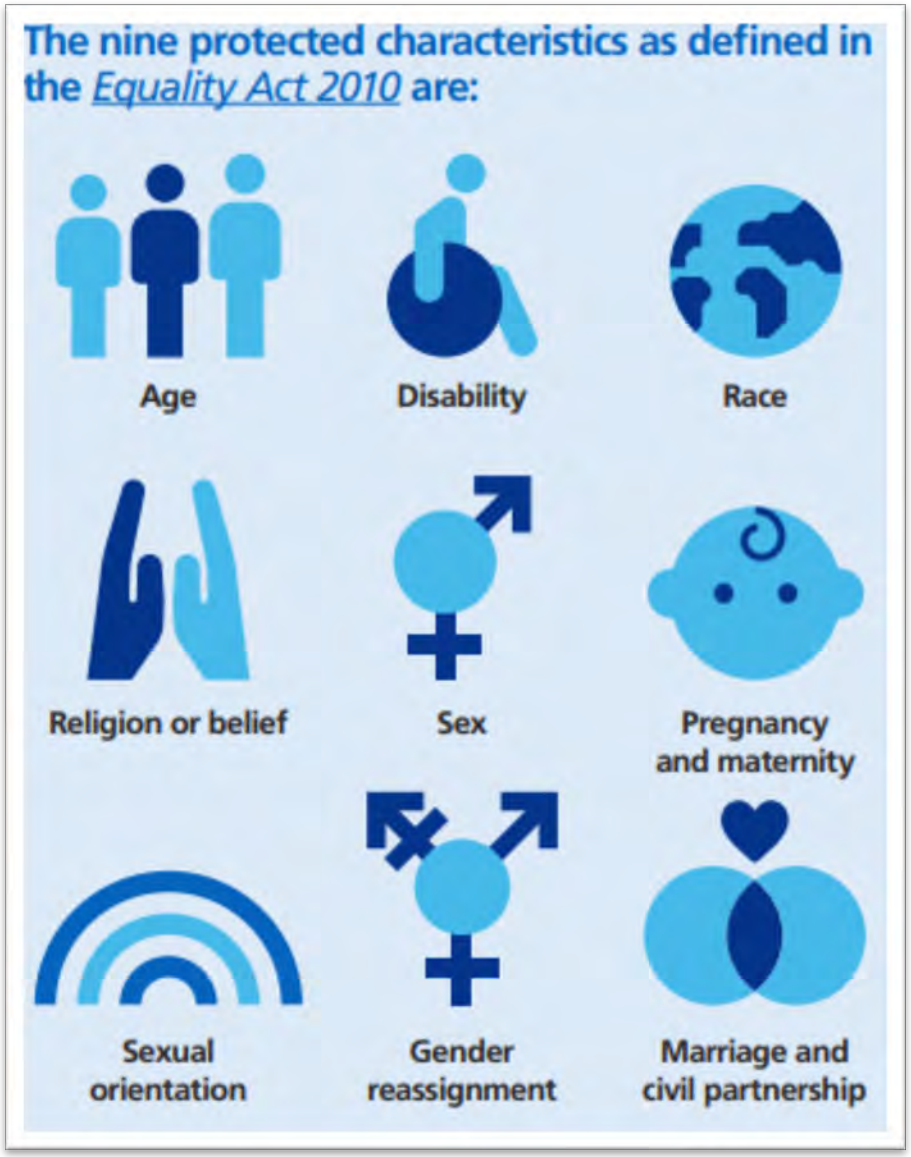
Some of the questions are optional and the survey is still strictly confidential, where only aggregated data with more than 10 responses will be reported on.

Local team data will soon be available allowing us to share success and teams to take local actions to address concerns.

11.0 UHD Workforce Profile, Headlines and Charts

UHD has over 9700 staff serving a population base of 400,300 [*Census: 2021 ONS*]. The workforce profile was taken as of 31 March 2023, this data will also feature in the 2023 WRES and WDES reports.

Due to the nature of the Electronic Staff Record there may be very slight variations in the data tables where later reports were added from the same sample period.



A new 'NHS equality, diversity and improvement plan' has been introduced within this reporting period from NHS England with a focus on 6 high impact areas for change, UHD will identify our NHS contractual obligation and how our work aligns to this plan.

11.1 Headlines 'at a glance'

The Trust Executive Board could be considered representative of the local population. UHD appointed a second Non-Executive Directors on the 1 April 2023 from a BME background.

The WRES indicator 9 for 2023 will report a continued gap in the Board/Workforce demographic due to the appointment taking place after 31 March 2023. It should be noted that there are variations in the reporting of Board membership within the WRES

reports nationally as some trusts include all members and others do not include non-executives. At UHD we have reported all voting members to include non-executives.

Ethnicity / Race. The percentage of BME staff is now 21.5% up from 18.7% in 2022, the local demographic when using comparable data from Bournemouth, Christchurch and Poole Council with the WRES mapping tool is 8.67% BME.

Sex. The trust reported male and female split to shows a slight increase in male staff headcount. For agenda for change the gender pay gap is closing.

Disability. The reported declaration for staff who are 'Disabled' has increased to 5.6% in 2023 an increase from the 4.77% reported in 2022.

This is a significant increase that is largely attributable to our ProAbility Staff Network's engagement. When considering the NHS Staff Survey our reported Disability/long term condition is reported to be much higher at 21.3%.

Age. UHD now has over 2000 staff aged 55 and over. When considering band 5, 190 are over 55 and a further 30 are over 65.

When comparing the age demographic and ethnicity at band 5 our BME staff are a comparably younger workforce. There is more parity by age and ethnicity up to the age of 44. A consideration for future progression, statistically within a few years' progression could therefore become more equal from band 5 to band 6.

Religion or Belief. Perhaps of less significance in 2023, however staff feel comfortable not to disclose their religion. Our chaplaincy service provides multi faith options and are notably an important source of support for our staff and patients.

Sexual Orientation. A characteristic along with sexual identity which requires greater consideration in relation to how staff identify and choose not to disclose.

Marriage and civil partnership. There was an increase in married staff in 2023 compared to 2022, and civil partnership has also increased.

Pregnancy & Maternity. The percentage of staff taking parental leave continues to be statistically significant for workforce planning and ward establishment reviews.

Fig. 11.1 Headcount by Occupation

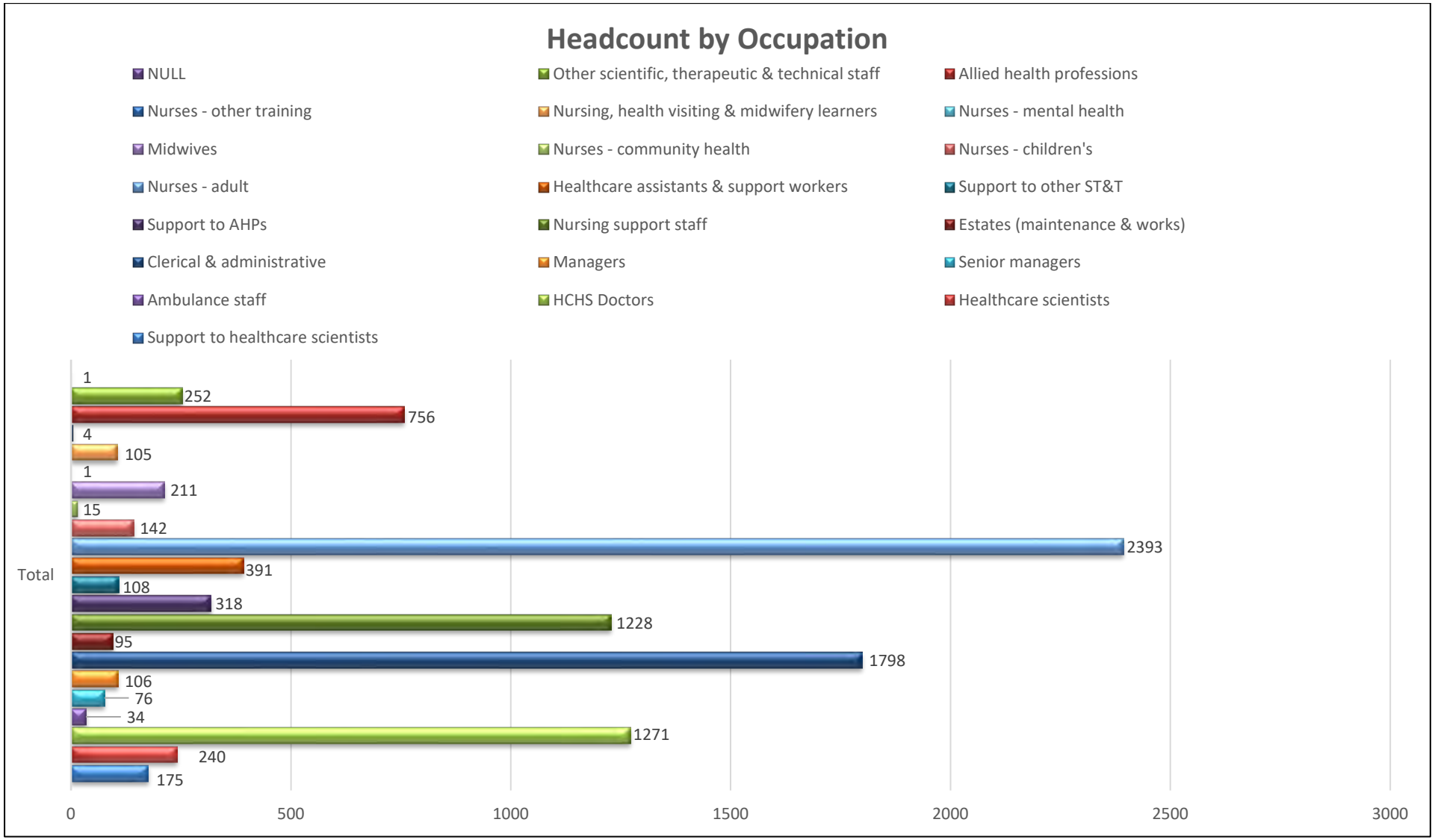
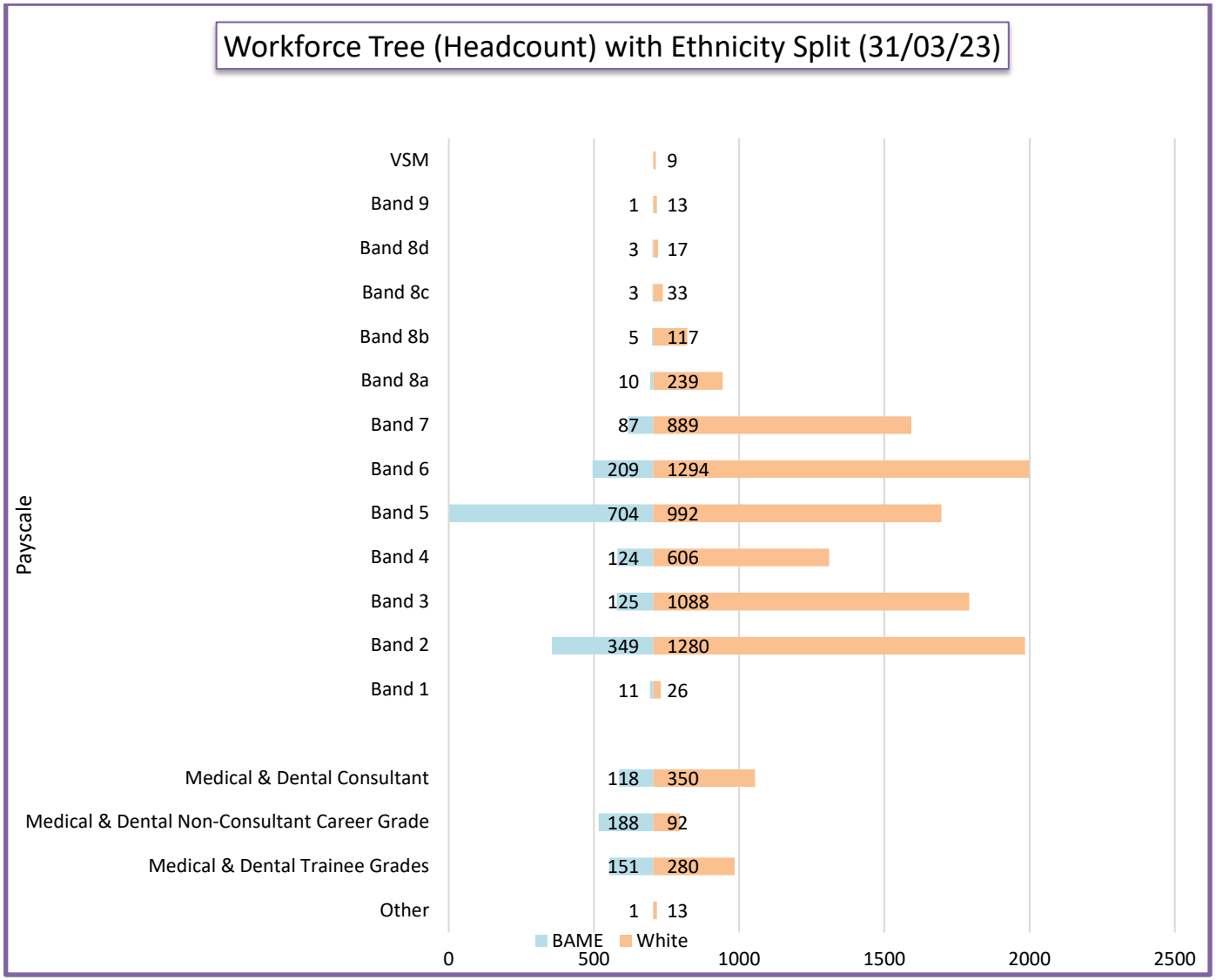
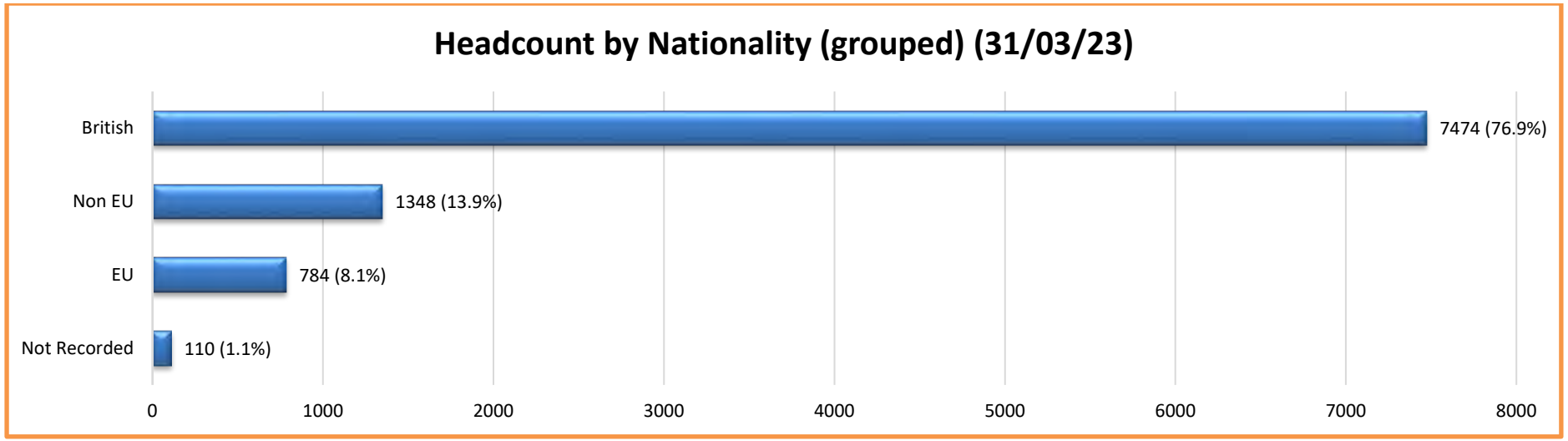
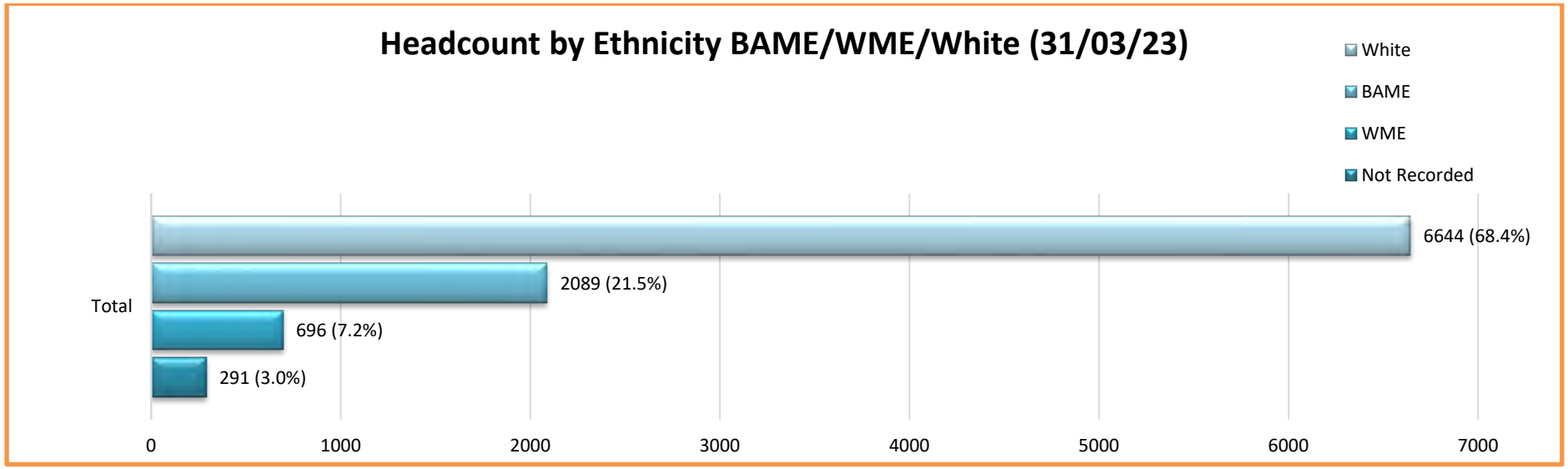
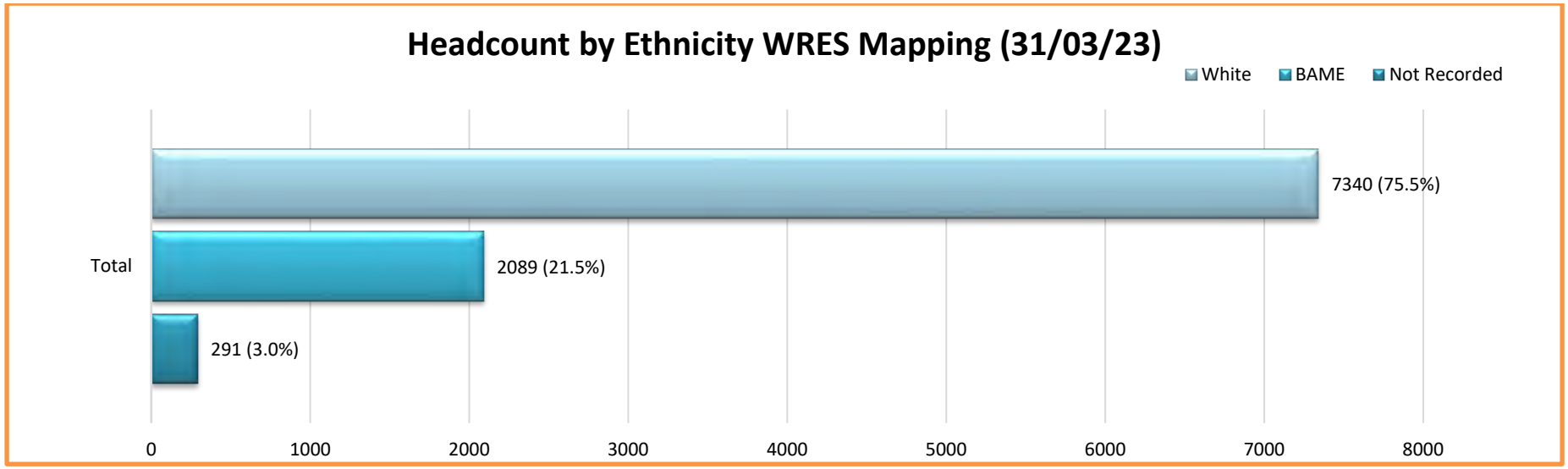


Fig. 11.2 Ethnicity / Race




Headcount by Nationality (grouped) (31/03/23)
British
Non EU
EU
Not Recorded
7474 (76.9%)
1348 (13.9%)
784 (8.1%)
110 (1.1%)
0
1000
2000
3000
4000
5000
6000
7000
8000


Headcount by Ethnicity BAME/WME/White (31/03/23)
White
BAME
WME
Not Recorded
Total
6644 (68.4%)
2089 (21.5%)
696 (7.2%)
291 (3.0%)
0
1000
2000
3000
4000
5000
6000
7000



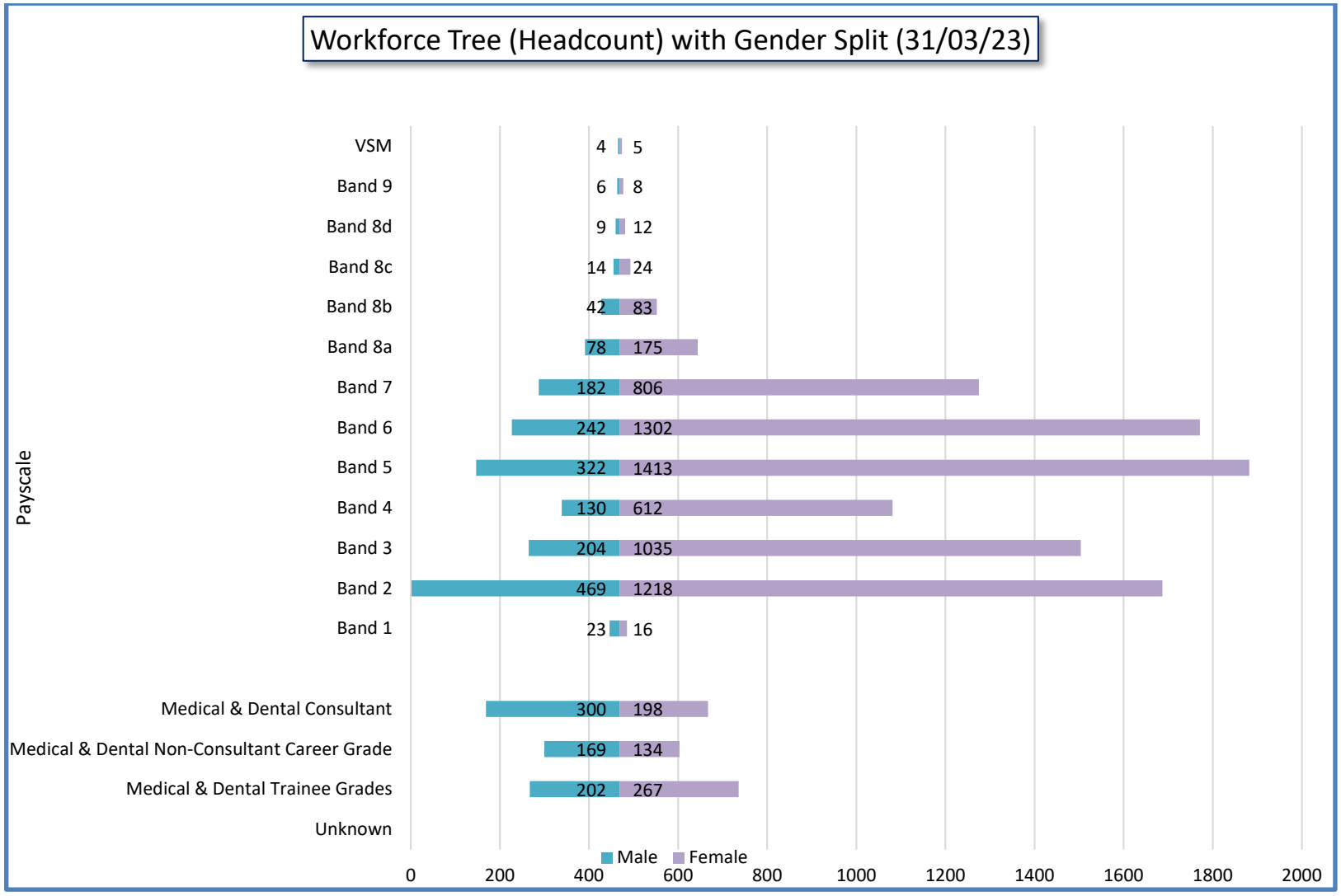
Race / Ethnicity

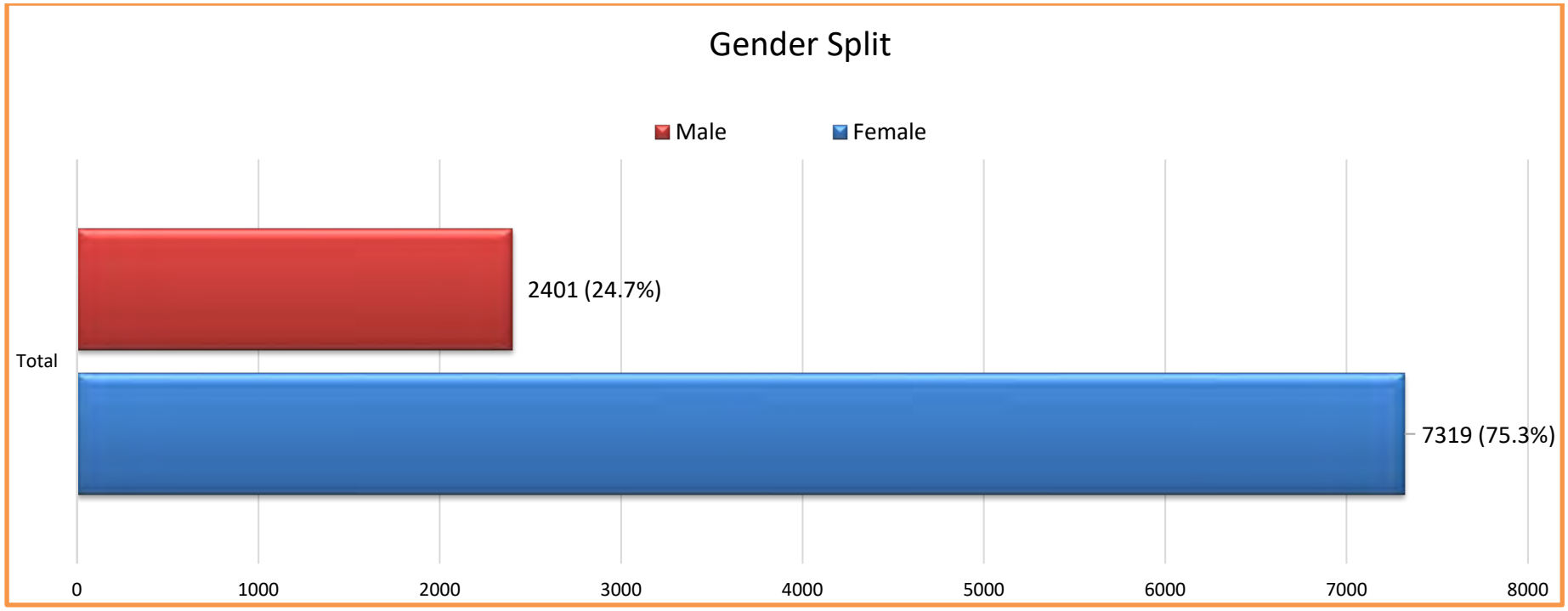
There are now 21.5% of staff declaring BME this has increased from 18.7% reported in 2022. There are now 704 BME Staff at band 5, an increase from 550 reported on the 31 March 2022.

	31/03/2023	
	Headcount	%
As	1044	10.75%
Bl	336	3.46%
C	51	0.52%
N	288	2.96%
O	381	3.92%
W	7340	75.55%
M	276	2.84%
Gra	**9716**	**100.00%**

data table may vary slightly from the charts p40 due to ESR report method

Fig. 11.3 Sex


Workforce Tree (Headcount) with Gender Split (31/03/23)
Payscale
VSM 4 5
Band 9 6 8
Band 8d 9 12
Band 8c 14 24
Band 8b 42 83
Band 8a 78 175
Band 7 182 806
Band 6 242 1302
Band 5 322 1413
Band 4 130 612
Band 3 204 1035
Band 2 469 1218
Band 1 23 16
Medical & Dental Consultant 300 198
Medical & Dental Non-Consultant Career Grade 169 134
Medical & Dental Trainee Grades 202 267
Unknown
Male
Female
0 200 400 600 800 1000 1200 1400 1600 1800 2000



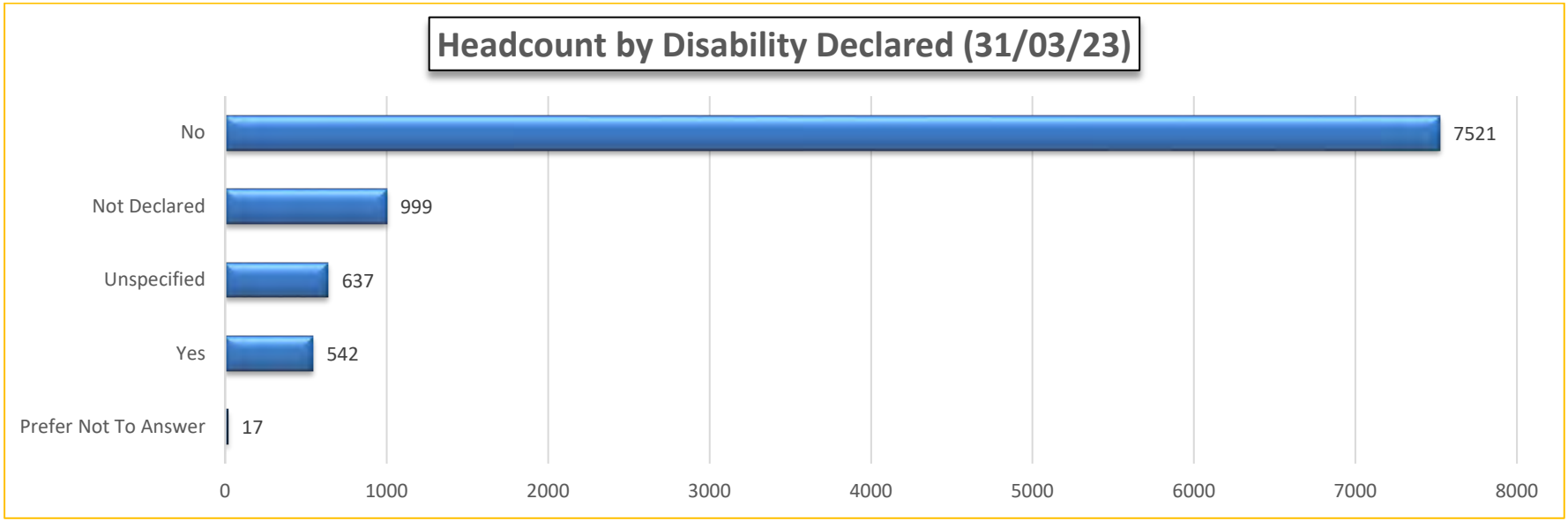
			31/03/2023	
			Headcount	%
Fema		7%	7319	75.30%
Male		3%	2401	24.70%
Grand		**.00%**	**9716**	**100.00%**

Gender / Sex

2401 Male - 7319 Female 2023

2278 Male – 7281 female 2022

Fig. 11.4 Disability



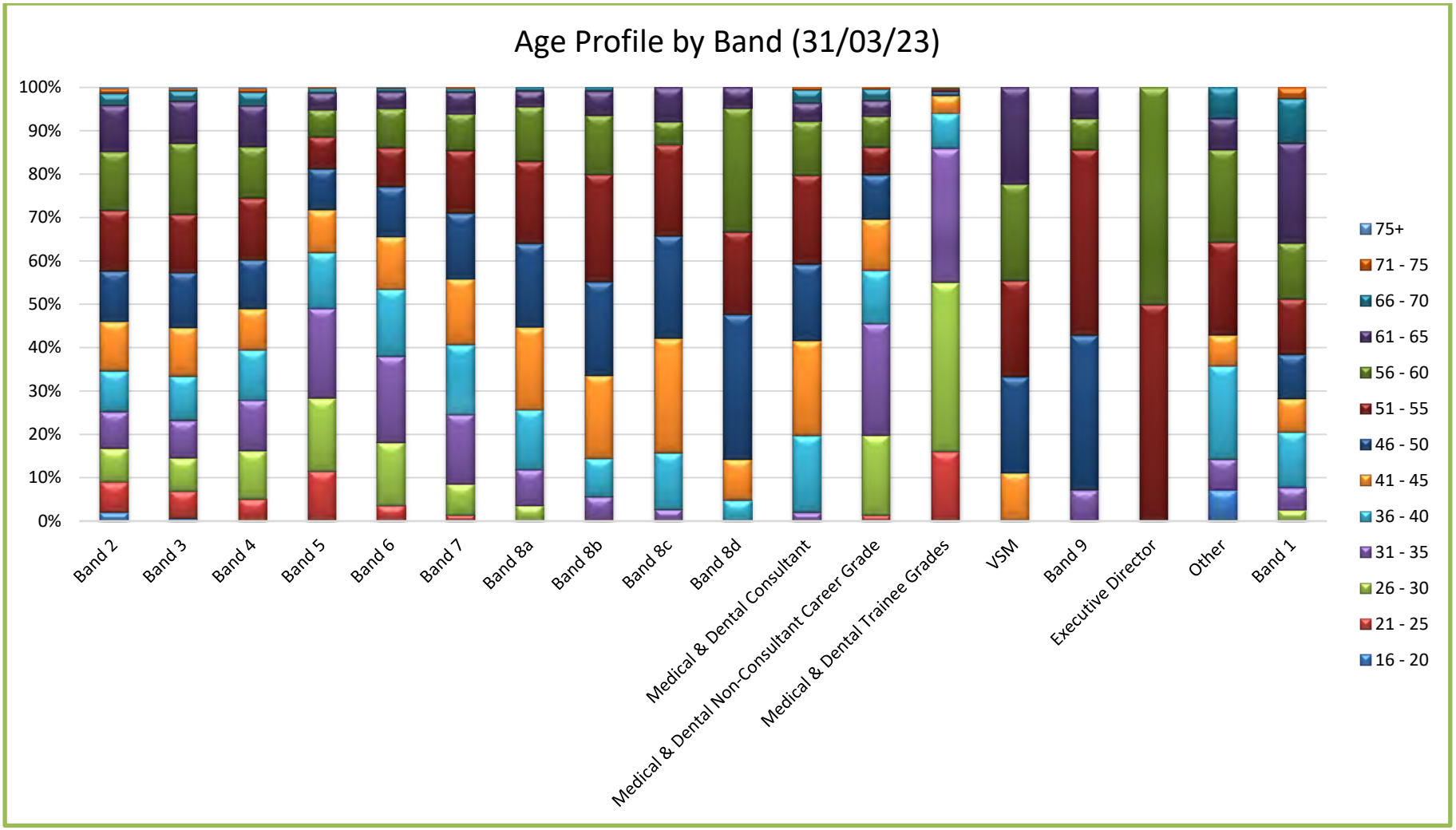
	31/03/2022		31/03/2023	
Disability	Headcount	%	Headcount	%
No	6856	71.72%	7521	77.41%
Not Declared	1552	16.24%	999	10.28%
Prefer Not to Answer	17	0.18%	17	0.17%
Unspecified	680	7.11%	637	6.56%
Yes	454	4.75%	542	5.58%
Grand Total	**9559**	**100.00%**	**9716**	**100.00%**

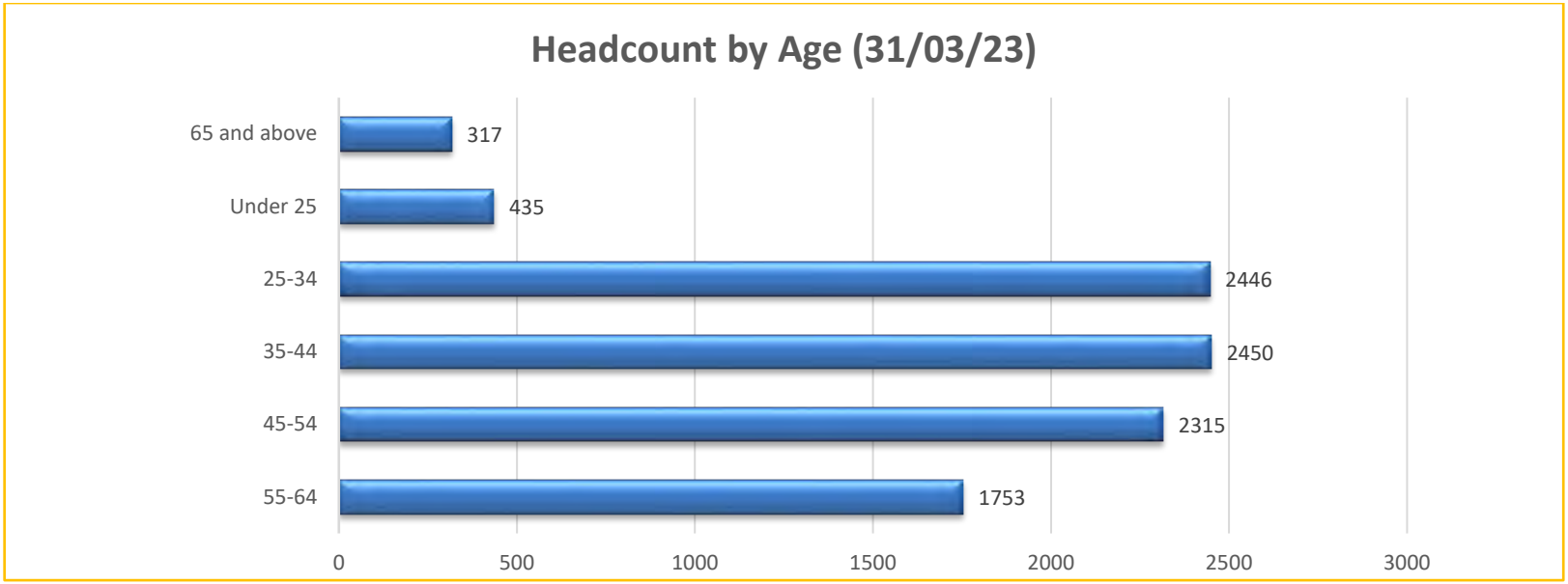
Disability

542 staff have declared a Disability or 5.6% of the workforce.

data table may vary slightly from the submitted WDES data

Fig. 11.5 Age





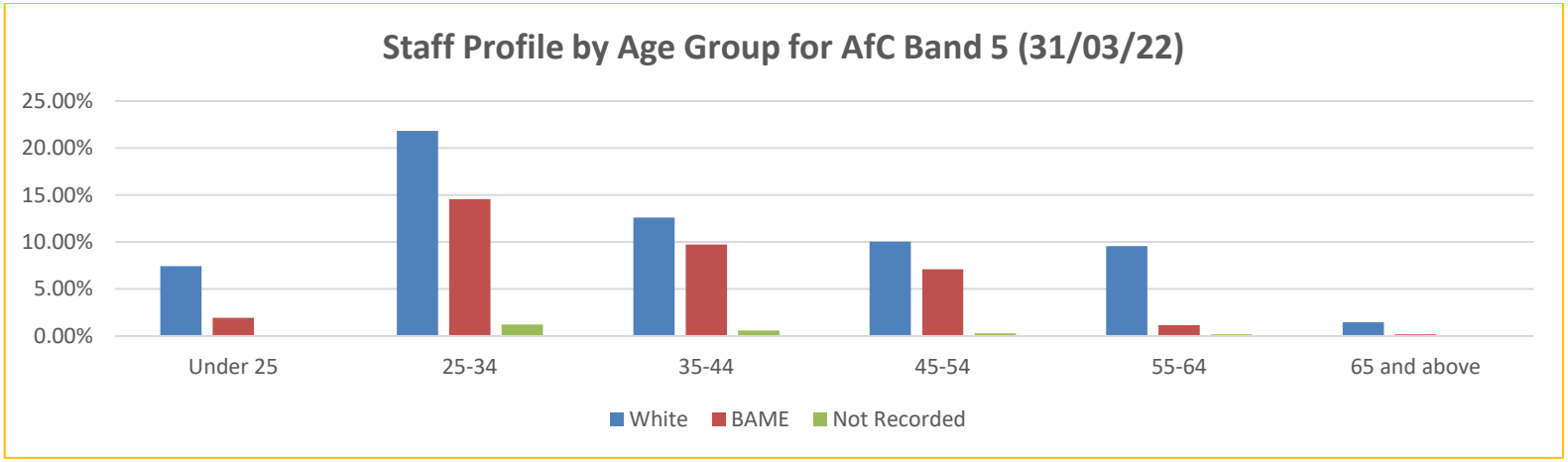
All Staff	31/03/2022		31/03/2023	
Age Profile	Headcount	%	Headcount	%
Under 25	481	5.03%	435	4.48%
25-34	2494	26.09%	2446	25.17%
35-44	2325	24.32%	2450	25.22%
45-54	2273	23.78%	2315	23.83%
55-64	1706	17.85%	1753	18.04%
65 and above	280	2.93%	317	3.26%
Grand Total	**9559**	**100.00%**	**9716**	**100.00%**

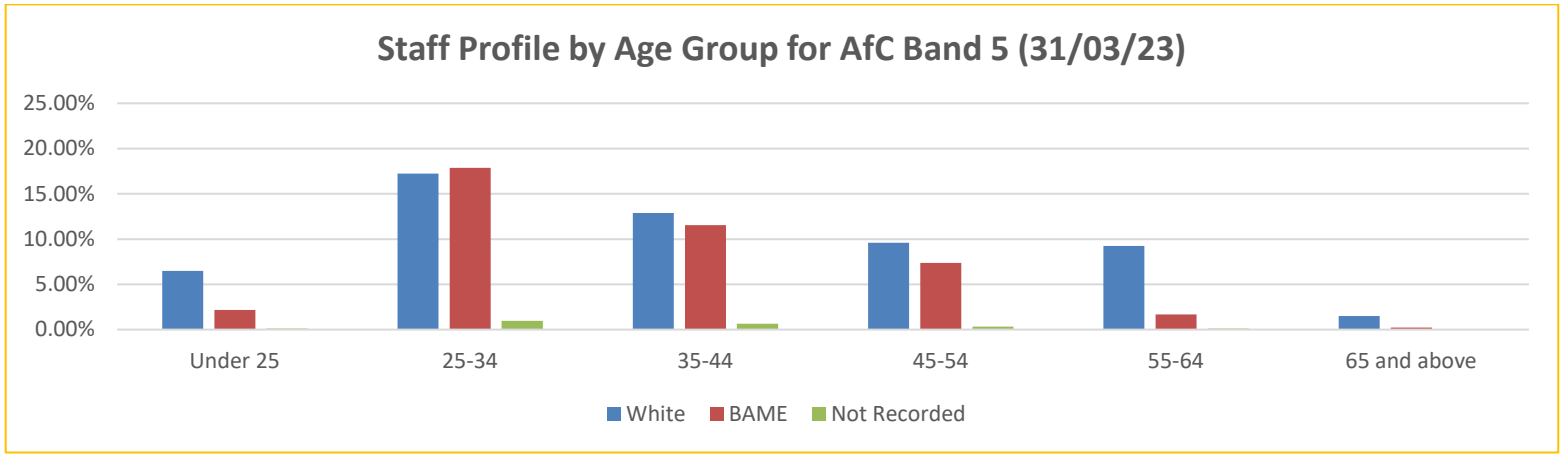
Age

There are 2060 staff aged 55 and over

Medical Staff	31/03/2022		31/03/2023	
Age Profile	Headcount	%	Headcount	%
Under 25	42	3.43%	30	2.36%
25-34	465	37.96%	472	37.17%
35-44	313	25.55%	336	26.46%
45-54	246	20.08%	269	21.18%
55-64	127	10.37%	130	10.24%
65 and above	32	2.61%	33	2.60%
Grand Total	**1225**	**100.00%**	**1270**	**100.00%**

Nursing and Midwifery	31/03/2022		31/03/2023	
Age Profile	Headcount	%	Headcount	%
Under 25	110	3.98%	107	3.79%
25-34	880	31.81%	851	30.13%
35-44	711	25.70%	794	28.12%
45-54	655	23.68%	668	23.65%
55-64	379	13.70%	367	13.00%
65 and above	31	1.12%	37	1.31%
Grand Total	**2766**	**100.00%**	**2824**	**100.00%**


Staff Profile by Age Group for AfC Band 5 (31/03/22)
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
Under 25
25-34
35-44
45-54
55-64
65 and above
White
BAME
Not Recorded


Staff Profile by Age Group for AfC Band 5 (31/03/23)
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
Under 25
25-34
35-44
45-54
55-64
65 and above
White
BAME
Not Recorded

Band 5	31/03/2022			31/03/2023		
Age Profile	White	BAME	Not Recorded	White	BAME	Not Recorded
Under 25	127	33	1	113	38	2
25-34	372	248	21	300	311	17
35-44	215	166	10	224	201	11
45-54	171	121	5	167	128	6
55-64	163	20	3	161	29	2
65 and above	25	3	0	26	4	0
Grand Total	**1073**	**591**	**40**	**991**	**711**	**38**

Band 5	31/03/2022			31/03/2023		
Age Profile	White	BAME	Not Recorded	White	BAME	Not Recorded
Under 25	7.45%	1.94%	0.06%	6.49%	2.18%	0.11%
25-34	21.83%	14.55%	1.23%	17.24%	17.87%	0.98%
35-44	12.62%	9.74%	0.59%	12.87%	11.55%	0.63%
45-54	10.04%	7.10%	0.29%	9.60%	7.36%	0.34%
55-64	9.57%	1.17%	0.18%	9.25%	1.67%	0.11%
65 and above	1.47%	0.18%	0.00%	1.49%	0.23%	0.00%

*As a percentage of total staff for year

Fig. 11.6 Religion or Belief

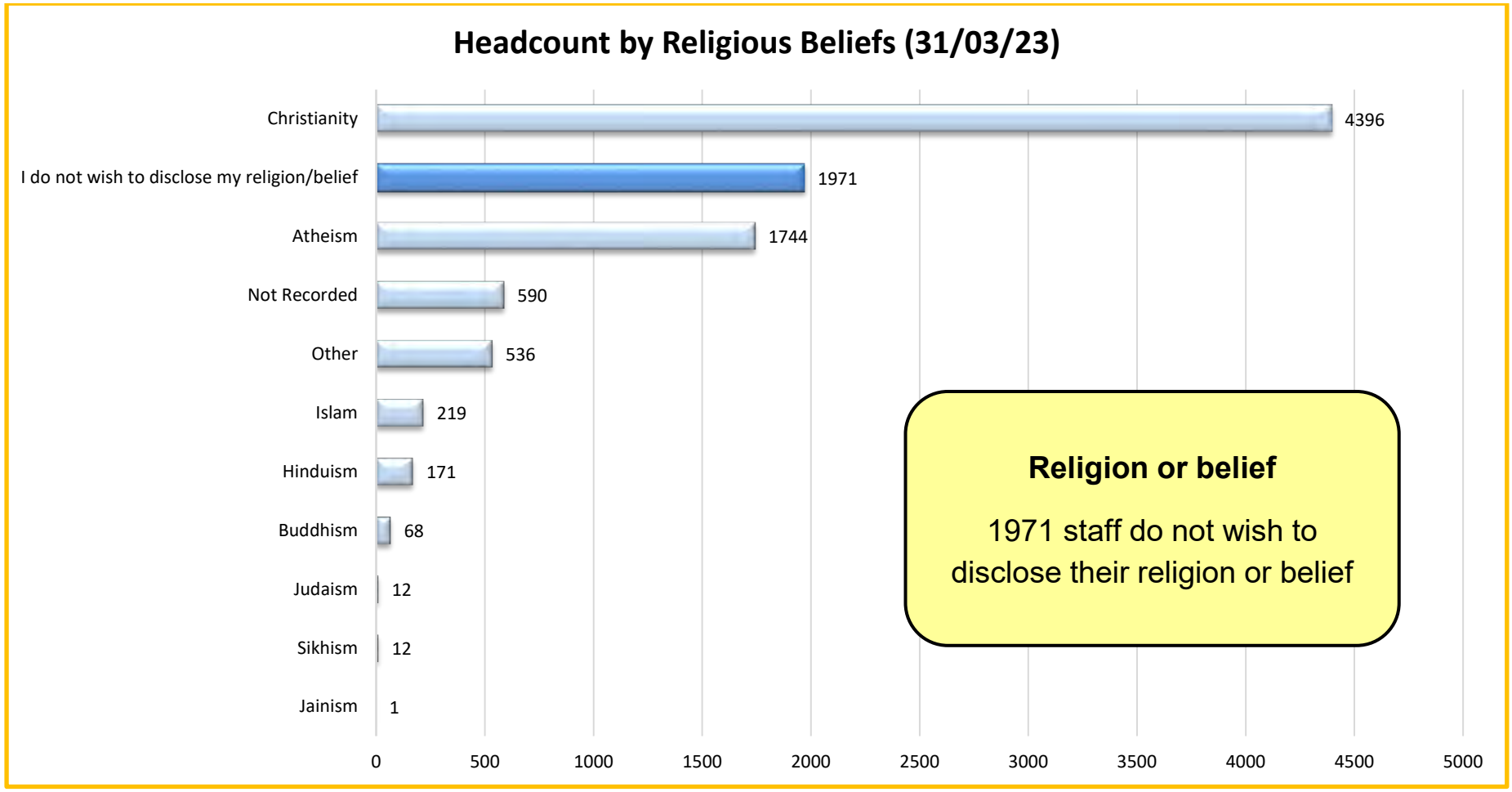
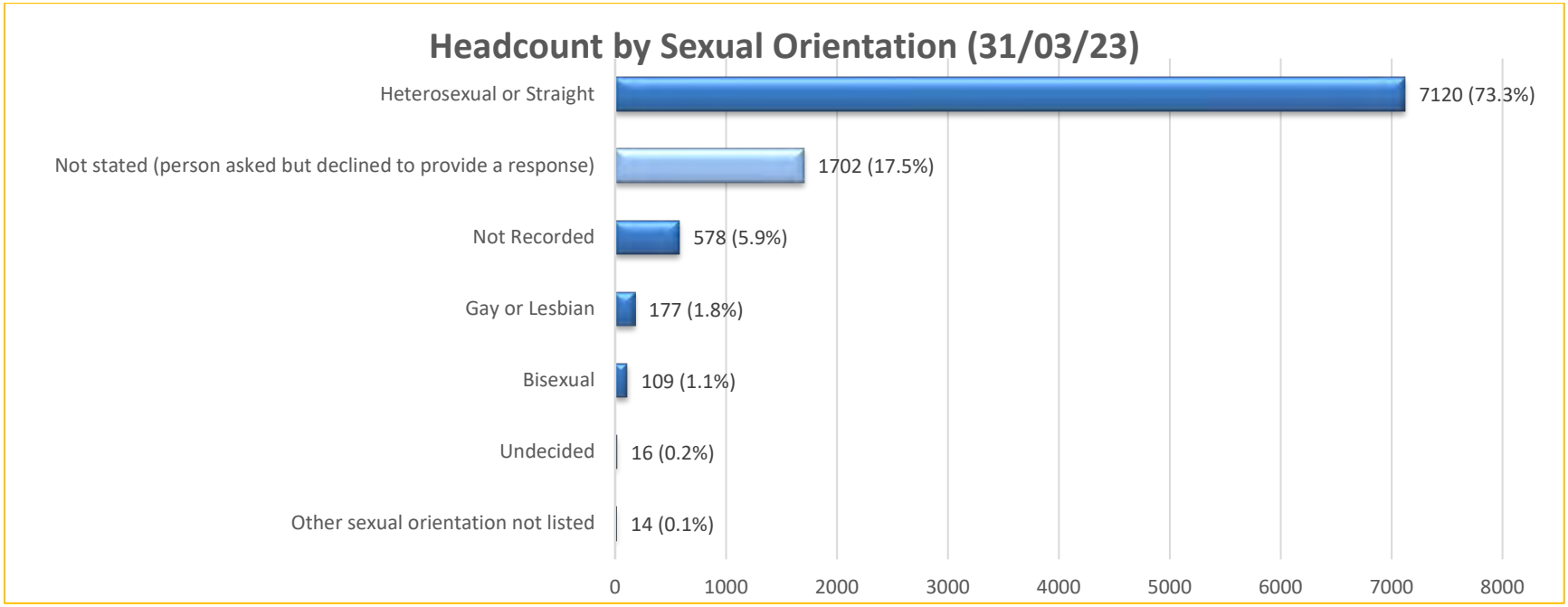
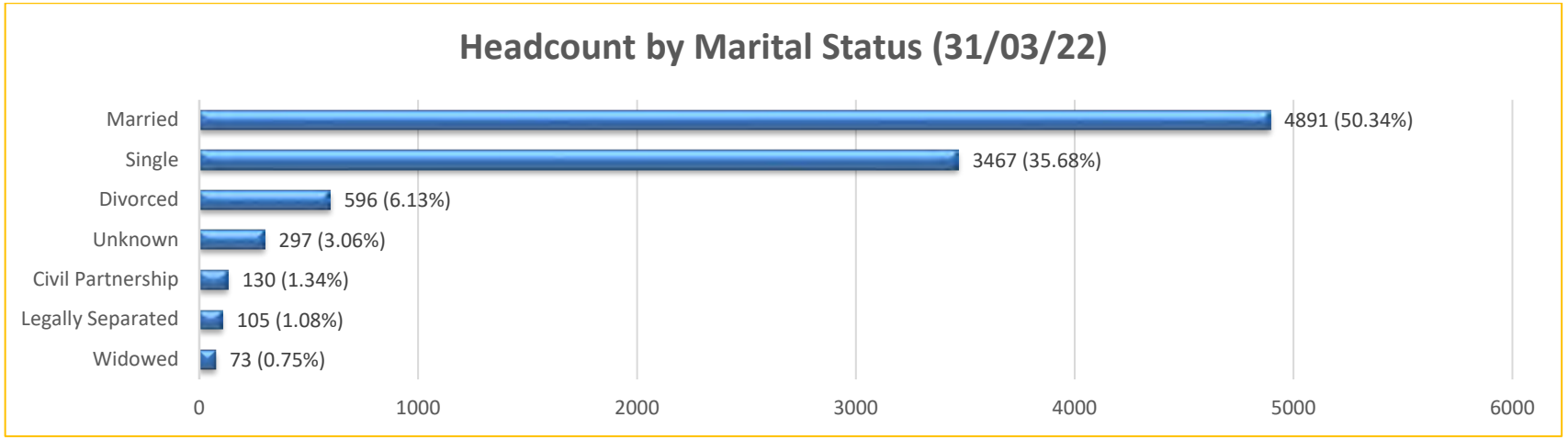


Fig. 11.7 Sexual Orientation



	31/03/2022		31/03/2023	
Sexual Orientation	Headcount	%	Headcount	%
Bisexual	129	1.35%	109	1.12%
Gay or Lesbian	185	1.94%	177	1.82%
Heterosexual or Straight	6901	72.19%	7120	73.28%
Not Recorded	651	6.81%	578	5.95%
Not stated (person asked but declined to provide a response)	1676	17.53%	1702	17.52%
Other sexual orientation not listed	11	0.12%	14	0.14%
Undecided	6	0.06%	16	0.16%
Grand Total	**9559**	**100.00%**	**9716**	**100.00%**

Fig. 11.8 Marriage & Civil Partnership



Sexual Orientation

There is a comparable stabilisation in 'not stated' with an increasing workforce sample.

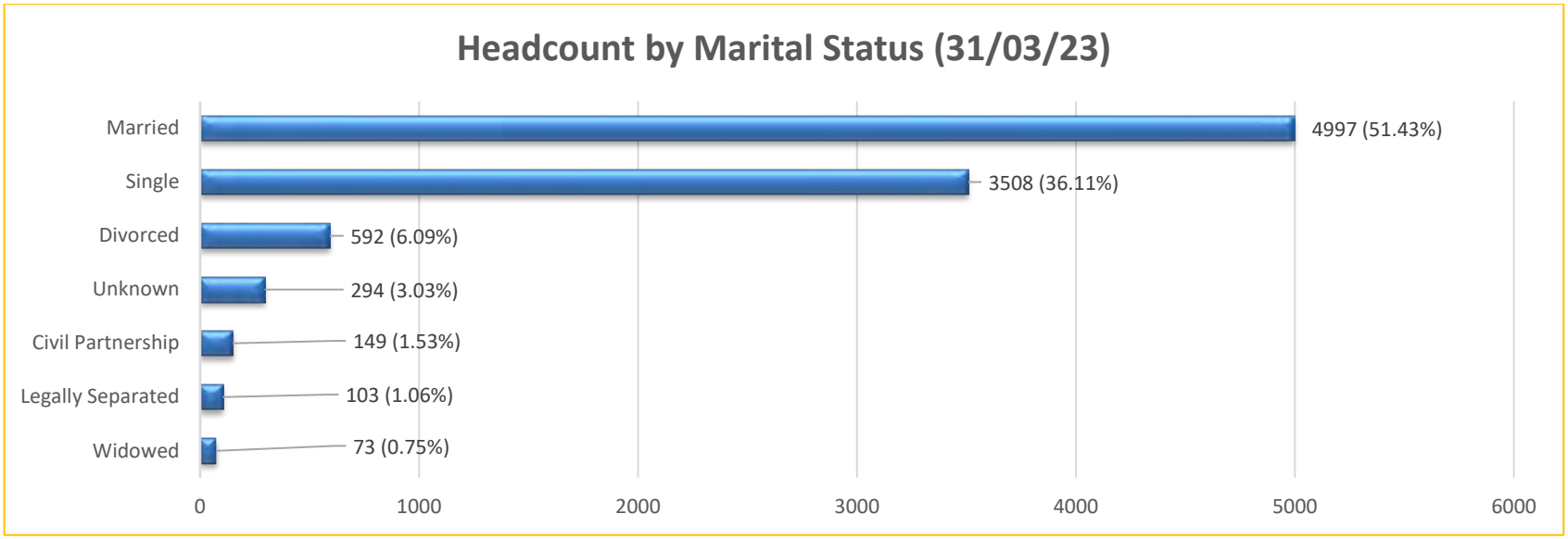

Headcount by Marital Status (31/03/23)
Married
Single
Divorced
Unknown
Civil Partnership
Legally Separated
Widowed
4997 (51.43%)
3508 (36.11%)
592 (6.09%)
294 (3.03%)
149 (1.53%)
103 (1.06%)
73 (0.75%)
0
1000
2000
3000
4000
5000
6000

Fig. 11.9 Employees accessing Parental Leave

(Maternity, Paternity, Shared Parental and Adoption)

	31/03/2022		31/03/2023	
	nt	%	Headcount	%
N		95.05%	9247	95.17%
Y		4.95%	469	4.83%
G		**100.00%**	**9716**	**100.00%**

Parental Leave

Staff accessing parental leave remains a significant statistic for the future of workforce planning and managing our ward establishment

*This is a percentage of employees in post on the reporting date that had accessed Parental leave within the previous 12 months up to the reporting date.

12.0 Summary

UHD appointed a second non-executive on the 1st April 2023 from a BME background and in the wider organisation UHD has continued to attract more diversity within the workforce.

UHD now has 21.5% of staff identifying from other ethnic backgrounds and more staff confident to disclose Disability rising to 5.6%. We are becoming comparably more diverse than the population we serve.

We have made progress in many areas and the overall NHS Staff Survey result for Compassionate and Inclusion was our best themed score in 2022, with 7.3. However, it is evident that not all staff experience working at UHD in the same way.

On a team and department level the picture is very different and the WRES indicators and WDES metrics show a very mixed picture. BME and Disabled staff are subject to greater levels of discrimination, lower levels of CPD and progression.

The Staff Networks impact staff positively across the Trust supporting and leading initiatives. New campaigns are aimed at addressing racism and violence and aggression towards staff from colleagues, managers and patients.

The Trust values will become a greater asset if we address the progression disparity noted on pages 57 - 59, BME clinical staff can take longer to progress than white staff over a career and non-clinical staff many more times.

Centralising funding for workplace adjustments and developing values or recruitment champions or similarly trained staff that understand protected characteristics to attend interviews UHD could promote greater inclusivity to attract staff.

The main recommendation from this report is to gift a review of all our action plans aligned to the new NHS EDI Improvement Plan. Including named executive sponsors and operational leads with accountability for delivering the plans.

'The NHS must welcome all, with a culture of belonging and trust. We must understand, encourage and celebrate diversity in all its forms'

'NHS People Plan 2020'

Appendix A: Disparity Ratios

Whole Organisation

Bands	White - Current Year	BME - Current Year	Unknown - Current Year
Under Band 1	0	0	0
Band 1	26	11	2
Band 2	1,280	349	58
Band 3	1,088	125	26
Band 4	606	124	12
Band 5	992	704	39
Band 6	1,294	209	41
Band 7	889	87	12
Band 8a	239	10	4
Band 8B	117	5	3
Band 8C	33	3	2
Band 8D	17	3	1
Band 9	13	1	0
VSM	16	1	0
Grand Total	**6,610**	**1,632**	**200**

Bandings	White - Current Year	BME - Current Year	Unknown - Current Year
1 to 5	3,992	1,313	137
6 and 7	2,183	296	53
Band 8a+	435	23	10
Grand Total	**6,610**	**1,632**	**200**

	White	BME
Lower to middle	**1.83**	**4.44**
Middle to upper	**5.02**	**12.87**
lower to upper	**9.18**	**57.09**

Disparity ratio - lower to middle	**2.43**
Disparity ratio - middle to upper	**2.56**
Disparity ratio - lower to upper	**6.22**

Total No of Staff	BME representation at trust
8,442	**19.3%**

*Note: the total number of staff differs from the total headcount. This is due to staff that did not have the required information recorded on ESR to attribute them to a banding or clinical/non-clinical grouping. This includes blank or 'not recorded' ethnicity on ESR.

Clinical Staff

Bands	White - Current Year	BME - Current Year	Unknown - Current Year
Under Band 1	0	0	0
Band 1	11	1	1
Band 2	825	232	32
Band 3	498	68	15
Band 4	166	92	3
Band 5	795	682	33
Band 6	1,173	192	36
Band 7	764	77	12
Band 8a	165	8	3
Band 8B	69	3	0
Band 8C	10	2	1
Band 8D	7	1	1
Band 9	2	0	0
VSM	7	1	0
Grand Total	**4,492**	**1,359**	**137**

Bandings	White - Current Year	BME - Current Year	Unknown - Current Year
1 to 5	2,295	1,075	84
6 and 7	1,937	269	48
Band 8a+	260	15	5
Grand Total	**4,492**	**1,359**	**137**

	White	BME
Lower to middle	**1.18**	**4.00**
Middle to upper	**7.45**	**17.93**
lower to upper	**8.83**	**71.67**

Disparity ratio - lower to middle	**3.37**
Disparity ratio - middle to upper	**2.41**
Disparity ratio - lower to upper	**8.12**

Total No of Staff	Clinical BME representation at trust
5,988	**22.7%**

Non - Clinical Staff

Bands	White - Current Year	BME - Current Year	Unknown - Current Year
Under Band 1	0	0	0
Band 1	15	10	1
Band 2	455	117	26
Band 3	590	57	11
Band 4	440	32	9
Band 5	197	22	6
Band 6	121	17	5
Band 7	125	10	0
Band 8a	74	2	1
Band 8B	48	2	3
Band 8C	23	1	1
Band 8D	10	2	0
Band 9	11	1	0
VSM	9	0	0
Grand Total	**2,118**	**273**	**63**

Bandings	White - Current Year	BME - Current Year	Unknown - Current Year
1 to 5	1,697	238	53
6 and 7	246	27	5
Band 8a+	175	8	5
Grand Total	**2,118**	**273**	**63**

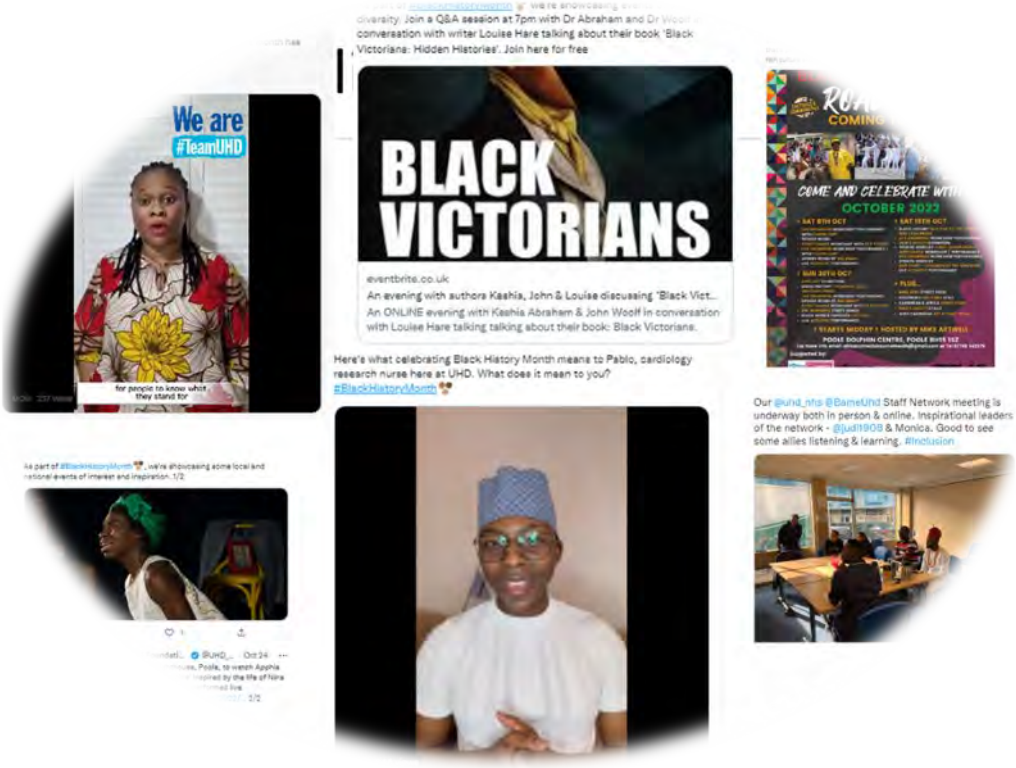
	White	BME
Lower to middle	**6.90**	**8.81**
Middle to upper	**1.41**	**3.38**
lower to upper	**9.70**	**29.75**

Total No of Staff	Non- Clinical BME representation at trust
2,454	**11.1%**

Disparity ratio - lower to middle	**1.28**
Disparity ratio - middle to upper	**2.40**
Disparity ratio - lower to upper	**3.07**

Appendix B: Media from Black History Month


Social media
Pink Zone
STAFF
7 A's of Authentic Allyship
BOOK YOUR VACCINE NOW
BLACK HISTORY MONTH 2022


We are #TeamUHD
BLACK VICTORIANS
eventbrite.co.uk
An evening with authors Kashka, John & Louise discussing 'Black Vict...
An ONLINE evening with Kashka Abraham & John Woolf in conversation with Louise Hare talking talking about their book: Black Victorians.
COME AND CELEBRATE
OCTOBER 2022

Appendix C: Feedback from Yvonne Coghill Visit

Zero tolerance. Demonstrated with actions rather than ignoring what has been reported. We tolerate racism at UHD. It's not OK from patients either. We need to be ready to have the conversation about race - helping staff to talk openly about race and how to challenge negative behaviours. There needs to be more visible expression from our leaders – this will create a ripple effect.

Reporting racism. There needs to be a clear escalation process and system to report

Empowering minorities to speak up. Encourage more engagement to help develop a culture where Black, Asian and minority ethnic staff can share their experiences, speak up and feel supported.

Diverse leadership career progression. There is more work we need to do on inclusive and diverse recruitment and progression. Take positive action to ensure more BAME representation amongst managers. The disparity of progression to more senior posts is felt by our Black, Asian and ethnic minority colleagues. Overseas students 'come and go' – poor retention rates may be due to racism - we need to understand more about their experiences via formal exit interviews – senior management need to ask why this is happening?

Mandatory racism training for line managers. and whole organisation. Promote cultural awareness and racial unity. Leaders need to be equipped to deal with the skills to deal with racism and encouraged to be more proactive – have conversations rather than 'wait for the complaint'. Appraisals review of how line managers have met EDI objectives. Acknowledge the importance of white allyship – move through the vulnerability, shame etc to acceptance and educate ourselves to understand how we take act.

Empowered networks with good funding. They are excellent but often find themselves dealing with support issues like 'unions' do, rather than helping to develop the organisation – vision and objectives.

Holding people accountable. There should be clear consequences for people who have shown repeatedly racism behaviour, especially our staff. We should also consider declining treatment to patients; this happens in other organisations.

'Staying with the truth over time, being deliberate, consistent and determined'

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 27 September 2023

Agenda item: 7.5

Subject:	Guardian of Safe Working Hours Report for UHD: April - June 2023
Prepared by:	Prof. Mike Vassallo; Mr. Paul Froggatt; Julie Mantell
Presented by:	Peter Wilson, Chief Medical Officer

Strategic themes that this item supports/impacts:	Systems working and partnership ☐ Our people ☒ Patient experience ☐ Quality: outcomes and safety ☒ Sustainable services ☐ Patient First programme ☐ One Team: patient ready for reconfiguration ☐
BAF/Corporate Risk Register: (if applicable)	1221, 1692, 1843
Purpose of paper:	Assurance
Executive Summary:	The number of exception reports raised has increased from the previous quarter, this is encouraging. In particular, it is helping in identifying specialties (oncology/haematology) where further work and support are needed to redress the situation. There were 6 patient safety concerns on the Royal Bournemouth and Christchurch sites and 10 at Poole Hospital. Further details are included in the attached report. Work has been undertaken by care groups to improve rota co-ordinators' employment and support - this has caused significant issues for trainees over the last 6 months. Work is being undertaken within care groups and directorates to address doctors' concerns around working patterns. The Trust's Chief Medical Officer/Chief Finance Officer/Chief People Officer are working on a process for hard pressed areas to over-recruit.
Background:	Trainees are working in increasingly difficult circumstances. Recruitment is difficult and industrial action has impacted both on the workforce and on training opportunities and resilience. Ongoing work between doctors in training, department of medical education and care groups is ongoing to improve rota co-ordination, workforce planning and training opportunities.

	The role of the Guardians of Safe Working Hours is essential to ensure the voice of doctors in training is heard and action is taken where concerns identified.
Key Recommendations:	Continue to support the process of exception reporting and therefore identifying problems early.
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 ☐ Finance- lack of staff increasing locum spend Operational- lack of staff decreases productivity People/Quality- lack of staff has the potential to worsen quality and will impact on staff experience
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	12/09/2023	Noted. Care Groups and specialties working with Guardians of Safe Working Hours to address concerns.
People and Culture Committee	09/08/2023	Noted.

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

University Hospitals Dorset
NHS Foundation Trust

GUARDIAN OF SAFE WORKING REPORT

1ST APRIL 2023 – 30TH JUNE 2023

UNIVERSITY HOSPITALS DORSET

POOLE HOSPITAL OVERVIEW (see page 3 for detail)

The number of exception reports has increased in this quarter. This is encouraging in so far as our post graduate doctors in training (PGDiT) feel empowered to exception report when they are working outside contracted hours. There are ongoing concerns in ENT and general surgery. These are all related to rota gaps and also within oncology concerns about an ever-increasing workload from multiple sources.

I have been in communication with the rota coordinators for general surgery & ENT and have begun to resolve the issue which also stemmed from a change of personnel in rota construction.

In addition I have already had response from the clinical directors in oncology acknowledging the very challenging situation for the wider team & PGDiT; with a plan to meet and work towards improving this situation.

Paul Froggatt

ROYAL BOURNEMOUTH HOSPITAL OVERVIEW (see page 7 for detail)

This quarter saw a drop in the number of exception reports submitted from the Royal Bournemouth Hospital. It is not possible to say with certainty what are the reasons for this. There has been a lot of work done by directorates to improve staffing. For example, in certain areas like OPAU where doctors used to stay late to finish jobs the situation has been improved and this may have contributed to some extent to a reduction. Of course, there are the ongoing junior doctor strikes taking place and these may be contributing to diverting the attention off exception reporting as well. The junior doctor forum has met on 2 occasions in this quarter and through the forum exception reporting continues to be encouraged. In relation to succession planning for the Junior Doctor Forum in RBCH, our current chair will continue to be in post into August providing continuity. Work is taking place for the new doctor in training induction in august and this will be a great opportunity to promote exception reporting

Mike Vassallo

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 Apr – 30th June 23	Exceptions raised outside of 14 days from event	Outcome agreed (*not closed*)	Number of exceptions closed	Number of exceptions outstanding
General Medicine	27 ↓	4	4	23	0
General Surgery	4 ↓	0	1	2	1
O&G	1	0	0	1	0
Oncology	69 ↑	5	4	53	12
Geriatrics	27 ↓	2	9	18	0
Respiratory	16 ↑	14	0	16	0
Paediatrics	2 ↑	0	0	2	0
ENT	6 ↑	0	1	5	0
Emergency	3 ↑	1	1	2	0
Total	**155 ↑**	**26**	**20**	**122**	**13**

(Source: Allocate)

Brief Overview of Exception Reports Raised

There were a total of 155 exception reports for the quarter 1st April 2023 to 30th June 2023, an increase of 25 from the previous quarter, mostly attributed to exceptions being raised outside of the quarter April-June.

Of the 155 exceptions raised there were 10 patient safety concern from various grades working in General Surgery, Oncology and ENT.

After each immediate safety concern exception report- the Guardian meets with the junior doctor concerned and also raises the concern with the relevant directorates so that the directorates can investigate and explore ways to prevent future incidents.

Reasons for Exceptions Raised

141 doctors have reported working over their contracted hours.

Working over contracted hours	Access to Education	Shift Pattern	Service Support	Natural Breaks/Rest
141	2	4	2	3

(Source: Allocate)

Reporting Grades for this Period

FY1	FY2	GP/ST1/2	Trust SHO	IMT1	IMT2	IMT3/ST3	ST4+
34	74	3	7	20	0	17	0

(Source: Allocate)

Outcome Types Agreed

Overtime payment	Time off in lieu	No further action	Created in error	Request for more info	Work Schedule Review/Pattern	Outcome Still Awaited
61	64	2	1	9	5	13

(Source: Allocate)

Fines

There were no fines this quarter.

Vacancies – awaiting information

Department	Number of vacancies
General Surgery	1.0
T&O	1.0

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	513 ↓	383 ↑	4,767 ↓	3,766 ↑
Anaesthetics	1 ↓	1 -	13 ↓	153 ↑
ENT	76 ↑	62 ↑	858 ↑	650 ↑
General Surgery	56 ↓	40 ↑	584 ↓	437 ↑
Medicine	438 ↓	327 ↓	4,008 ↓	3,002 ↓
Obstetrics and Gynaecology	68 ↑	46 ↑	578 ↑	413 ↑
Oncology	59 ↑	39 ↓	482 ↑	283 ↓
Orthopaedic Surgery	710 ↑	688 ↓	6,384 ↓	5,417 ↓
Paediatrics	55 -	44 ↑	526 ↓	395 ↑
TOTAL	**1,976** ↓	**1,630** ↑	**18,199** ↓	**14,517** ↑

(Source Temp Staffing Office)

Locum bookings (Bank) by Grade				
Grade	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
F1	19 ↓	19 ↓	129 ↓	385 ↓
F2	21 ↑	12 ↑	125 ↑	335 ↑
ST/CMT1/2	1,436 ↓	1,236 ↑	13,377 ↓	11,143 ↑
ST3+	500 ↑	363 ↑	4,569 ↑	2,653 ↑
TOTAL	**1,976** ↓	**1,630** ↑	**18,199** ↓	**14,517** ↑

(Source Temp Staffing Office)

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	11 ↑	2 ↑	88 ↑	0
Adhoc	225 ↓	225 ↓	1,801 ↓	2,206 ↑
Annual Leave	19 ↑	15 ↑	181 ↑	126 ↑
Coronavirus	5 ↓	3 ↓	36 ↓	0 ↓
Deanery Vacancy	100 ↓	74 ↓	1,127 ↓	861 ↓
Escalations	105 ↑	42 ↑	1,004 ↑	228 ↑
LTFT Cover	52 ↑	40 ↑	440 ↑	0 -
Maternity/Paternity Leave	8 ↑	7 ↑	95 ↑	0 -
Service Demand (e.g winter pressures)	122 ↓	105 ↑	1,186 ↓	4,098 ↑
Sickness	146 ↓	112 ↓	1,454 ↓	994 ↓
Study Leave	4 ↓	0 ↓	40 ↓	27 ↓
Trust vacancy	922 ↓	834 ↓	8,329 ↓	4,666 ↓
Urgent Clinical Need	257 ↑	171 ↑	2,419 ↑	374 ↓
Waiting List Initiative	2	2	12	12
TOTAL	**1,976 ↓**	**1,630 ↑**	**18,199 ↓**	**13,580 ↑**

(Source Temp Staffing Office)

Locum Bookings via Agency

Locum bookings by Grade		
Grade	**Number of shifts requested**	**Number of shifts worked**
Foundation Year 1	2 ↑	0 -
Foundation Year 2	105 ↑	91 ↑
ST1/2 - CT1/2	0 -	0 -
ST3	273 ↑	198 ↑
TOTALS	**380 ↑**	**289 ↑**

(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 Apr – 30th June 23	Exceptions raised outside of 14 days from event	Outcome agreed (*not closed*)	Number of exceptions closed	Number of exceptions outstanding
Acute	18 ↑	0	0	17	1
A&E	2 ↓	0	0	1	1
General Medicine	23 ↓	1	0	19	4
General Surgery	16 ↑	0	0	11	5
Geriatrics	1 ↓	0	0	1	0
O&G	1 ↑	0	0	0	1
Cardiology	3 ↓	0	0	1	2
Respiratory	2 ↓	0	0	2	0
General Practice	1 ↓	0	0	1	0
Ophthalmology	3 ↓	0	0	3	0
Urology	2 -	0	0	2	0
Vascular	8 ↑	0	0	7	1
Total	**80 ↓**	**1**	**0**	**65**	**15**

(Source: Allocate)

Brief Overview of Exception Reports Raised

There were a total of 80 exception reports for the quarter 1st April 2023 to 30th June 2023, a decrease of 48 from the previous quarter.

Of the 80 exceptions raised there were 6 patient safety concerns in General Surgery of which there are 4 and General Medicine being 2 concerns.

After each immediate safety concern exception report- the Guardian raises the concern with the relevant directorates so that the directorates can investigate and explore ways to prevent future incidents.

Reasons for Exceptions Raised

7 doctors have reported a lack of service support.

Working over contracted hours	Access to Education	Shift Pattern	Service Support	Natural Breaks/Rest
66	4	2	7	2

(Source: Allocate)

Reporting Grades for this Period

FY1	FY2	GP/ST1/2	Trust SHO	IMT1/ST1	IMT2/ST2	IMT3/ST3	ST4+
46	14	0	1	10	3	0	6

(Source: Allocate)

Outcome Types Agreed

Overtime payment	Time off in lieu	No further action	Created in error	Request for more info	Work Schedule Review/Pattern	Outcome Still Awaited
53	0	10	0	2	0	15

(Source: Allocate)

Vacancies

Department	Number of vacancies
Acute	1.0
Diabetes and Endocrine	1.0
OPS	1.0
Respiratory	1.0

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	2 ↓	0 ↓	4 ↓	24 ↓
Emergency Medicine	664 ↓	532 ↑	6,106 ↓	5,034 ↑
Surgery	146 ↓	127 ↓	1,482 ↓	1,709 ↓
Medicine	793 ↓	691 ↑	7,277 ↓	6,434 ↑
Oncology	3 ↓	1 ↓	24 ↓	8 ↓
Ophthalmic	9 ↓	9 ↓	136 ↓	136 ↓
Vascular	1 ↑	1 ↑	8 ↑	8 ↑
Orthopaedic	37 ↑	36 ↑	263 ↑	228 ↑
TOTAL	**1,655 ↓**	**1,397 ↓**	**15,300 ↓**	**13,580 ↑**

(Source Temp Staffing Office)

Locum bookings (Bank) by Grade				
Grade	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
F1	9 ↑	7 ↑	48 ↓	548 ↑
F2	11 ↓	11 ↓	103 ↓	171 ↓
ST/CMT1/2	895 ↓	734 ↑	8,415 ↓	9,261 ↑
ST3+	740 ↓	645 ↑	6,734 ↓	3,601 ↑
TOTAL	**1,655 ↓**	**1,397 ↑**	**15,300 ↓**	**13,580 ↑**

(Source Temp Staffing Office)

Locum Bookings (Bank) by Reason				
Reason	**Number of shifts Requested**	**Number of shifts worked**	**Number of hours Requested**	**Number of hours Worked**
Ad-hoc	222 ↑	222 ↑	2,206 ↑	2,206 ↑
Annual Leave	20 ↑	15 ↑	165 ↑	126 ↑
Escalations	77 ↑	66 ↑	509 ↑	461 ↑
Service Demand	542 ↑	465 ↑	4,689 ↑	4,098 ↑
Sickness	125 ↓	103 ↓	1,221 ↓	1,034 ↓
Deanery Vacancy	61 ↓	53 ↓	609 ↓	861 ↓
Study Leave	7 ↑	3 ↑	58 ↑	27 ↑
Urgent Clinical Needs	75 ↑	32 ↑	693 ↑	374 ↑
7-day Pilot	3 ↓	0 ↓	32 ↓	0 ↓
Trust vacancy	613 ↓	517 ↓	5,674 ↓	4,883 ↓
TOTAL	**1,745 ↓**	**1,476 ↑**	**15,856 ↓**	**14,070 ↑**

(Source Temp Staffing Office)

Locum bookings by Grade		
Grade	**Number of shifts requested**	**Number of shifts worked**
Foundation Year 1	9 ↓	7 ↓
Foundation Year 2	117 ↑	103 ↑
ST1/2 - CT1/2	900 ↑	739 ↑
Specialty Registrar	756 ↑	661 ↑
TOTALS	**1,782 ↑**	**1,510 ↑**

(Source Temp Staffing Office)

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 27 September 2023

Agenda item: 8.1.1

Subject:	Key Issues and Assurance Report to Board of the Quality Committee meeting held on 15 August 2023
Prepared by:	Cliff Shearman, Chair of the Quality Committee
Presented by:	Cliff Shearman, Chair of the Quality Committee

Key Issues/matters discussed by the Committee:	The Committee received the following: • Update from the Chief Nursing Officer, Dorset Integrated Care Board • Update on BAF Strategic Risks 4, 5 and 6 for assurance • Risk Register: risks rated 12-25 (new and current) for review • Integrated Performance Report: Quality Report for assurance • CQC Update for assurance • Maternity Safety Champions Report for assurance • Paediatric Services Report for assurance • Interim update on the Quality Governance Audit Action Plan • Quality Impact Assessment Report • Assurance alerts from the Clinical Governance Group (including End of Life Care) and the Medicines Governance Group.
Significant issues for escalation to Board for action:	The Committee received an update on actions being taken in relation to fractured neck of femur following the meeting of the Finance and Performance Committee held on 14 August 2023. A Board seminar has since been scheduled to discuss this further.
Progress of Board Assurance Key Risks Assigned to Committee:	In relation to: • BAF Risk 4 *(related to patient feedback)*, there was discussion at the Committee meeting about whether additional communications were needed and visible indicators for patients on how to give feedback. The use of external independent resources for gathering feedback was also discussed. It was reported to the Committee that an area of focus within the

	engagement strategy would be hard to reach groups and how to support them with providing feedback. Work would be undertaken with the Trust's Business Intelligence team to develop a target level of feedback that was sought to be achieved. • BAF Risk 5 The Committee was reassured that mortality was acceptable and was informed of the numerous steps in place for improvement.

NHS
University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 27 September 2023

Agenda item: 8.1.2

Subject:	Key Issues and Assurance Report to Board of the Quality Committee meeting held on 19 September 2023
Prepared by:	Cliff Shearman, Chair of the Quality Committee
Presented by:	Cliff Shearman, Chair of the Quality Committee

Key Issues/matters discussed by the Committee:	The Committee received the following: • Board Assurance Framework for assurance • Risk Register: risks rated 12-25 (new and current) for review • Integrated Performance Report: Quality Report for assurance • CQC Update for assurance • Maternity Safety Champions Report for assurance • Annual Safeguarding Report for assurance • Complaints and Patient Experience Report for assurance • Clinical Governance Report including: o End of Life Care Report o Annual Radiation Safety Report o Quarterly Safeguarding Report o Serious Incidents Report • Assurance Alerts from the Safeguarding Group.
Significant issues for escalation to Board for action:	1. New Risk 1950 rated 20. Graphnet Electronic Patient Record (EPR) not fit for purpose – impact on patient flow, lack of closed loop reporting and further deterioration in current EPR. 1. Complaints and Patient Experience. In Q1 only 49% of responses to complaints were made within the expected 55 days. 2. Mortality. The Hospital Standarised Mortality (HSMR) had increased to 126 for April 2023. The Committee was informed that this was due to a coding issue. This will be an ongoing problem for some months. It is expected that an improvement in the April 2023 mortality (due to correction of the coding) will be seen by next month. Other indicators such as Summary Hospital-level Mortality Indicator (SHMI) may have to be used in the interim.

	3. The Trust remains an outlier for obstetric hemorrhage in excess of 1.5l. UHD is 3.5%; national standard is 2.6%. Training and raising awareness is being undertaken in unit. 4. The Somerset external review of the maternity unit has been delayed until November 2023.

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 27 September 2023

Agenda item: 8.1.3

Subject:	UHD Annual Safeguarding Report for 2022/23
Prepared by:	Pippa Knight, Head of Safeguarding
Presented by:	Paula Shobbrook, Chief Nursing Officer

Strategic themes that this item supports/impacts:	Systems working and partnership ☒ Our people ☒ Patient experience ☒ Quality: outcomes and safety ☒ Sustainable services ☐ Patient First programme ☒ One Team: patient ready for reconfiguration ☒
BAF/Corporate Risk Register: (if applicable)	N/A
Purpose of paper:	Decision/Approval
Executive Summary:	During the year 2022 -2023 the corporate safeguarding team completed its post-merger restructure and achieved full recruitment by year end. Attention is drawn to the following key points: • Trust Performance for level 3 children's and adults Safeguarding Training which falls outside of current compliance levels. This training is covered within the Essential Core Skills Framework. Robust action plans are in place to improve compliance. • Safeguarding supervision provision has improved but still remains a challenge. Supervision is an ICS focus for 2023/24 and is part of the safeguarding improvement plan. • Increases in domestic abuse referrals for staff and patients; Section 42.1 concerns against the Trust; and safeguarding e-forms raised by the Trust out of concern for our patients. • An Improvement with embedding the Reasonable Adjustment e-form system to support our patients with learning disabilities (LD). Since year end a vacancy has arisen in this sole practitioner service which has offered opportunity to review the service

	which is pressured due to increasing patient numbers. • Fewer children have attended our emergency departments however an increase in the number of safeguarding referrals is noted. With an increase in children attending due to significant assault, including assaults with knives and other weapons. We have also seen an increase in the number and length of stay for children with complex mental health and social needs. A patient cohort that can be challenging with regards to safe and appropriate discharge into partner organisations care. • An increase in the number of child deaths, Child Safeguarding Practice Reviews and Rapid Reviews is noted. • There has been good improvement around reported allegations against staff with an increase in the number of staff being supported whilst appropriate checks and investigations are conducted. This has been achieved through on-going close working relationships between HR and the Safeguarding team to support staff whilst protecting patients. • The safeguarding team commences 2023/24 with full team of staff but there will need to be consideration for whether the size of the team is sufficient to meet the increasing numbers and complexity of safeguarding cases UHD support.
Background:	This report details activity in respect of Safeguarding Adults and Children for the year 2022/23 for University Hospital Dorset NHS Foundation Trust. It is presented in accordance with CQC Regulation 13. Safeguarding Service Users from abuse and improper treatment; and provides assurance around all elements of the regulation.
Key Recommendations:	To note the current safeguarding statistics, risks, governance structure and risk mitigation as set out within the paper.
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
Safeguarding Group	29/08/2023	Approved
Quality Committee	19/09/2023	Received for assurance and noted by the Committee

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

University Hospital Dorset (UHD) Annual Safeguarding Report 2022-23

1. Introduction

This report details activity in respect of Safeguarding Adults and Children for the year 2022/23 for University Hospital Dorset NHS Foundation Trust.

It is presented to provide assurance of Safeguarding across the Organisation.

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

Those most in need of protection include:

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

NHS England (2022)

2. Strategic Context

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

'The Bournemouth, Christchurch and Poole Safeguarding Adults Board (BCPSAB) has been set up to improve the safety and well-being of adults who might be at risk of harm. It does this through joint leadership and working together. In April 2021 the Board welcomed a new Independent Chair, Siân Walker. Siân is driven by a passion for excellence, ensuring all services to vulnerable people are person-centred, easy to access and more importantly promote independence, while making sure people are safe. The BCP Safeguarding Adults Board works to support all partner agencies in applying the 6 Safeguarding principles in all areas of work.'
Bournemouth, Christchurch and Poole Safeguarding Adults Board (BCPSAB) - Bournemouth, Christchurch and Poole Safeguarding Adults Board (BCPSAB) (bcpsafeguardingadultsboard.com)

'The Partnership for Children's Safeguarding arrangements in Dorset was launched on the 1 August 2019. The changes have come about as a result of the Children and Social Work Act 2017 and have seen the Bournemouth and Poole Local Safeguarding Children Board (LSCB) and Dorset Safeguarding Children Board (SCB) replaced by the Pan-Dorset Safeguarding Children Partnership.

The aim of the Partnership is to develop excellence in the way we carry out our business, leading to a clearer strategy, more participation and better decision making.

We work to promote good working practices in three key areas:

- To safeguard all children to ensure they grow up in a safe environment with people who protect and care for them
- To work proactively to protect particularly vulnerable children

- To work responsively to protect children who are suffering, or are at risk of suffering harm

Pan-Dorset Safeguarding Children Partnership - Pan-Dorset Safeguarding Children Partnership (pdscp.co.uk)

UHD safeguarding professionals work closely with NHS Dorset, Dorset County Hospital Foundation Trust and Dorset Healthcare Foundation Trust Safeguarding Professionals.

UHD believes that safeguarding is everybody's business. Every member of our staff has an individual responsibility for safeguarding; all our staff and volunteers are equipped with training to recognise abuse and respond accordingly.

3. Safeguarding Infrastructure

As a corporate team the merger restructure for Safeguarding as UHD has taken place this year.

In March 2022 Consultation for the Head of Safeguarding post commenced, with an appointment being made to commence post 1st September 2022. Due to significant operational staffing absence and vacancies the appointed Head of Safeguarding has worked operationally as a practitioner through to 31st March 2023.

It is important to highlight that there have been vacancies within the Child Safeguarding arm of the team between October and February (50%) and due to absence and vacancy within the Adult arm of the team between October and March (50% gap during November, and fluctuating from 0 – 50% through December, January, February and March).

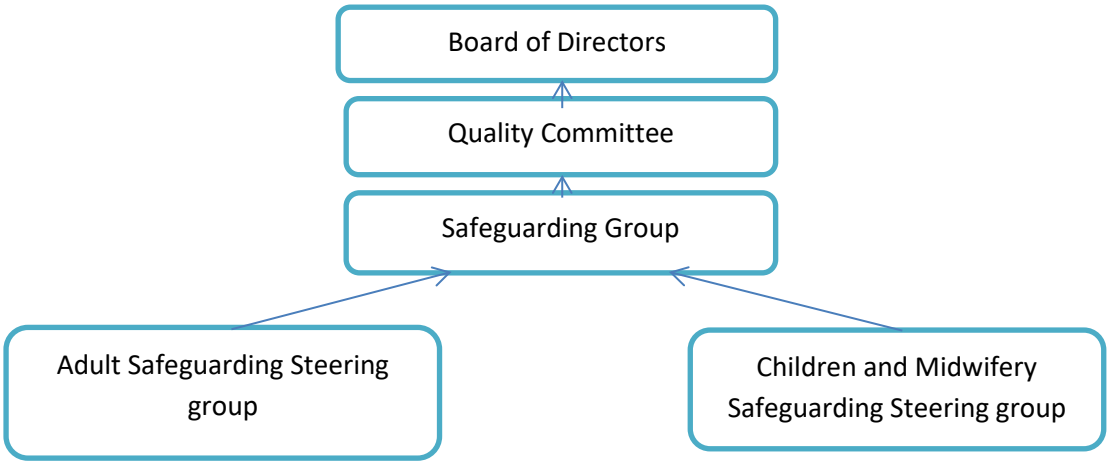
There has been a significant volume of work completed to align referral pathways, procedures, training and policies for staff, whilst covering the day to day operational safeguarding cases with very reduced staffing. In addition there has been strategic alignment with partners across Dorset in preparation for the Integrated Care System launch in July 2022.

Safeguarding Staff (1st April 2022 to 31 March 2023)	
UHD Executive Lead for Safeguarding	Paula Shobbrook
Designated Officer for Safeguarding Allegations and Deputy to Executive Lead	Fiona Hoskins
Head of Safeguarding (including Named Nurse for Children, Lead Nurse for Adults and Lead for Domestic Abuse)	Pippa Knight Appointment made in September 2022 but due to vacancies not able to commence until 1st April 2023.
Interim Named Doctor for Safeguarding Children	Dr Matt Baker supported by Dr Delyth Howard and Dr Mark Tighe
Named Nurse for Safeguarding Children	Lynne Lourence and Pippa Knight until 1st March 2023 when this role became integrated to Head of Safeguarding.
Safeguarding Children Practitioners	Natalie Hawker until 30th September 2022

	Lynne Lourence from 1st March 2023 Adama Otter from 20th February 2023
Safeguarding Adult Practitioners	Helen Beaulieu in post until 30th November 2022. Teresa Izzo in post until 12th February 2022, then 0.2WTE only until 31st March 2022 Lisa Midgely in post 0.4WTE from 31st January 2022.
Learning Disability Liaison Nurse	Naomi Rees
ED Lead Safeguarding Nurse	Allison Crocker from October 2022.
Named Midwife for Safeguarding Children	Kerry Medina
Lead Midwife for Safeguarding	Kelly Phillips
Lead for Domestic Abuse	Pippa Knight supported by Teresa Izzo until 12th February 2022 when this became integrated to Head of Safeguarding.
Domestic Abuse Advocates (Paragon Charity)	Michelle Ioannou (until January 2023) Emily Briston (from July 22)

4. Governance Arrangements

The current reporting structure for safeguarding.



Risks associated with Safeguarding as at 31st March 2023

Open

1641 - Held by Safeguarding Children Child Safeguarding – *UHD Transition*
1780 - Held by Safeguarding Team - *Safeguarding Children Level 3 training compliance*

1782 - Held by Safeguarding Team - *Safeguarding Adult Level 3 training system*
1781 - Held by Safeguarding Team - *Reasonable Adjustments system governance including CPI flag.*
1836 - Held by Safeguarding Team - *Staffing Gap within UHD Safeguarding Team*
1752 - Held by Safeguarding - *Absence of Named Doctor for Child Protection within UHD*

1300 - Held by Child Health - *Provision of 24hr specialist care for children under 18 who have mental health needs*
There has been agreement that this Risk is better to be held by a central team as the risk reflects all Children and Young People with Mental Health Needs and a proportion of these young people are cared for on adult wards across UHD.
1340 - Held by Child Health - Risk of the Children's Safeguarding on-call rota destabilising due to loss of consultant workforce.
1755 - Held by Child Health - Looked After Children Initial Health Assessments

1832 – Held by ED – *Risk of Missed Safeguarding Opportunities*

Closed in year

1723 - Held by Safeguarding - *Liberty Protection Safeguards (LPS)*

5. Safeguarding Inspections

The CQC carried out a focused inspection with a short notice on 28 September 2022. Bournemouth site was inspected but not rated and Poole site was inspected with some areas rated as well. Considering safeguarding as a service the CQC told us;

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff understood the different forms of abuse and what action to take to promote patient safety. They knew how to report safeguarding concerns and understood how to identify patients with safeguarding concerns on the IT systems.

The provider had a safeguarding team which staff could approach for additional advice. We observed staff from different professions coming together to discuss plans for a patients discharge to ensure they were safe to return to their usual home.

The provider had an internal target of 90% of staff to be trained to Level 1 and Level 2 Safeguarding Adults. Poole hospital did not meet the trust target for adults safeguarding Level 1 and 2 at 86.8% and 87.7% respectively. The provider had made the decision to increase the requirement for Level 3 safeguarding children to a wider range of staff and was currently working to train more staff to this level. The current number of staff trained to this level was 67.9%. This item was on its risk register and was being monitored. However, not all trusts train staff to Level 3 for safeguarding children.

From the inspection there are areas for us to improve but positively throughout the report there is consistency in the care and compassion seen (and described by patients) by our staff to support people in our care.

6. Safeguarding Training

Safeguarding Training is covered within the Essential Core Skills Framework. All staff are offered Safeguarding training appropriate to their role and at the end of this year all staff access training requirements via the VLE system. The Trust are engaged with partners in the ICB to seek and offer training opportunities across Dorset. The Key Performance

Indicator (KPI) for safeguarding training is locally agreed with NHS Dorset and is 85%, Trust target is 90%

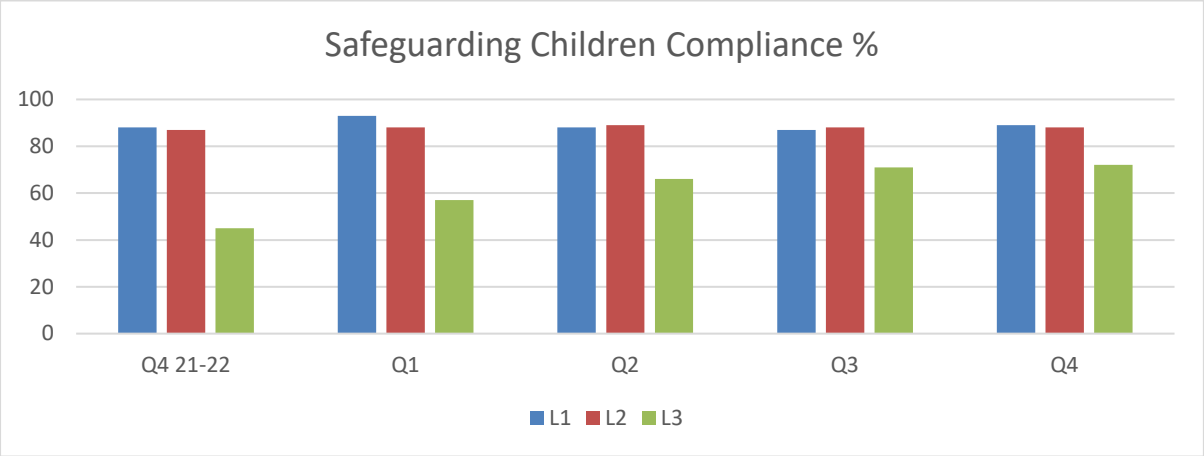
Overall Safeguarding Adult Training compliance at reporting end: 90% across UHD

Overall Safeguarding Children Training compliance at reporting end: 86% across UHD

Safeguarding children training is assigned to staff depending on role.

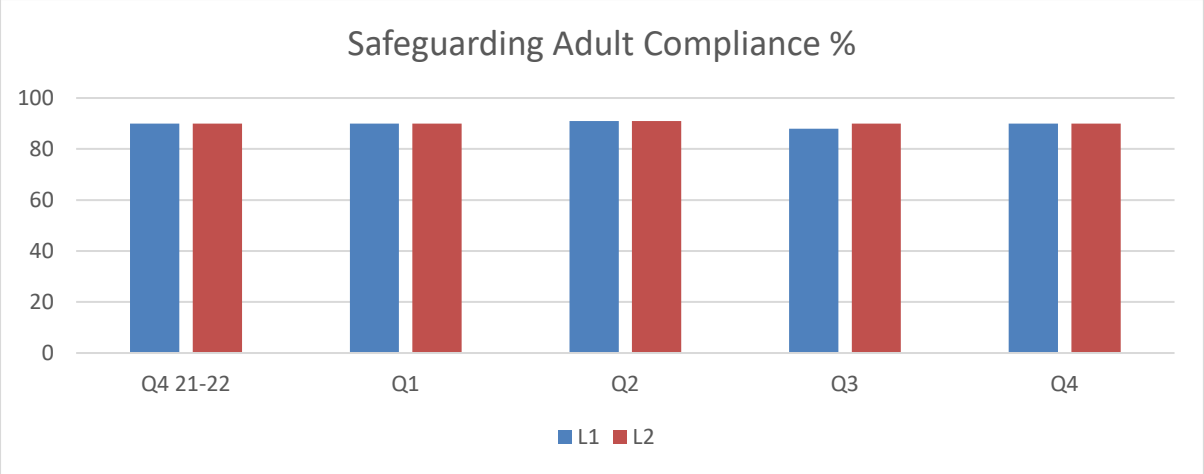
- L1 is combined with L1 adults and is in-house e-learning
- L2 is also in-house e-learning.
- L3 is available as either a national e-learning programme, an off-site Partnership training (face to face and on-line) or in-house face to face training day. Reflecting on training evaluations the in-house face to face and e-learning are both well received. The partnership multiagency training receives mixed feedback from our staff with some feeling it does not meet their needs as health professionals and the group may be heavily dominated by social care or nursery provider staff. However some sessions, especially themed sessions are better evaluated.

There has been a consistency in L1 and L2 compliance hovering just below the 90% target. With the stronger more embedded reporting structure there will be more focus on specific care group and directorate training compliance at the Steering Groups in 2023-24. There has a demonstrable improvement in L3 which is extremely positive given the challenges in staffing, workload on patient facing staff in our front door areas, escalated Trust OPEL status and industrial action, all of which affects impacts attendance on face to face training.



Safeguarding adult training is also assigned depending on role. Historically staff have been assigned level 1 or 2 but no staff have been assigned level 3. This is not in-keeping with the Intercollegiate Document and so a project to assign and develop level 3 adult training has commenced in Q4 this year for delivery in 2023/24.

- L1 is combined with L1 children and is in-house e-learning
- L2 is also in-house e-learning.



There is consistency in the overall training compliance however there is a significant gap with no Level 3 training being offered UHD. This has been a new risk for the safeguarding team but there has been little opportunity to improve against the challenge of safeguarding practitioner vacancies.

Named professionals are required to complete Level 4 training and this has been offered and completed by all Named Professionals in UHD. UHD aspire for all safeguarding practitioners to complete Level 4 and are working towards this with our NHS Dorset partners.

Mental Capacity Act (MCA) training is a stand alone e-learning module created in-house. Across the ICS other Trusts have adopted the NHS England e-learning module and so UHD continue to consider whether to align to the ICS or continue with the in-house provision. End of year compliance for MCA training is 89%.

Learning disability awareness training has and continues to be embedded within the safeguarding e-learning modules. However, in 2022-23, to strengthen that offer and in anticipation of the launch of Oliver McGowan training, UHD worked with our ICS partners and launched the Dorset wide Autism e-learning package commissioned through Autism Unlimited. This training was available to all staff and could be accessed via our VLE system. This was available until March 2023.

On 6th March 2023 UHD, along with all Dorset ICS partners made a soft launch of Oliver McGowan training. Oliver McGowan training was made available to all staff via the VLE 'heart', this will switch to their 'brain' once the training becomes a national essential core skill.

Prevent training is delivered by our Prevent Lead as Essential Core Skills. End of year compliance for prevent training is 81%.

There was a significant crash in compliance in October 2022 from the typical 94/95% to 54%. Since then there has been a rapid improvement. The 'crash' was linked to an alignment of training allocation across UHD, resulting in an increase of staff requiring WRAP level training.

7. Policies and SOPs

The overarching ICS Safeguarding Policy was updated by our Designated Nurse in July 2022. UHD specific Trust guidance sit below and is aligned to the ICS policy. Policies and SOPs updated this year include;

- SOP - Managing Safeguarding Allegations against Staff & Workers within UHD

- SOP - Consent and capacity in children and young people up to 18 yrs. (This aligns to the main Trust Policy for Consent being updated).
- SOP - Demographic changes for Looked After Children/Children in Care
- SOP - Demographics changes for children with Adoption Orders
- Policy - Trust Domestic Abuse Policy

8. Safeguarding Supervision

Safeguarding supervision provision has improved but still remains a challenge.

- The child safeguarding team offer routine programmed sessions for certain teams plus adhoc supervision for any member of staff.
- Safeguarding adults do not currently offer regular supervision to groups of staff but can offer case by case support.
- The Named Safeguarding Professionals have had intermittent access to regular supervision.

Supervision for safeguarding is a work plan item across the ICS for 23/24 and UHD are engaging in this workstream as we are keen to have a more robust offer for our staff and our safeguarding practitioners. The Supervision Policy requires updating as part of this improvement plan.

9. Safeguarding Adults

Safeguarding Adults referrals

	2020-21	2021-22	2022-23	**% change in 2 years**
C4C submitted	1057	1025	1112	↑ **5%**
Domestic Abuse cases	141	143	416	↑ **195%**
S42.1 received	139	146	230	↑ **65%**
S42.2 Nominated Enquiries	62	67	17	↓**72%**

C4C (Cause for Concerns) are raised when staff within UHD have a concern for a patient who might be an Adult at Risk and needs additional support to keep them safe. These concerns are shared to the Local Authority where the person resides. UHD have seen an increase in these concerns being raised reflecting possibly the impact of cost of living crisis or an increase in the number of patients admitted to UHD. The largest concerns continues to be self-neglect, neglect and emotional harm.

Section 42.1s are safeguarding concerns raised by external partners and parties against UHD and brought to UHD via the Local Authority. The UHD increases in S42.1s from 20/21 to 21/22 reflect the national 9% increase. This was higher than previous years where nationally the increase had been approximately 8%. There is no national data available yet to confirm whether the significant increase seen in 22/23 at UHD is also in line with the national picture. This 65% increase in enquiries has a huge impact on staffing with each enquiry requiring at a minimum of 2 hours of time from the safeguarding practitioners plus time from ward staff. Disappointingly there are recurring themes around the 42.1s including

- Communication around discharge

- Medicines on discharge
- Tissue injury
- Documentation of care

These themes in the safeguarding concerns may align to the CQC findings of

- The service did not always have enough nursing and health care assistants to care for patients and keep them safe. Staff did not always complete and update risk assessments for each patient.
- The service was blocked by patients in beds who were medically fit for discharge due to a lack of community and social care packages in the region.

These will become focussed areas for improvement in 2023-24.

It is positive that the rate of S42.2 Nominated Enquiries has reduced.

The learning from all our S42s and our C4C will be integrated into our Level 3 training being developed to launch in 2023/24.

Minor differences have been identified between the historic systems pre-merger and complete alignment will be completed in 2023/24. These differences do not negatively impact our patients.

Prevent

The prevent leads for UHD are the security managers on each site. It has been confirmed the Trust is completing is contractual duties. There have not been any referrals during this reporting timeframe.

Human Slavery

There are very few cases of Human Slavery reported within the adult services at UHD but there is a definite at risk group of children. This may reflect a gap in professional curiosity which will be strengthened through introducing Level 3 training. There has been one case which UHD raised with the Safeguarding Adult Board as an opportunity for shared learning. UHD raised concerned about a potential case of Human Slavery. Despite reaching out to several partner agencies there was a delay in making a National Referral as partners mistakenly deemed that the NHS could make such referrals. Via our Domestic Abuse advocates persistence to reach out for support the person of concern was eventually supported even though they had fled to another area.

Safeguarding Adult Reviews (SARs)

Bournemouth, Christchurch and Poole Safeguarding Adult Board (BCPSAB) have commissioned this Safeguarding Adult Review (SAR) after “Aziza” was found dead in March 2021, having taken her own life. The report was published in January 2023.Although UHD were not directly involved with the SAR there are recommendations for all partners to consider. One such recommendation regards Trauma Informed Care. UHD are engaged with multi-agency groups to introduce and embed this practice into our services. UHD will be working towards being Trauma Aware.

Domestic Abuse

Systems are now aligned and embedded across sites with Policies and SOPs in place.

Our joint domestic abuse health advocates project with Paragon continues and funding has been extended to at least September 2023. Our domestic abuse health advocates have

reported improved quality of risk assessment and Multi-agency Risk Assessment Conference (MARAC) referrals by staff. This is positive as more referrals will progress and be accepted for MARAC intervention. This improvement is highly likely to reflect the training delivered to staff by our advocates. Training is offered to small teams, larger directorates and is included on the L3 Safeguarding Children programme, it is always evaluated positively. Through our advocates we have identified better collaboration with external partners including Maple Team, Community Safeguarding Homeless Team and Psychiatric liaison team. We have an improved referral and outcome information data base which has enabled the admission of referrals vs just MARAC referrals this. There has been a significant increase in the number of referrals for domestic abuse (195%) which is both challenging due to the workload and very positive as it reflects embedded consideration for domestic abuse and support for people – patients and staff.

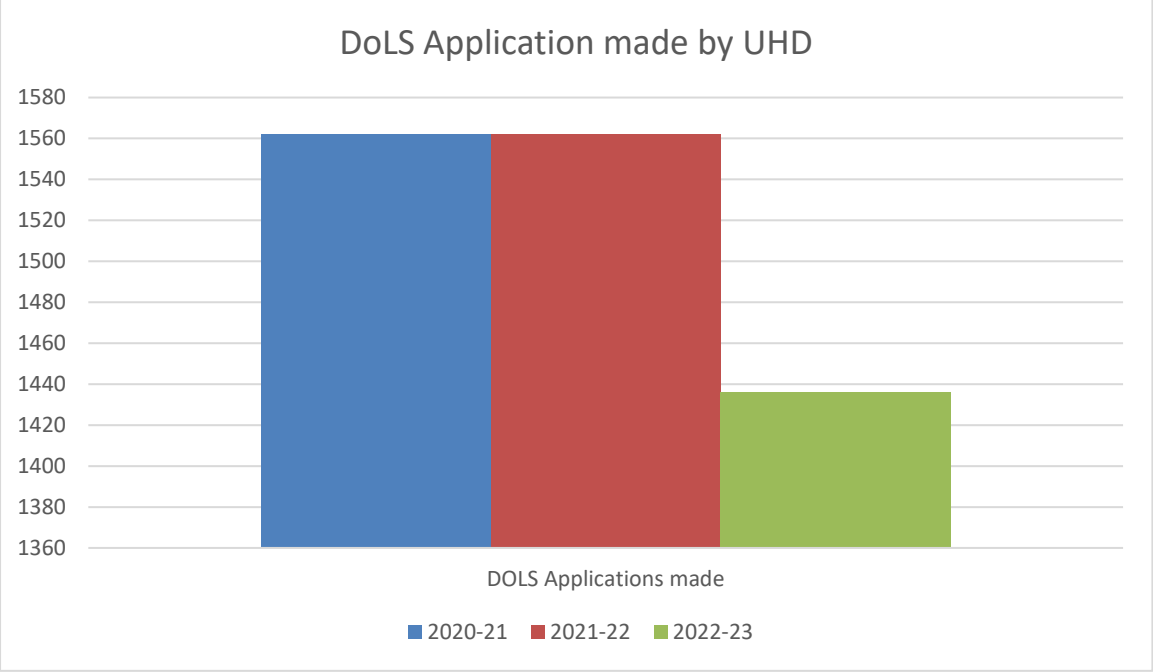
MARAC referrals from UHD = 101 (n=65 in 21/22)
Staff supported by Paragon Advocates via UHD = 32

Domestic Homicide Reviews (DHRs)

No DHRs contributed to by safeguarding at UHD.

10. MCA and DOLs (Deprivation of Liberty Safeguards)

Activity



All applications for DoLS continue to be made electronically to the local authority and recorded within a central database.

The trust remains compliant with mandatory reporting to the CQC. The internal difference between sites for how the report to the CQC has been resolved and DoLS administration has been supported via the clinical practice administrator. There will be a safeguarding administrator appointed in 2023/24.

The CQC finding with regard to DoLs process across UHD are being attended to and expected to be completed by end of Q2. The CQC told us;

Staff could describe and knew how to access the policy to get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. They understood how and when to assess whether a patient had the capacity to make decisions about their care. We saw patient files that showed the correct processes for assessing capacity had been followed and staff implemented Deprivation of Liberty Safeguards (DoLS) in line with approved documentation. However, each ward had a separate method of communicating DoLS authorisation to other members of their staff team. For example, on one ward they communicated patients' DoLS status into the ward handover book, on another staff copied all senior nurses on the ward into the DoLS authorisation email. A lack of cohesion in communicating important legal information could result in a patient being detained unlawfully.

The Trust has responded to this finding through an action plan to align practice across UHD. Each ward will have a single email address for all applications to be made via, this will strengthen communication channels between the managing authority and the ward. Health of the Ward will be utilised as the tool to communicate a DoLS application has been made as this is a visible communication tool that transfer across areas if the person moves. Additionally, consideration is being given to add an information bar to the Electronic Patient Record (EPR) when an application is made.

There will be greater scrutiny around the DOLS applications in 2023/24, in light of the decrease in number this year. Training and systems will be reviewed to assure ourselves we are correctly applying legislation.

Liberty Protection Standards (LPS)

The new code of practice for Liberty Protection Standards was not implemented as anticipated. In April 2023 the Government announced a full pause with working towards LPS.

11. Learning Disabilities (LD)

Data

UHD	2020/21	2021/22	2022/23	Change % in year
Reported admissions for patient with LD	990	999	1373	↑**27%**
Confirmed LD	No data	364 *no Q1 est = 485	726	↑**33%**
Death of patient with confirmed LD	No data	18	16	↓**12%**

With our Learning Disability Liaison Nurse in post full time and covering all sites there has been a tangible increase in awareness for Reasonable Adjustments and partnership working with our community colleagues. These are definite improvements for people with Learning Disability who flow through our hospitals. However, the improvements have also brought challenges for our system.

Challenges include

- The daily workload for a single service practitioner has increased significantly (see data). In recognition of more direct support for our LD nurse the post has become more deeply integrated within the Safeguarding team. This allows our LD nurse to focus on our patient journey and allow some work to be supported by the Head of Safeguarding – an example is the LD Provider Forum and LeDeR meetings. By being more integrated into an established team our LD messages can be more widely shared and any learning can be more embedded via existing frameworks. Our

Specialist nurse continues to develop a team of LD link nurses who will be able to support their clinical areas.

- Q3 highlighted that we are seeing an increase in people with autism (and other neurodiversity diagnosis) and our LD liaison nurse is often seen as the only professional who can support ward teams. This person stayed at UHD for an extended length of time and despite challenges when not heavily involved, and requests for on-going intensive support, it was identified that other patients with LD were not having as much support as they potentially required. The LD nurse and whole safeguarding team worked very closely with our medical care group colleagues and our amazing Trust volunteers to support this complex patient. This case demonstrated a need for improved training for our staff.
- The job description for our LD post will require review to ensure a broader scope of conditions people may have and include our young people aged 16/17 year who are in transition to adult services and may be on our adult wards.

The Trust has a Learning Disability Policy in place, Reasonable Adjustment e-form system in place and strengthened considerably, Reasonable Adjustment CPI flag system in progress. There is improvement to be made to our external website regarding Reasonable Adjustments, which was highlight at a provider Forum and has been fed back to our Web Team. There is a risk associated with the improvemnts required, and being made around Reasonable Adjustments.

The CQC inspection also identified that there was not a consistency in Reasonable Adjustments or access to appropriate professionals;

In Surgery - *We spoke with a patient with a profound learning disability and autism, and their parent. The parents were taking it in turns to provide round the clock care and supervision for their son in a side room. The patient had not been visited by a learning disability nurse and he did not have a named nurse. The parents did not get breaks from providing care, and they told us there had been no attempt by staff to assess the communication needs of their son. Some of the nurses we spoke to did not know there was a specialist team to work with patients with learning disabilities and autism.*

In Medicine - *Staff mostly made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.*

The Trust participates in the annual NHSE & NHSI Learning Disabilities Standards Project. During Q3 100 questionnaires were sent out to patients with LD who have accessed our services during the last financial year as part of this project. Benchmarking questions were sent to relevant colleagues in respect of the above project to request data in order to submit the responses at the end of Jan 2023. It is anticipated result will be shared in September 2023.

UHD is compliant regarding reporting the death of a patient with a learning disability to the Learning Disability Mortality review (LeDeR).

12. Safeguarding Children

<u>Safeguarding Children referrals</u>

Staff continue to use our e-form system to share information relevant to safeguarding children with partners in Primary Care, Community Health Services, Children's Social Care and Community drug and alcohol services. Some of these contacts are pure information sharing, for example if a child attending the emergency department is noted to have a

national CP-IS alert. At other times e-forms are used to refer a case to our Children's Social Care Services.

Emergency Department

	2021/22	2022/23	% change in 1 year
Total number of child attendances to ED	38849	33074	↓ **17%**
Total number of e-Forms submitted	5825	6126	↑ **5%**
% e-forms for attendances	15%	18%	↑ **3%**
% compliance with CP-IS checks	No robust historic data - new report initiated in 22/23	96%	

In October 2022 the daily safety checks to ensure children who attend ED have had appropriate e-forms sent to partners was integrated into the ED workload. This has been both positive and challenging. It is positive that ED complete the checks and feedback directly to the ED staff and at ED governance meetings. Safeguarding is a central aspect of care and should be considered as department business as usual. As the daily checks are part of ED work, system improvements are quickly identified, an example includes the change to adult mental health referrals triggering the practitioner to also make a safeguarding children referral if children (U18 years) are identified. It is a challenge to the department, especially given the increase in numbers of e-forms being generated as this new practice is currently adopted as a single practitioner role and the department continue to develop a robust system to cover times of absence. The safeguarding team continue to support the ED for escalated, complex or challenging cases and to support during times of absence. The safeguarding team will re-commence the regular quality checks of the safeguarding e-forms generated from ED in 2023/24 and introduce safeguarding supervision for staff to continue to reduce errors and support staff development.

In year a Reachable Moments project was launched by BCP, Police and ED at UHD in response to a CSPR. UHD engaged with The Children's Society for training sessions for Child Exploitation and the Reachable Moments project. Unfortunately, due to service redesign within BCP the Reachable Moments Project was halted. UHD continue to work with multiagency partners to support young people at risk of exploitation and the serious violence agenda. This year, in particular, UHD noticed an increase in assaults to children, by children but also by non-familial adults. Knife crime has been a concern and has resulted in 2 rapid review briefings for the Pan Dorset Partnership. There have been 8 referrals for children with a significant injury with a knife recorded as the weapon. Monthly lists for children considered to be at significant risk of exploitation are received from both BCP and Dorset Council areas, and when identified a CPI exploitation flag is applied.

Corporate Referrals (non-ED)

	2021/22	2022/23	% change in 1 year
Total number of e-Forms submitted	2192	1830	↓ **19%**
Areas forms received from	Child Health AMU, Medical wards, Surgical wards, out-patient areas including dermatology,ophthalmology, radiology, Early Pregnancy, plus Mac Unit, ITU, other therapy teams and specialist alcohol teams	Child Health AMU, Medical wards, dermatology, Ophthalmology, Radiology, OPD, Early Pregnancy, SAU, Physiotherapy, MIU, Mac Unit, ITU, Theatres and specialist alcohol teams	

Although a significant percentage of the corporate forms are submitted by Child Health and child out-patient areas, we continue to a have good representation of forms about the child when the adult is our patient. We receive safeguarding children e-forms from all areas.

Children with longer stays

UHD Safeguarding continue to support an increased number of children who have neurodevelopmental, mental health or complex social needs. These children attend our ED and require admission to UHD as there is deemed no safe place for them in the community or in a mental health unit. UHD significantly contribute in multiagency discharge planning for these children and young people. In Q2 a Memorandum of Understanding was ratified and published by NHS Dorset to promote timely and appropriate discharge for young people. An example of when the MOU may be used to support discharge might be:

Q3 - A 17 year old with significant learning disability who did not have capacity to make decision about their discharge placement, carers felt they could no longer manage their care needs. Working with the family, Trust solicitors and Local Authority the young person was safely discharged with an intensive wrap around support plan.

Q4 - 14 year old admitted following a significant suicide attempt where all services agreed that they should be discharged to Intensive Care mental health in-patient bed due to high level of risk to self. The safeguarding team worked intensively to plan and support staff, ensuring the young person was kept safe in our care until the discharge bed could be sourced.

The safeguarding team are working with the Business Intelligence team to build robust data reporting tools.

Serious Incidents

There have been 3 Safeguarding Children SIs in year (n=0 in 2021/22)

Child Safeguarding Practice Reviews and Rapid Reviews

UHD have submitted 8 Briefing Reports as part of the Rapid Review process to our Safeguarding Partnership which is a considerable increase on 2021/22 (n=3). Three progressed to CSPRs and 1 to a case audit, all required an Individual Agency Report from UHD.

Locally published Child Safeguarding Practice Reviews

The Siblings – no involvement from UHD
River – involvement from UHD
Thematic Intra-familiar sexual abuse review – no involvement from UHD

Even when UHD have not had contact with the child or family and have not written a single agency report, there is learning. The learning from published reviews is integrated to our Level 3 face to face training and added to our intranet page as a reference.

UHD have escalated that the sharing of review outcomes from the Partnership is not always as strong as it could be. Working with NHS Dorset this will be reviewed and improved for 2023/24.

Nationally published – Star and Arthur. The report was disseminated widely, the Safeguarding Children Partnership have produced a response to the report for our System and UHD intend to conduct an internal survey to consider our Trust safeguarding systems and any key areas for improvement. Due to the significant gap in our safeguarding practitioners during this year, it will be on our improvement plan for 2023/24 when we welcome new staff into post.

FGM

Reporting systems are in place across UHD however the variance in the systems across the sites remains and is captured through Risk 1641. The work to align a single system across UHD is underway and is agreed to be led by Maternity as most identified cases of FGM are within Directorate.

Maternity services are compliant with FGM-IS.

Child Deaths

There have been 21 child deaths in year (n= 12 21/22). Most of these deaths have been anticipated due to a medical condition although some have been unexpected.

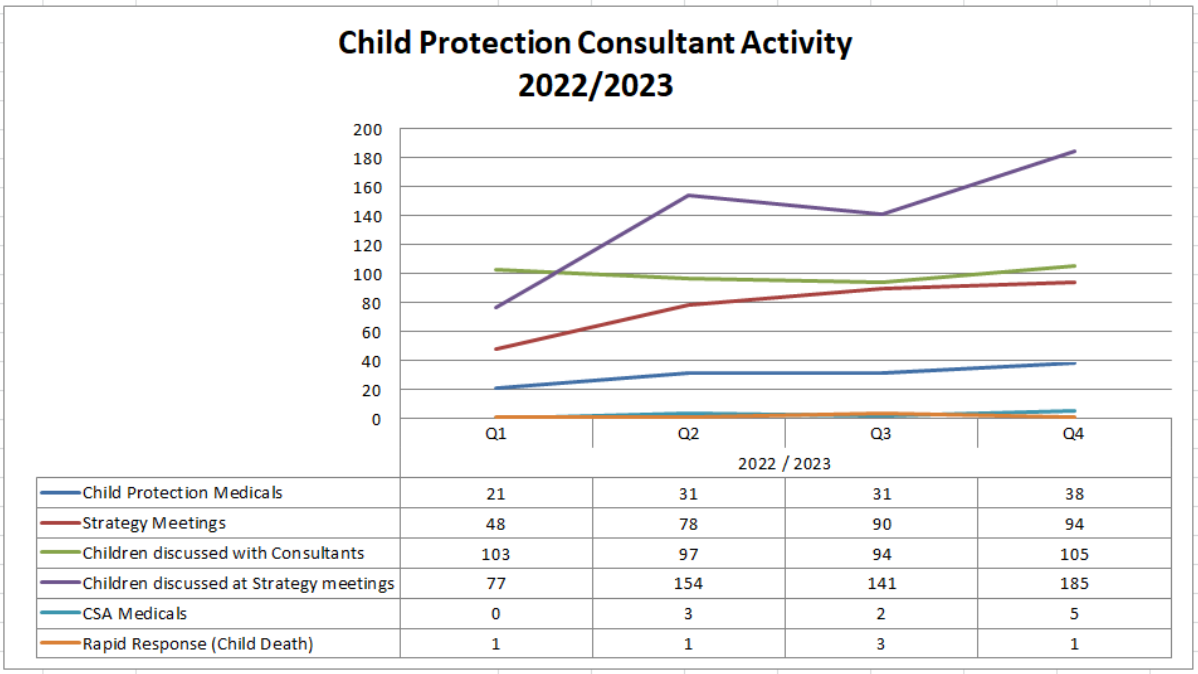
The Child Death process is led by Child Health.

- Where appropriate all would have had a Joint Agency Review (JAR) meeting, or be reviewed under Perinatal Mortality Review Tool (PMRT) either locally or regionally
- Safeguarding, police, GP's, HV, education, and ambulance providers are part of all JARS to ensure safety netting and support for families
- Place of death varied between home, emergency department, paediatric intensive care unit, Southampton Hospital Neonatal unit, Gully's end of life suite or hospice
- Where needed any immediate learning/changes to pathways within hospital shared and actioned via Safety Huddles, Quality and Risk group and Clinical Governance
- Positive feedback from many of the families for the compassion showed by staff in sudden unexpected death situation
- We join West Dorset, Somerset, and Yeovil for our Child Death Overview Panel (CDOP) panels to ensure thematic learning can be shared

- All families made aware of Gully's Bereavement support network

Named Doctor and Child Protection Activity

Below is a table showing the Child Protection Consultant activity.



	Q1	Q2	Q3	Q4
Child Protection Medicals	21	31	31	38
Strategy Meetings	48	78	90	94
Children discussed with Consultants	103	97	94	105
Children discussed at Strategy meetings	77	154	141	185
CSA Medicals	0	3	2	5
Rapid Response (Child Death)	1	1	3	1

Within the time period the Named Doctor role has been covered by Dr Baker (ED Consultant, Bournemouth site) on an interim basis. As an ED consultant with an interest in paediatrics and with previous forensic experience, this has brought a more generalist overview approach and work on the family approach integrating with teams and agencies within and outside of UHD with paediatric support from both the Clinical Director of Child Health and an experienced Child Protection Paediatrician.

During this time we have worked to reinvigorate the child protection team and address some of the challenges around this service. We have developed the relationship between UHD and the SARC and are now hosting quarterly joint peer review meetings both in line with RCPCH guidance but also to foster closer working and shared learning. With the revised peer review guidance we have also opened the invitation on a quarterly basis to the wider paediatric dept.

We have audited the compliance with the RCR guidance around skeletal surveys after concern was expressed around the number of paediatric radiologists within the trust able to report the skeletal surveys and as a result this is on the risk register and a network solution is being sought to address a national shortage. In addition, a second radiologist with paediatric expertise has just been appointed, which should help promote resilience and enable greater second reporting.

There has been much work around safeguarding of children who present through urgent and emergency care around training but also having robust daily checks on both sites to identify children at risk who attend our hospitals. We have also liaised

with our social care colleagues to improve strategy conference scheduling to avoid parallel strategy meetings needing a safeguarding consultant presence.

We have submitted our child protection standards audit to the RCPCH which overall confirmed good practice in most areas, and has highlighted some gaps within our service around protocols and recording and a draft policy has been circulated for comment to address these.

There remains challenges in accessing nursing chaperones, ensuring safety of staff following medicals, and medical photography at times and we are collecting data to see how big an issue this so that we can work with these teams to address

13. Allegations against staff

Data

There is no robust combined data for both old Trust across adults and children workforces pre merger.

2021/22	2022/23	% change in 1 year
7	44	↑ 500+% Caution required as 21/22 may have been unusually low numbers.

This year has seen a demonstrable improvement in the robustness of a UHD system for reporting and receiving allegations about staff. A SOP has been produced and widely circulated.

Within the Safeguarding there is a clear escalation route and we share strong links with our CMO office and HR. Although we continue to receive allegations via the external Local Authority Designated Officer (LADO) or People in a Position of Trust (PiPoT) processes we have seen an increase in UHDs self-reporting. Internally, we support staff from across most care groups and a range of staff roles, we additionally receive reports regarding external contractors such as security workers, agency nurses and specialist 1-1 carers. All allegations follow the strong processes we have in place. Internally a theme around befriending patients has become apparent. Given the increase in concerns regarding staff being raised the safeguarding team have requested to be part of face to face Induction training again.

In year UHD joined a cross-border LADO investigation which was considered as an SI. UHD have reviewed their Modern Slavery Statement and ID checks for non-UHD staff when they arrive for shifts as an action of the case.

14. Safeguarding within Midwifery

Safeguarding within maternity has continued to be challenging this year. The Oasis team has seen a large turnover of staff this year, mainly due to pregnancies, but also staff moving to pastures new. The team consists of a Named Midwife for Safeguarding, one Lead Midwife for Safeguarding, 9 midwives and 2 support workers. There is also a Perinatal Mental Health midwife who is part of the wider team.

The following policies have been written this year:

- Substance Misuse Policy
- Care of complex needs

- Mental Health policy

Level 3 training has increased significantly this year from 65% to 95% with the Named Midwife for Safeguarding targeting practitioners personally to ensure compliance.

Supervision has continued to be facilitated by the Named Midwife for Safeguarding and the Lead Midwife for Safeguarding and a robust system is now in place to capture compliance of all staff.

Activity:

- A total of 10 escalations were made to BCP Children's Social Care this year and none to Dorset Social Care.
- 5 Female infants were born to mothers with a history of FGM and FGM-IS flags were put on the infants medical record
- There were 10 concealed pregnancies
- There were 2 Serious incidents this year – one IUD at home, one IG Breach
- There were 2 rapid reviews for maternity, one leading to a Child Safeguarding Practice Review for "Daniel and Sarah" following the death of Daniel at 7 weeks
- No cases were reported to LADO for maternity

Good multi-agency work continues with the Named and Lead Midwife for Safeguarding meeting with Children's Social Care weekly to discuss babies on the unborn tracker from referrals made by all agencies to ensure good communication regarding concerns for unborns. Edge of care meetings have been introduced this year to support families at risk of having a child removed with all professionals associated with their care

The Named Midwife for Safeguarding received a UHD Excellence award following a challenging case within maternity and multi-professional working.

15. Monitoring and Assurance

This report is a broad overview of safeguarding across UHD. The more detailed quarterly reports are discussed in depth at the Safeguarding Steering groups and the Trust Safeguarding Group and are available to read.

Author: Pippa Knight

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 27 September 2023

Agenda item: 8.2.1

Subject:	Key Issues and Assurance Report to Board of the People & Culture Committee meeting held on 09 August 2023
Prepared by:	Pankaj Davé, Chair of the People & Culture Committee
Presented by:	Pankaj Davé, Chair of the People & Culture Committee

Key Issues/matters discussed by the Committee:	The Committee reviewed and received reports and assurance for the following: • Update on BAF Strategic Risks • Chief People Officer Report (Mandatory training, People Pulse Survey and Industrial Action) • Chief Nursing Officer Report (Nursing Establishment Review and Maternity Safe Staffing) • Chief Medical Director Report (Revalidation – Annual Organisational Audit, GMC Survey and Guardian of Safe Working Hours Report) • Care Group Reports and alerts • Equality, Diversity & Inclusion Annual Report • Annual Security Report • Freedom to Speak Up Report • Education & Training Report • Modern Slavery Statement The Committee noted: • Our people are delivering strong performance within a backdrop of large workloads, staff shortages and strike related matters. • The Committee was pleased to note that staff sickness, recruitment and retention are improving. However, there are opportunities and challenges which need to be addressed, including implementation of the Recruitment and Retention Policy. The Committee asked to improve exit interviews to better understand why people are leaving. • The important work done on the Nursing Establishment Review (safe staffing) was discussed at length as this will identify harmonized UHD templates to deliver safe staffing and create a platform for transition to new ways of working once the Trust transitions fully to the CSR two site working model. The templates are undergoing review by the Finance Team with final papers to be presented to the Executive Team.

	• The Committee reviewed Maternity safe staffing. This work formed part of supporting evidence for the Maternity Incentive Scheme (MIS) and would also be shared with the Local Maternity & Neonatal System (LMNS). This It is continuous process and will be reported every six months to the board as per MIS.
Significant issues for escalation to Board for action:	• **Industrial action** and related staffing and cover issues were discussed. It was noted that as the next planned action was by Junior Doctors and Consultants the customary 'Christmas cover' would not be enough and there will be staffing and service implications. This matter needs to be discussed in more detail at Board to assure all possible mitigations are in place to provide safe and quality care for patients. • **Staff Vacancies** - There are staff vacancies in key areas, including theatre staff mix, which continues to impact service and capacity. • **Surgical Care group Alerts**: Unsustainable 1:4 on-call rota for ENT with insufficient consultant numbers to reduce burden and impact of reduced number of trainees from August 2023, specialties reviewing impact. • **Medical Care Group Alerts** - The Emergency Department implemented a new electronic PAS system called 'Agyle' in June and July 2023. The Committee were informed that since implementation no friends and family data has been available for the implementation period and both ED departments had reverted back to paper to ensure that patients were still able to provide feedback and the Trust can collect the data for review and response. • **Women's, Children's, Cancer and Support Services Care Group** – (a) Consultant shortages are driving cost /service gaps in radiology/breast screening in particular. (b) Continued high level of risks associated to gaps in workforce, namely Therapies, Pathology, Pharmacy and Radiology are the highest areas of impact/concern and (c) Interventional Radiology Nurse Staffing – increasing risk of closure due to vacancy. Risk to DMO1 and future service provision.
Progress of Board Assurance Key Risks Assigned to Committee:	• The risk review identified staff vacancies and skill mix deficit as key risks. The CMO informed that the longstanding risks related to implementing Electronic Job Planning were complex and would take time and come with related costs that could be significant. The Committee agreed that this important matter needs to be discussed at Board so that there is collectively a consistent understanding instead of this being covered separately by various board committees.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 27 September 2023

Agenda item: 8.2.2

Subject:	Quality Assurance for Responsible Officers and Revalidation
Prepared by:	Rachel Ivamey
Presented by:	Peter Wilson

Strategic themes that this item supports/impacts:	Systems working and partnership ☐ Our people ☒ Patient experience ☐ Quality: outcomes and safety ☒ Sustainable services ☐ Patient First programme ☐ One Team: patient ready for reconfiguration ☐
BAF/Corporate Risk Register: (if applicable)	
Purpose of paper:	Assurance
Executive Summary:	Section 1 demonstrates compliance with the statutory obligations of the organisation and Responsible Officer. Area of concern is the ability to recruit appraisers due to ongoing work commitments. Area for improvement is to create a leavers report. There are mitigations in place around ensuring appropriate connections of doctors to an RO. Section 2a gives details of the effectiveness of appraisal. There are good processes in place to ensure appraisal for all, offer support where difficulties occur and processes in place around non-compliance. Areas of work are around recruitment of appraisers. Section 2b- over last 2 years appraisal has stood above 74%. Revalidation – 80% only 20 people have been deferred for revalidation.
Background:	The framework for quality assurance of responsible officers and appraisal was introduced in 2014. This was to ensure the ability for assurance within an organisation and at board that appraisals were being undertaken and to a satisfactory standard and that the duties laid out by the GMC for all doctors and responsible officers were being carried out effectively. This report lays out that assurance. Section 1 demonstrates general structure and effectiveness within the organisation. Section 2a demonstrates effectiveness of appraisal and section 2b demonstrates the appraisal data. Section 3 demonstrates our revalidation processes and section 4

	demonstrates effectiveness of participation in medical governance.
Key Recommendations:	Continue to support the process of exception reporting and therefore identifying problems early.
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 ☐ Ensuring our staff are looked after and managed within the correct governance framework. Ensuring our patients are kept safe.
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	09/08/2023	Summary of key areas of focus (not full report enclosed) presented.

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

Classification: Official

Publications approval reference: B0614

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2021

Contents

Introduction:

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

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

Annual Organisational Audit (AOA):

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

Board Report template:

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

A link to the letter is below:

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

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

Section 2a – Effective Appraisal

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

Section 2b – Appraisal Data

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

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

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

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

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

c) act as evidence for CQC inspections.

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

Statement of Compliance:

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

Designated Body Annual Board Report

Section 1 – General:

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

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

Action from last year: To remain an active member of the network meetings and updates. Comments: Professor Alyson O'Donnell stepped down as Responsible officer of UHD with effect from May 2022 and Dr Ruth Williamson as Acting CMO took over this role while applications were considered for the permanent replacement. Dr Williamson is fully trained in her duties as Responsible Officer and contributes regularly to regional Responsible Officer network meetings and feeds back to the Revalidation Team here. As of 1st April 2023, Dr Peter Wilson was appointed as Chief Medical Officer and Responsible Officer for the Trust. Action for next year: To remain an active member of the network meetings and ensure smooth handover to new Responsible Officer

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

Action from last year: To increase the number of appraisers, to enable an average of 5/6 appraisals per year. Comments: The software for both appraisal and 360 feedback have remained the same, with annual costs budgeted for and due to be reviewed in May 2024.

We currently have two administrators who support the Revalidation process FTE for this is 1.6. The number of medical staff we employ is increasing year on year, in particular the number of Clinical Fellows who are generally stay for 12 to 18 months before securing a place on a training programme. In the main these are Locally Employed Doctors or International Medical Graduates which often require additional support with appraisal as this is their first UK and NHS role.

We have a group of established appraisers within the Trust, currently 113 of which 6 have advised they will not continue in this role leaving 107 active appraisers to appraise approximately 880 doctors.

Our appraisers currently appraiser a range of between 2 and 23 doctors each, Appraisers are asked to complete 5/6 per year receiving 0.25PA in the SPA allocation of their job plan which allows 8 hours per appraisal, across the region this is a generous allocation.

There have been several appraisers retiring or leaving the role in the past 12 months and this has put some pressure on the rest. We have trained 5 new appraisers since the last board report and one has joined the trust, as the number of doctors continues to increase we would need a pool of 145 appraisers to match our appraiser to appraisee ratio, therefore we need to increase the numbers or look at different methods of appraising.

Action for next year: To review options for appraising and increasing the number of appraisers.

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

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

Comments: A Leavers report has not been accessible as hoped; however, the Premier IT system has been improved this year and we now utilise the GMC connection tool within the system.

We continue to keep GMC Connect updated as and when we become aware of leavers and starters. This is also reviewed 6 monthly when we review our 360 requirements for Revalidation.

Action for next year: Investigate an accessible leavers report and improve new starter information.

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

Action from last year: All doctors to be back to annual appraisals 12 months apart with little slippage. Comments: Appraisal engagement has increased significantly in the past 12 months, and the majority of our doctors are compliant with the annual appraisal process. Support from the team and realistic postponements have been used throughout the year. Action for next year: To continue to work in line with the policy, a review of the policy will take place in March 2024.

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

Actions from last year: Continue to keep standards high in preparation for a review.

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

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

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

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

Comments: We continue to ensure that all non-training doctors directly employed by UHD on a fixed term contract of at least 4 months will be given access to Premier IT and allocated with an appraiser employed by the Trust if required.

All are invited to an Appraisal Training Session (ATS) where they can meet with the revalidation team. We review those with short term contracts individually to determine their individual requirements from the Trust.

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

In most cases we offer appraisals to those who request it, where they are connected to us rightfully. Anyone working with us via a locum agency will not be offered an appraisal by the trust.

We continue to advise, support and enable them to have access to the supporting information they will need to fulfil their revalidation requirements.

For doctors working in the Trust but connected elsewhere we ask that they share with us a copy of their appraisal output, or a letter from their

designated body confirming no concerns and that their role at UHD was covered.

Action for next year: Continue to review the needs of all short- term doctors to ensure their appraisal needs are covered and they are supported with their revalidation.

Section 2a – Effective Appraisal

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

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

Comments: Since April 2022 we have been working on a 15-month escalation plan and the number of overdue appraisals has reduced and with the support of Clinical Directors we have reduced the number of REV 6's issued this year.

Action for next year: To ensure all doctors have an annual appraisal as covered within our Appraisal and Revalidation policy.

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

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

Comments: The appraisal support team attend all medical inductions to meet with new doctors who attend. During our session we outline the appraisal and revalidation process, the systems we use and the support available together with the requirement for their engagement in the process.

The Intranet across both sites were merged last year and we have now completed a review of the information available. This has been updated with useful links and guidance in a more user-friendly layout.

With more doctors engaging in the appraisal process, this has allowed the team to offer support to those who need it earlier.

Action for next year: To meet all new non-training doctors and explain the appraisal and revalidation process and offer support to anyone who needs it but in particular, those new to the UK / NHS.

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

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

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

Adjustments were made to policy between 2020 and 2022 during and following Covid. We will review these adjustments and learning during our review in 2023/24.

Action for next year: To complete a review of the Appraisal and Revalidation policy in line with national policy.

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

Action from last year: Work with Clinical Directors to ensure that adequate SPA is allocated for appraisals. Comments: Last year at this point we reported 798 connections with 111 appraisers, 12 months later we have 880 connections with 104 active appraisers. As noted earlier in the report we have trained 5 appraisers in the 12 months but again have lost more than we have recruited. The appraisal administration team hold regular meetings with Clinical Directors to discuss outstanding appraisals, revalidation, new starters and include a review of the number appraisers each department has and the number of appraisals they complete. Action for next year: To review the number of appraisers and to look at ways to improve the process in particular for those doctors on short term contracts who are returning to training to see if there is a better way of appraising them and in turn freeing up appraisers time.

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

Action from last year: Appraisers workshops are planned for October 2022 and May 2023 Comments: We held Appraiser Workshops in both October 2022 and May 2023 both on Teams, which works exceptionally well for this type of forum. Different topics were covered including Racism in the Workplace, Appraising the Neurodiverse, Appraising an Educational Supervisor as well as standard items including GMC updates and an Open Forum. These were received well and were a great opportunity for new information and best practice to be shared.

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

Action for next year: Include a face to face meeting as well as a Teams meeting for both Workshops to allow for more networking to take place.

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

Action from last year: First Revalidation Governance Committee meeting to be planned as UHD. Further discussions for an appraiser network forum to be held Comments: The Terms of Reference have been provisionally approved although the first meeting has not yet taken place due to changes within the RO / CMO role over the last year. The Appraiser network forum has also not been reinstated and due to the reduction in Appraiser numbers our focus is for recruitment of appraisers. The Revalidation team along with senior leadership and HR meet monthly to review overdue appraisals and agree actions required. Action for next year: To review Revalidation Governance Committee meeting with new CMO.

Section 2b – Appraisal Data

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

Name of organisation: University Hospitals Dorset	
Total number of doctors with a prescribed connection as at 31 March 2023	**838 (773)**
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	**616 (611)**
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	**258 (162)**
Total number of agreed exceptions	**129**

Section 3 – Recommendations to the GMC

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

Action from last year: Increase the number of doctors who we recommend Revalidation first time for which for this period is 70%. This will come from recognising earlier where support is needed.
Comments: During the reporting period 1st April 2022 – 31st March 2023 107 recommendations were made to the GMC relating to 101 doctors. The number of recommendations to revalidate first time was 81 = 80% 20 recommendations to defer were made, in the main due to minor delays in appraisal meetings or lack of 360. Of these, 3 doctors were deferred twice. In most cases the ability to collect patient feedback is returning to normal, although some are still finding that the reduced number of patients is causing this feedback to take longer. At the end of March 2023, we have all of those doctors due to revalidate up to 2024 set up with a 360 feedback with Edgecumbe.
Action for next year: To continue to improve the first-time recommendations to 85%, keeping focus on 360's in year 3 of revalidation cycle.

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

Action from last year: To sustain the recommendations at 2-3 months prior to the submission date.
Comments: We have made recommendations to the GMC at least two months prior to the submission date, in 51% of cases with many being over three months ahead. When any recommendation is due to be made, where the recommendation is for a deferral or non-engagement the doctor will be fully aware. The team ensure that we support the doctor to achieve a positive recommendation on time. Where this is not possible, the doctor will be part of the discussions and

fully understand the reason for deferral and know what is required and by when for a positive recommendation.

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

Action for next year: To increase the number of recommendations made at least 2 months ahead of the submission date.

Section 4 – Medical governance

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

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

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

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

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

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

Comments: With the team based within the Medical Staffing team across both sites we can share relevant information quickly and understand where there may be underlying issues.

The doctors are still expected to request information regarding any complaints and SUI's from the Patient Advice and Liaison Service (PALS)

and risk teams on their sites. These departments provide doctors with a record where they have been named or they are the named consultant which they can then reflect upon and include within their appraisal. We have been unable to find a way our systems can upload this information directly to the appraisal system and this will be reviewed again in 2023.

Edgecumbe 360 is now fully up and running across all sites with no issues outstanding. All doctors are expected to have at least one 360 in the five-year revalidation cycle covering both colleague and patient feedback.

Action for next year: Continue to review the facilities within each system to ensure they are used to maximum benefit for the doctors.

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

Action from last year: To have a joint Maintaining High Professional Standards Policy in place across both sites and review as necessary.

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

Action for next year: Continue to review as necessary.

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

Action from last year: Continue with current practice and review as necessary This information should include consideration of any protected characteristics and a timeframe for conclusion of investigations. Comments: The Strategic Workforce Committee receives a report from the Chief Medical Officer on the number and nature of any concerns raised about a doctor that are being investigated under the trust's Maintaining High Professional Standards procedure. This includes the principal place of work for the doctor together with nature of the investigation being undertaken, whether the doctor has been excluded or if any restrictions have been placed on their practice and the outcome if known. Action for next year: This information should include consideration of any protected characteristics and a timeframe for conclusion of investigations.

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

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

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

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

Comments: Our Company Secretary team hold this information centrally; this is collated through the Declaration of Interest forms which we request all doctors complete and return at time of appraisal.

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

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

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

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

Action from last year: Continue to monitor outcome of concerns raised about doctors and review where required.

Comments: A UHD policy and procedure for Maintaining High Professional Standards is in place which includes the arrangements for investigation and intervention for capability, conduct, health and fitness to practice concerns.

The trust has a Raising Concerns policy and a Freedom to Speak up Guardian and Freedom to Speak Up Ambassadors.

Action for next year: Continue and review where required.

Section 5 – Employment Checks

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

Action from last year: To continue to adhere to NHS Employers guidance

Comments: The Medical Resourcing Team adheres to the guidance set by NHS Employers for recruitment of doctors. This process includes checking that they are active on the GMC register, and any undertakings that they may have.

References are taken for all staff employed directly by the Trust.

Action for next year: Continue adhering to NHS Employers guidance and review our practices where required.

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

General review of actions since last Board report

- The single appraisal e-portfolio and 360 feedback providers are now fully embedded within the Trust with no issues outstanding.
- This year we have seen a great increase in the number of doctors returning to annual appraisals which in turn has allowed the team to offer more support and guidance to those new to NHS or struggling with the process.
- In April 2022 87% of doctors were up to date with annual appraisals compared to 61% in April 2021.
- The quality of appraisal outputs has continued to improve with the use of the checklist which is then offering great assurance to the RO.
- The GMC Connect issue with Premier IT has now been resolved.
- The Appraisal and Revalidation team now attend all Medical Inductions and use this time to introduce themselves and give an overview of the Appraisal & Revalidation systems, processes and support available.

- Clinical Directors are met with regularly to discuss overdue appraisals and establish any barriers to the appraisals and offer support where required.

Actions still outstanding:

- The report from the RBCH Audit in 2019 is outstanding, and therefore we are unable to follow up any actions from this.

Current Issues:

- The number of appraisers we have in the trust is still insufficient to cover the growing number of doctors including those we have for one year on a fixed term. We are aware of several appraisers who are due to retire or reduce their hours in the next 12 months which will have further impact.

New Actions:

- The appraisal team will look at ways to improve the Appraiser issue, with discussions with other local trusts and ICB and look at ways they are covering those who are on Bank only contracts or who are on one-year contracts with a plan to return to training.

- To look at the Premier IT system capabilities with regards to the ASPAT reporting to quality assure the appraisal outputs. Review how this compares to our current checklist and how this can be used for improved feedback to the appraiser.

Overall conclusion:

We have had a positive year with an increase in appraisal compliance, systems are well embedded and additional support such as the intranet and attendance at medical induction has been introduced which has all improved the engagement with appraisals.

We still have lots we would like to achieve in the next year, with the main focus being on the most effective way to appraise Bank only colleagues and those who plan to return to training. Which in turn, we hope, will help with the pressure on Appraisers.

Section 7 – Statement of Compliance:

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

Signed on behalf of the designated body

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

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

Role: Chief Executive Officer

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

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This publication can be made available in a number of other formats on request.

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University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 27 September 2023

Agenda item: 8.2.3

Subject:	Maternity Midwifery six monthly staffing paper
Prepared by:	Lorraine Tonge Director of Midwifery
Presented by:	Kerry Taylor Head of Midwifery on behalf of Director of Midwife Lorraine Tonge

Strategic themes that this item supports/impacts:	Systems working and partnership ☒ Our people ☒ Patient experience ☒ Quality: outcomes and safety ☒ Sustainable services ☐ Patient First programme ☒ One Team: patient ready for reconfiguration ☐
BAF/Corporate Risk Register: (if applicable)	Risk rating 12: 1642 Midwifery staffing
Purpose of paper:	Assurance
Executive Summary:	**Advise:** This report gives a summary of all measures in place to ensure safe midwifery staffing, including fully funded workforce planning in line with birth-rate plus, the midwife to birth ratio, vacancies, turnover and sickness rates, specialist hours, compliance with supernumerary labour ward coordinator, one to one care in labour and red flag incidents is analyzed and recommendations given. **Assure:** • Birthrate plus completed. • Template reviews in line with birthrate plus • 100% supernumerary labour ward coordinator • 100% one to one care in labour • Daily safety huddles to maintain safety and clinical review of red flags. **Alert:** • Vacancy rate at 16 % for this six-month period however actions taken to address and 8% rate by October 2023 expected. •
Background:	A staffing report for midwifery was included previously within nursing staffing papers. It is now a requirement of Maternity Incentive scheme year 5 for safety that this is now presented to the Board as a separate paper to meet safety standard action 5.

Key Recommendations:	The information held in this report is for receipt and noting the Trust Board.	
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**
Directorate quality and risk Safety champions report Care Group Board	July	Assurance and findings disseminated
People and Culture Committee	09/08/2023	Noted.

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

University Hospitals Dorset
NHS Foundation Trust

MIDWIFERY STAFFING REPORT

Author: Lorraine Tonge

Director of Midwifery

Background

It is a requirement that as NHS providers we continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (NQB) requirements.

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings.

Previously midwifery staffing data has been included in the nurse staffing paper, however, to provide evidence for NHS Resolutions Maternity CNST Incentive Scheme, (See appendix 1) a separate paper is now provided.

1.0 Executive Summary

This report gives a summary of all measures in place to ensure safe midwifery staffing, including fully funded workforce planning in line with birth-rate plus, the midwife to birth ratio, vacancies, turnover and sickness rates, specialist hours, compliance with supernumerary labour ward coordinator, one to one care in labour and red flag incidents is analysed and recommendations given.

2.0 Birthrate Plus Workforce Planning

Birth-rate Plus is a clinical workload exercise which calculates the need for clinical midwives in each clinical setting with recommendations of specialist's midwives to support care. It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one to one midwifery care throughout established labour. It also takes local factors into consideration.

To calculate the required whole time equivalent (WTE) midwives the Birth-rate plus reports adds an uplift of 23% for annual leave, sickness, and training.

A formal Birth Rate Plus assessment was completed at UHD in June 2021 (See appendix 2) which reviewed the acuity of women who used maternity services, at UHD Trust.

3.0 The Birth to Midwife Ratio

The birth to midwife ratio is calculated monthly using Birth Rate Plus methodology and the actual monthly delivery rate. This is reported monthly on the maternity dashboard so that it can be monitored alongside clinical data.

The table outlines the real time monthly birth to midwife ratio.

Month	January	February	March	April	May	June
Birthrate Plus Ratio	1:23	1:23	1:24	1:24	1:25	1:25

Birthrate plus assessment recommended 1:23.5 midwives per birth for UHD. This ratio shows a slight increase from the recommended ratio which reflects our current vacancies. This is being addressed through our recruitment campaign.

4.0 Vacancies

Area	Funded FTE	Employed FTE	Vacant FTE	Vacancy Rate
153 Specialties Care Group	207.46	174.02	33.44	16.12%
153 Womens Health Directorate	**207.46**	**174.02**	**33.44**	**16.12%**
153 Ante and Postnatal Screening 20497	4.00	3.80	0.20	5.00%
153 Community Midwifery - West 20496	43.68	31.07	12.61	28.88%
153 IT Midwives 20488	2.40	2.51	-0.11	-4.44%
153 Labour Line Triage 20487	4.39	4.60	-0.21	-4.78%
153 Oasis - Safeguarding support 20489	9.15	12.40	-3.25	-35.52%
153 Outpatient Antenatal 20478	18.44	14.92	3.52	19.09%
153 Specialist Midwives 20511	23.68	28.95	-5.27	-22.24%
428 Ante Natal Ward 20481	14.82	4.56	10.26	69.23%
428 Haven 20509	10.38	8.41	1.97	18.95%
428 Labour Ward 20479	38.72	39.89	-1.17	-3.03%
428 Midwifery Management Team 20485	9.00	8.00	1.00	11.11%
428 Post Natal & TCU 20482	28.80	14.91	13.89	48.22%
Total	207.46	174.02	33.44	16.12%

From our data on cosmos there is a current vacancy of 16.12%. It is reassuring that our high-risk areas such as Triage and labour ward do not have a high vacancy rate however areas such as community and postnatal ward, antenatal ward and community are more vulnerable.

Safe staffing of these areas depends on bank midwives filling the shifts.

Maternity bank midwives provide stability to our workforce, and we have a committed bank workforce at UHD. However, these midwives tend to want to choose their working pattern that is very flexible. For instance, they will work more hours in the winter months and then have a period of limited or no work during holiday periods. The school holidays in the summer can be the most challenging to manage.

Our long-term strategy must be to reduce our vacancy rate and reduce the reliance on bank midwives and work towards more flexible contracts.

To address our vacancy rate, we have taken several actions and monitor these through our workforce action plan.

- We now have appointed a lead midwife for recruitment and retention. This post will be essential in developing our recruitment drive but both locally and nationally. It also is to support and understand why midwives are leaving UHD. The recruitment and retention midwife will work closely with the Director of Midwifery and Head of midwifery to deliver the workforce action plan.

- Additional wellbeing support is given to midwives by our Professional advocate midwives (PMA).

- We have held successful recruitment days in April and May, with 17 band 5 posts offered. These midwives will join us from September and to support them in their new career we have a dedicated midwife to deliver a preceptorship programme and offer them additional training and support.

- We have a continual rolling advert for band 6 midwives however this gives us approximately one post per month.

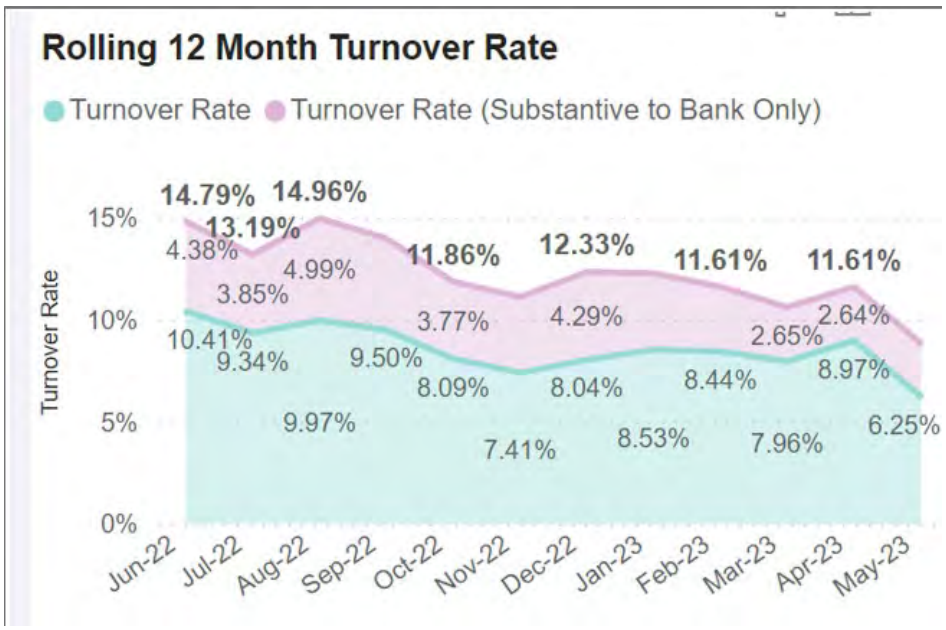
- We have a lead midwife for international recruitment and are part of the international recruitment of midwives' programme. Two midwives have started with further are expected throughout the year.

- We have joined the apprentice programme for midwives and training will commence in January.

- Additional students started with us in September to support long term workforce planning.

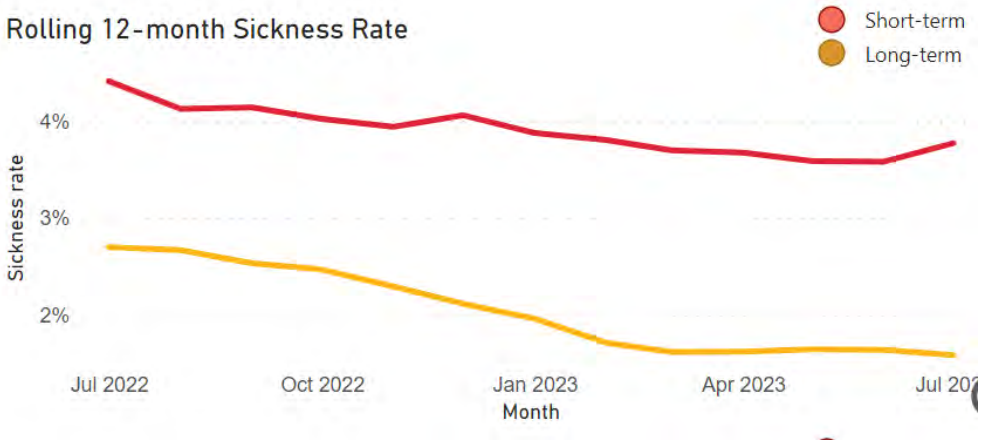
- We therefore expect our current vacancy to reduce in October but will continue with our recruiting campaign.

5.0 Turnover

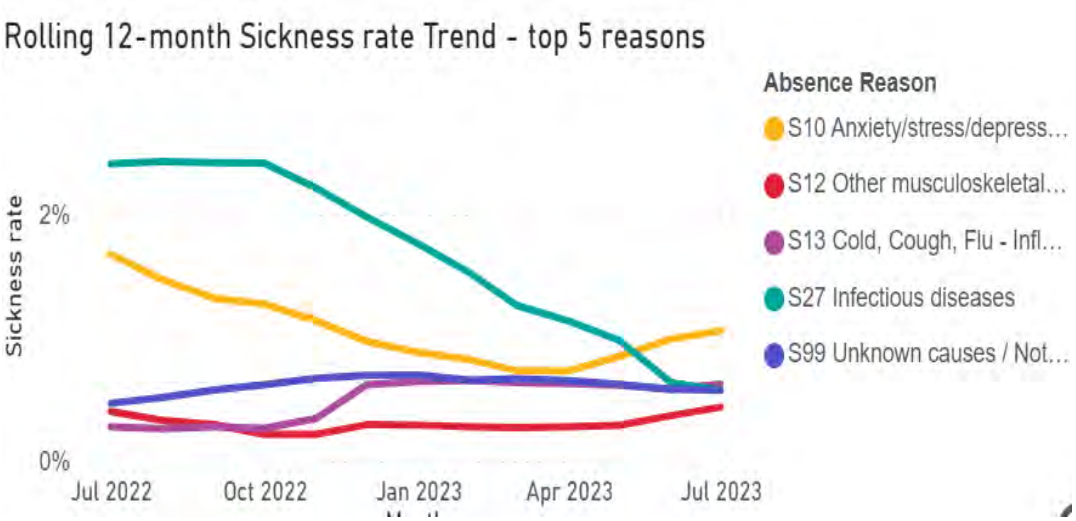


We can see from our data that our turnover has decreased over the last 12 months from 10.41 % to 6.25% of our substantive staff. It is predicted to remain at the same rate for the next six months. Our turnover of our bank staff has also decreased showing a more favourable position.

6.0 Sickness



From our data we can see a slight reduction in sickness from January to June. Overall sickness 5.9% in January 5.4 % in June with the slight improvement in long term sickness.



Anxiety stress and depression is the top reported reason for sickness.

Further work to support staff and understanding to identify work related stress and its prevention may reduce these absences from work.

An overall recommendation would be for in the next 12 months will be:

A workforce review and strategy for the transfer to the new build is required and this review will provide the Trust Board with assurance of midwifery staffing planning over the next 3 years.

7.0 Systematic reviews of implementing birth rate plus staffing allocations aligned with safety.

7.1 Band 5-7 clinical midwives staffing templates were completed by the interim Director of midwifery with ESR allocate, finance team and rostering team in January 2023 which provided assurances to the board that staff were allocated accordingly to provide safe care.

On return of the substantive Director of Midwifery there has been an additional **systematic overview of the templates.** Again, this was done with finance, ESR workforce and allocate. The staffing templates and allocation required minor adjustment (and this was within the current funded establishment) The Director of Midwifery is therefore able to provide the same assurance to the board of implementation birth rate plus staffing allocations in clinical roles.

7.2 The review can confirm that **all posts are fully funded to birthrate plus recommendations.**

	Band 5-7 Clinical WTE	Band 3 providing postnatal care 10%	Band 7 to 8 Additional Specialist and management WTE	Total includes all clinical specialists and management roles
Birth- rate plus recommendations WTE (June 2021)	174.61	19.40	21.34	215.35
Current Funded WTE (June 2023)	179.80	20.96 (Postnatal ward)	21.97 band 7-8 4.69 band 6 Total 26.66	227.42

7.3 Band 7 midwives -overnight safety

The template review identified the safety need for an additional supernumerary midwife on maternity unit overnight. The overall senior presence relies on one clinical lead midwife to manage safety on the labour ward, triage, antenatal ward and postnatal as there is only one senior midwife present overnight within the unit. A request is being made through the Care Group to address this concern converting 5 funded posts at band 6 to band 7 clinical leaders. This will enable the maternity service to develop a specialist training programme for future coordinators of the delivery suite, in line with Ockenden 2 recommendations and immediate senior presence. The additional clinical leaders will also provide additional support to the delivery suite coordinators who manage escalation throughout the maternity service out of hours (night duty) which has been reported as a very challenging responsibility, taking them away from their core work, supporting staff working on the

delivery suite and obstetric theatres. This change can be made within the current funded posts and will provide safety in the maternity unit overnight. This plan needs to be implemented as soon as possible to provide assurance of safety. It is expected that these Band 7 clinical leads are in place within the next 4 months.

7.4 Band 3 maternity support workers

There have been national changes since birth-rate plus was undertaken in 2021 with upskilling of all maternity band 2 support workers giving any clinical work will be upgraded to band 3 in line with national recommendations. The Trust is working through this process however our current birth-rate plus will not represent this adjustment. Maternity support workers will however support midwifery staff in providing care within their remit and competency levels but must not be seen as a substitute midwifery care.

7.5 Specialist's midwives' roles

The calculations and review of midwifery management and specialist roles of 11% allowance in our birth-rate plus assessment in 2021 would not be considered sufficient in June 2023 to provide all the specialist trained midwives recommended in recent safety reports. Ockenden, East Kent and 3-year delivery plan.

Additional roles requirements have been recommended by the Ockenden report and our current funded establishment accounts for these recommendations. Roles such as audit midwife, policy and guidelines midwife, increase quality and risk midwives, increase Professional midwifery advocate (PMA) support for midwives, fetal monitoring midwife and patient experience midwife are now in place.

It also accounts for maternity transformation roles such as digital, perinatal mental health (part funded by perinatal mental health service)

In addition to our current funded roles and the maternity incentive safety actions, it is expected that trusts are planning for future roles which are currently being funded by the ICB and transformation. These roles include Breastfeeding initiative lead (BFI), continuity of care, preterm birth midwife, and additional digital midwife time.

The current Birthrate plus model did not take the extra requirements into consideration and is undergoing a model review.

A business case for these any additional posts will be presented at the next trust budget setting for consideration.

7.6 Training requirements

Although Birth-rate plus allocates an uplift of 23%, this is now considered inadequate for the number of professional training hours midwives require as they care for both mothers and babies. This is represented in an increase in training requirements set out by the maternity

incentive scheme year 5. To achieve this standard, it is likely that the uplift will need to be increased to between 25% and 27% (as in line with UHD's A and E department). Currently our dedicated bank staff fill the vacant shifts due this additional training however as our vacancies are filled throughout the year funded shifts will not be available and a deficit will be evident. As staff vacancy is filled a business case is presented to outline the increase which will be needed.

8.0 Safety

To monitor safety there are several systems and polices in place to provide consistence assessments of the maternity unit. The frequency of the assessment is dependant on our opal status which can be changeable in maternity over the 24-hour period due to the nature of our work which is predominately unpredictable and changeable.

MDT Safety huddles occur each day with a standard meeting each morning at 9:30 and additional meetings within the day according to opal status and change in activity.

To determine the need for additional assessments, we monitor change of activity in a variety of ways.

8.1 Birth Rate Plus Live Acuity Tool

The Birth Rate Plus Live Acuity Tool was introduced in the intrapartum areas in April and further role out to other areas is required once intrapartum is established.
It is a tool for midwives to assess their 'real time' workload arising from the number of women needing care, and their condition on admission and during the processes of labour, delivery and postnatally. It is a measure of 'acuity', and the system is based upon an adaption of the same clinical indicators used in the well-established workforce planning system Birth Rate Plus.

The Birth Rate Plus classification system is a predictive/prospective tool rather than the retrospective assessment of process and outcome of labour used previously. The tool is completed four- hourly, by the labour ward co-ordinator. An assessment is produced on the number of midwives needed in each area to meet the needs of the women based on the minimum standard of one-to-one care in labour for all women and increased ratios of midwife time for women in the higher need categories. This provides an assessment on admission of where a woman fits within the identified Birth Rate Plus categories and alerts midwives when events during labour move her into a higher category and increased need of midwife support.

This safe staffing tool kit supports most of the components in the NICE Guidance (and is endorsed by NICE) on safe midwifery staffing for maternity settings necessary for the determination of maternity staffing requirements for establishment settings. It provides evidence of what actions are taken at times of higher acuity and use of the escalation policy when required.

The Birthrate Plus acuity tool is now implemented on the labour ward. This provides 4-hourly reports on the safety of the staffing and workload, which informs quality and risk reporting. It was expected to be implemented in January however a digital assessment needed to be carried out to ensure the software was compatible with UHD systems. Training of the team was also required. The system has now been in place since April. Staff are not yet consistently implementing data as this is a new system however the matron from labour ward is working with the team and many improvements have been made.

The labour ward matron will oversee this in the coming months and provide quarterly reports to the care group and workforce committee for assurance.

From the data we have received, we are providing 1:1 care in labour.

In addition to this monitoring tool staff complete a Datix/Learn should the 1:1 standard not be met. There has been no Datix/LERNS submitted from January to June.

The additional reporting to Datix/LERNS will stay in place as we transition to birthrate plus acuity tool for full assurance of data reliability.

The plan is to introduce this acuity tool to other areas such as postnatal ward and this should be done once assurances that it is embedded into the delivery suite.

8.2 Red Flags

NICE recommend the use of red flags. A midwifery red flag event is a warning sign that midwifery staffing is limited which requires review, escalation and support. If a midwifery red flag event occurs, the midwife in charge of the service should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed. During this period January to June there has been a transition from Datix/LERN reporting to safe staffing trust system in recording data. From August this will be implemented to improve data quality.

The Datix/LERN shows:

	Jan	Feb	Mar	April	May	June
Home birth suspension	2	8	11	19	21	6
Haven low risk birth centre closure	3	1	3			2
Women unable to have birthplace of choice.	3	4	0	1	0	0

Centralising services to high-risk area	**8**	**13**	**14**	**20**	**21**	**8**
OPEL 2	12	8	8	12	6	7
OPEL 3	0	3	1	2	2	3
OPEL 4	0	0	0	0	0	1
Total escalation	**12**	**11**	**9**	**14**	**8**	**11**
LSCS Delay	1	0	0	0	0	1
IOL red flags	70	47	27	50	37	48
Delays of greater than 30 minutes between presentation and triage	0	0	0	0	0	0

This data shows us that low risk births were centralised to provide safe care but therefore limiting choice for women.

There was 1 occasion of opal 4 in the six-month period.

Audits show that 97% of women were seen by 15 minutes and all were seen by a midwife in ss than 30 minutes.

8.3 Planned versus actual staffing.

	Jan		Feb		Mar		Apr		May		Jun	
Actual vs Planned	Day %	Night %	Day %	Night %	Day %	Night %	Day %	Night %	Day %	Night %	Day %	Night %
Midwife Inpatients	87	88	81	86	81	85	93	91	90	83	87	78
Maternity Care Assistant Inpatients	92	89	93	101	89	90	101	102	91	93	86	84
Midwife Labour Ward	84	85	83	86	75	81	84	90	86	90	83	91
Maternity Care Assistant Labour Ward	93	102	95	90	90	90	101	98	90	101	84	95

When staffing is less than optimum, the following measures are taken in line with the escalation policy:

- Request midwifery staff undertaking specialist roles to work clinically.
- Elective workload prioritised to maximise available staffing.
- Managers at Band 7 level and above work clinically
- Overstaffing of maternity support workers to assist with basic care needs.
- Relocate staffing to ensure one to one care in labour and dedicated supernumerary. labour ward co-ordinator roles are maintained.
- Activate the on-call midwives from the community to support labour ward.
- Request additional support from the on-call midwifery manager.
- Request additional support from Trust nursing colleagues.

- Liaise closely with maternity services at regional sites to manage and move capacity as required.

All the above actions are designed to maximise staffing into critical functions to maintain safe care for the women and their babies.

In addition, a significant number of bank hours have been used across the service to cover maternity leave and long and short-term sickness.

Overall strategy will be to continue with recruitment and retention.

8.4 Supernumerary Labour Ward Co-ordinator

Availability of a supernumerary labour ward co-ordinator is recommended as best practice to oversee safety on the labour ward. This is an experienced midwife available to provide advice, support, and guidance to clinical staff and able to manage activity and workload through the labour ward.

The following table outlines the compliance by month:

	Number of days per month	Number of shifts per month	Compliance
January	31	62	100%
February	31	62	100%
March	31	62	100%
April	30	60	100%
May	31	62	100%
June	30	60	100%

8.5 One to One in Established Labour

Women in established labour are required to have one to one care and support from an assigned midwife. One to one care will increase the likelihood of the woman having a 'normal' vaginal birth without interventions and will contribute to reducing both the length of labour and the number of operative deliveries. Care will not necessarily be given by the same midwife for the whole labour.

If there is an occasion where one to one care cannot be achieved, then this will prompt the labour ward co-ordinator to follow the course of actions within the acuity tool. These may be clinical, or management actions taken.
The following table outlines compliance by Month.

	Birth Centre	Labour ward
January	100%	100%
February	100%	100%
March	100%	100%
April	100%	100%
May	100%	100%
June	100%	100%

9.0 Recommendations and actions

From this report there are several recommendations and actions which will be taken to continue to maintain safe midwifery staffing and assurances to the Trust Board.

1. NICE (2017) recommend that an assessment is carried out every three years. It is therefore recommended to the board - to carry out a birth rate plus assessment in June 2024. The assessment in June 2024 should be in line with the current maternity service we provide but also to assess for the delivery of the service in the new build. (The new build has different layouts so services will be delivered differently.)

2. It is recommended to the continue with the workforce strategy in improving recruitment and retention, reducing the reliance on bank staff, understanding and supporting staff with work stress improving staff wellbeing.

3. To implement a second band 7 in the maternity at night within the next four months.

4. As training requirements are increased for midwives in year 5 MIS a business case for increase uplift will be presented to the trust for consideration.

5. The plan is to introduce this acuity tool to other areas such as postnatal ward and this should be done once assurances that it is embedded into the delivery suite.

6. To work with the ICB on transformation posts for improvement and the bring a business case to the Trust in next year's budget setting for continuing with these improvements' posts.

10.0 Conclusion

This report provides assurances of systematic reviews of our workforce and our current position. It is continuous process and will be reported six monthly to the board as per MIS year 5 safety standards.

It also provides assurances of safety measures in place to address safe staffing and provision of care.

It is requested for the Board to note the contents of the report and formally record to the Trust Board minutes.

Appendix

Appendix 1: MIS year 5 standards

MIS-Year-5-Guidanc e-July-2023.docx

Appendix 2: Birth rate plus assessment UHD June 2021

final br plus reportUniversity Hos

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 27 September 2023

Agenda item: 8.2.4

Subject:	Annual Security Report 2022-2023
Prepared by:	Stuart Willes – Head of Operations & Facilities Dave Bennett – ASMS Malcolm Keith - ASMS
Presented by:	Mark Mould – Chief Operating Officer

Strategic themes that this item supports/impacts:	Systems working and partnership ☒ Our people ☒ Patient experience ☒ Quality: outcomes and safety ☒ Sustainable services ☒ Patient First programme ☐ One Team: patient ready for reconfiguration ☐
BAF/Corporate Risk Register: (if applicable)	Security Risks: Risk 1767 Loss of service delivery from Portering Department. Currently rated as 8 (Moderate) New Risk/new to this group No risks added since the previous report Risks Increased No risks increased since previous report. Risks Decreased None Risks Closed None
Purpose of paper:	Assurance
Executive Summary:	**<u>Areas to Alert (1)</u>** **Restraint** There were a total of 257 incidents across UHD where a restraint was recorded as being applied, this is marginally down from the 2021-22 figure of 264.

- All incidents of restraint reported are followed up by Risk Management, under the Post Restraint review process (PRIM).
- Restraint training compliance for Security and Portering staff is 99%.

Action taken

- Across UHD 119 warning letters were issued in this period.
- Warnings are issued in line with the Violence Prevention & Reduction Policy (formerly Violence & Aggression Policy. Group Directors of Nursing (GDoNs) are now taking the lead oversight in agreement to issue these warning letters and any escalation of actions with nursing and security teams or Exec led intervention.

Areas to Advise (3)

1. Incidents reported

In 2022-23, there was an overall 9.5% increase in the number of security related incidents recorded compared to 2021-22.

- There was a 32% increase in comparison to 2020–21.
- Reports indicate that the higher-level severity incidents remain relatively low. No reports recorded a severe rating with moderate reports averaging at 5% of all incidents.
- 60% of Datix incidents received are recorded as 'No Harm/Near miss'.

(However, it is worth noting that 2020-21 resulted in low activity due to the Covid pandemic.)

2. Staff survey responses

Questionnaire Section	Question		20-21	21-22	22-23
YOUR HEALTH, WELL-BEING AND SAFETY AT WORK	Q13a	In the last 12 months how, many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public (Never).	86.00%	87.00%	85.20%
YOUR HEALTH, WELL-BEING AND SAFETY AT WORK	Q13b	In the last 12 months how, many times have you personally experienced physical violence at work from managers (Never).	100.00%	99.00%	99.40%
YOUR HEALTH, WELL-BEING AND SAFETY AT WORK	Q13c	In the last 12 months how, many times have you personally experienced physical violence at work from other colleagues (Never).	99.00%	98.00%	98.50%
YOUR HEALTH, WELL-BEING AND SAFETY AT WORK	Q13d	The last time you experienced physical violence at work, did you or a colleague report it (Yes).	47.00%	51.00%	66.90%

3. Body Worn Cameras (BWC)

Following a successful trial period BWC have been introduced in a number of areas across UHD, these includes:

- Clinical Site Management Team
- Emergency Department
- Acute Medical Units
- Security Response Team

Feedback so far is positive with staff reporting wearing of the cameras has given staff an increased confidence when having to deal with challenging situations.

	Areas to Assure (3) 1. Violence & Aggression signage for public/patients approved and will replace existing signs across all main sites. 2. 'Security Road Show' workshops, security team leads will be going to every ward and other high security incidence areas to inform and update what options are available and advise how to use tools including: Enhanced Care, Supportive Observation, hints and tips and how staff can access further support. 3. Security Risk Assessment - Template now available for all wards and staff clinical areas to assess risk levels and mitigations.
Background:	The full annual security briefing is attached
Key Recommendations :	The Board is asked to note the content of this paper and the individual areas of alert, advise and assurance.
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 ☐ The contents of this report support the delivery of the Trust's strategic aims and goes across all areas of operational delivery, including how staff are supported to deliver equity of access, experience and outcomes for patients.
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	09/08/2023	Approved

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

Health & Safety Group
Security Briefing Paper: (Data April 2022 to March 2023)

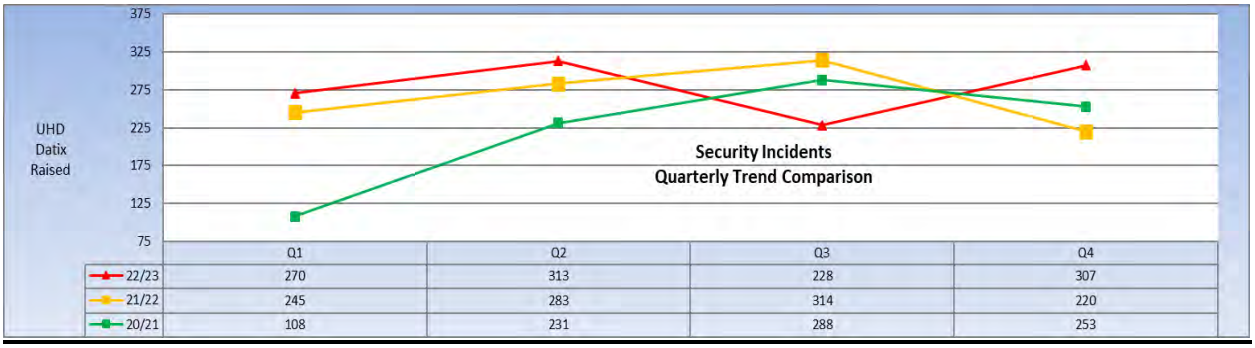
1. Introduction

The purpose of this paper is to update the Health & Safety Group on security related incidents for April 2022 – March 2023 and to provide updates on UHD initiatives completed or in progress over the year. The report has been prepared using data collated from the Datix Web reporting system. Data is correct as of 17th April 2023 and will have been ratified through the Security Management Group (SMG).

There is a risk register entry, ID 1767, Loss of service delivery from Portering Department. This risk reflects the impact on Porters to deliver core business in support of the Trust when responding to calls for security response.

2. Yearly Comparisons

Trend Comparison

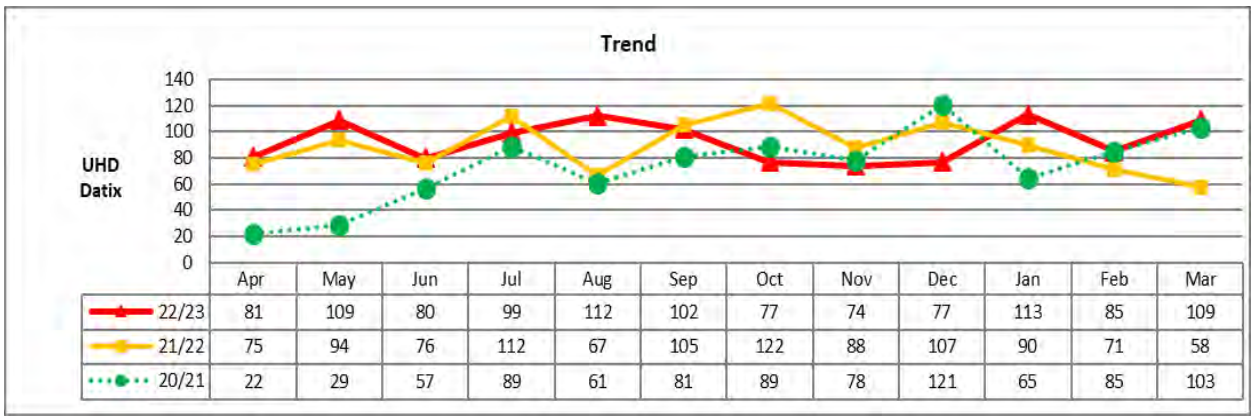


	Q1	Q2	Q3	Q4
22/23	270	313	228	307
21/22	245	283	314	220
20/21	108	231	288	253

Year-end saw an upward trend in the number of incidents reported when compared to previous years. There has been an overall in a 9.5% increase in number of security related incidents recorded over that of year 2021-22 and some 32% on period 2020 – 21. Low attendance numbers during Covid would to some extent account for the differential.

The chart below shows the monthly variation in the number of reports received.

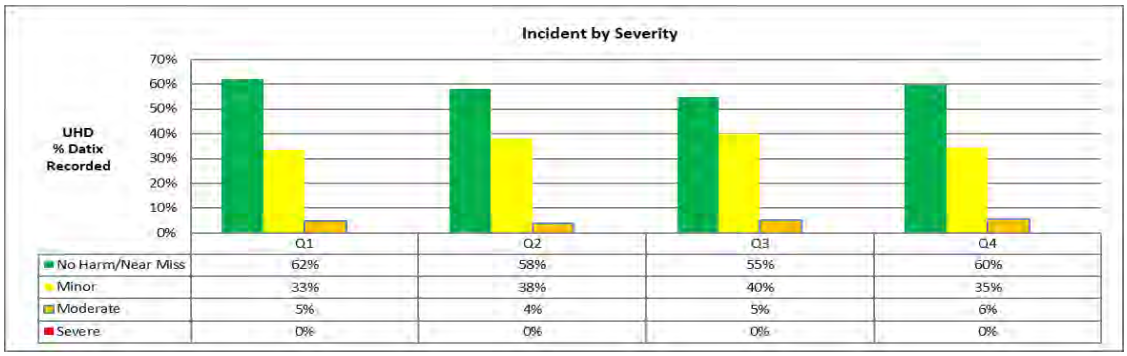
UHD



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
22/23	81	109	80	99	112	102	77	74	77	113	85	109
21/22	75	94	76	112	67	105	122	88	107	90	71	58
20/21	22	29	57	89	61	81	89	78	121	65	85	103

There is no identifiable trend in the number of reports by month. In the main peaks can be attributed to the number of patients within the Trust at any given time, displaying challenging behaviours, in particular patients with Mental Health issues that may be responsible for multiple incident reports.

3. Security Related Incidents (Behavioural) – Severity



	Q1	Q2	Q3	Q4
No Harm/Near Miss	62%	58%	55%	60%
Minor	33%	38%	40%	35%
Moderate	5%	4%	5%	6%
Severe	0%	0%	0%	0%

Reports indicate that the higher-level severity remains relatively low. No reports recorded as severe with moderate reports averaging at 5% of all incidents. 60% of Datix incidents received are recorded as No Harm/Near miss.

Appendix 1 & 2 contain additional data by incident group & top reported.

Restraint

There were a total of 257 incidents across UHD where a restraint was recorded as being applied, this is slightly down from the 2021-22 figures of 264. The table below indicated where a restraint was recorded by incident type.

UHD

LSMS where (any) restraint recorded UHD	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Total
Inappropriate/Aggressive Behaviour towards Staff by a Patient	10	6	3	5	15	8	4	7	5	13	5	10	91
Self-harming Behaviour	0	4	2	0	6	4	2	6	10	1	0	5	40
Inappropriate/Aggressive Behaviour by a Patient towards an Object/Structure	0	3	2	2	0	2	2	1	4	6	7	6	35
Uncooperative/Stubborn patient Behaviour	1	2	0	0	6	4	2	3	1	3	5	7	34
Patient refusal of diagnostic/therapeutic recommendations/interventions	0	2	0	0	4	0	0	1	4	3	1	1	16
Patient Restraint Processes	11	2	0	0	0	0	0	0	0	0	0	0	13
Inappropriate/Aggressive Behaviour towards a Patient by a Patient	0	0	2	2	2	1	0	1	1	1	2	0	12
Missing Patient (absconded/abducted patient)	0	3	1	1	2	1	0	1	0	0	0	1	10
Inappropriate/Aggressive Behaviour towards a Patient by Staff	0	0	0	1	0	1	0	0	0	1	0	0	3
Inappropriate/Aggressive Behaviour towards Visitor by a Patient	0	0	0	0	0	0	0	0	0	1	0	1	2
Exposure to Hazardous Substances	0	0	0	0	0	0	0	0	0	0	1	0	1
Total	22	22	10	11	35	21	10	20	25	29	21	31	257

All incidents of restraint reported are followed up by Risk Management, under the post restraint review process. The introduction of Post Restraint Investigation Meeting (PRIM) has proved successful in ensuring restraints are investigated for appropriateness, legal frame works and learning outcomes.

4. Warnings Issued & Multi-Disciplinary Team Meetings

119 warning letters were issued in period. As indicated in the table below;

Warnings Issus	Q1	Q2	Q3	Q4	Total
First Warning Letter (FWL)	24	45	17	17	**103**
FWL - Racial content		2		5	**7**
FWL - Transphobic				1	**1**
Acceptable Behaviour Agreement	2	3	2	1	**8**

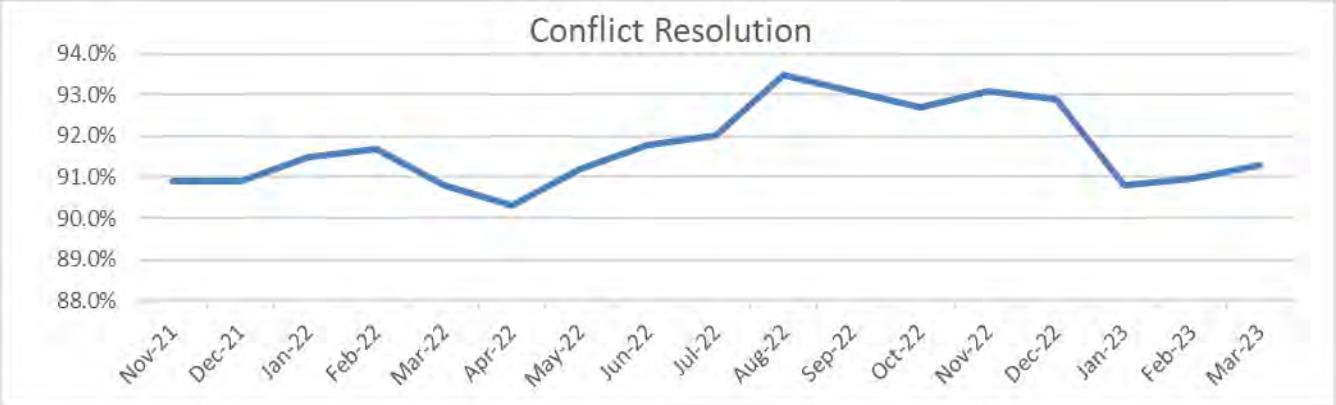
Warnings are issued in line with the Violence Prevention & Reduction Policy (formerly Violence & Aggression Policy.

5. Other Issues & Updates

Training compliance (Target is 95%)

Security

Conflict Resolution



Prevent (WRAP)

Where compliance is low or seen to be in decline this is raised at the Security Management Group meeting for discussion to identify actions required with relevant care group to make improvements.

These data sets are also provided in the training compliance reports presented to the Health and Safety Group for wider support and agreement on any proposed actions.

Preventative Management of Violence & Aggression (PMVA) Training

This training is provided to support the security response team with enhanced de-escalation skills and application of restraint as a last resort.

Poole	Count	Compliant	Unfit	Non-Compliant	%
Porters	51	47	3	1	99%
Security	10	10	1	0	100%
RBCH					
Porters	48	40	7	1	99%
Total	**109**	**97**	**11**	**2**	**99%**

Violence Prevention & Reduction Standards

Violence and aggression is a concern in most health care settings. Repeated exposure to violent and aggressive behaviour can have a highly negative effect on staff morale and performance. It can leave staff feeling vulnerable, and undervalued. It can also be very costly to the organisation as it may also result in high levels of sickness and failure to retain staff.

In January 2021 NHS Improvement published the Violence Prevention and Reduction (VPR) Standards to provide a risk-based framework to support a safe and secure working environment for NHS staff, safeguarding them against abuse, aggression and violence.

The definition of violence that is being used in this context is: 'the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either result in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation." This definition includes verbal assaults and aggressive behaviour. The NHS does not accept violence or the threat of it as an inevitable part of daily routine and aims to develop a culture of effective prevention and reduction and management of violence. The Assault on Emergency Workers (Offences) Act 2018 has increased the maximum custodial punishment for violence against NHS staff from six months to a year.

The standards state that all NHS Commissioners and all providers of NHS-funded services operating under the NHS Standard Contract should 'have regard' to the standards and are required to review their status against it and provide board assurance that they have met the standards twice a year.

At University Hospitals Dorset, compliance with the VPR Standards was reviewed by a Task & Finish group. The aim of which was to match current compliance and to formulate an action plan to manage and where possible improve compliance rating.

		Compliant					
Section	**Elements**	**Y**	**N**	R	A	G	Check Total
PLAN	**14**	**13**	**1**	0	1	13	14
DO	**11**	**5**	**6**	1	5	5	11
CHECK	**12**	**7**	**5**	0	6	6	12
ACT*	**5**	**3**	**2**	1	4	15	20
	42	**28**	**14**	**2**	**16**	**39**	**57**

The variation in the Check Total reflect that the 5 elements in ACT* have multiple conditions to be met. Compliance is based on Yes or No and as such 3 are met and 2 are not. The RAG rating indicates the number of those conditions that are met and those requiring additional work in order to move to full compliance. This is reflected on the VPR Action Tracker.

A decision is to be taken on where overall responsibility and lead for the standards will sit in the future.

Audit

Trust audit (BDO) were engaged to perform an internal audit on compliance with the VPR Standards. The report states:

- *In conclusion, our review noted a number of areas of good practice, including the progress that has been made to demonstrate the Trust's compliance with the VPRS Standard and the strong governance and reporting structures in place.*
- *We have raised two findings in relation to the governance and progression of the standards and around recording actions taken for reported incidents. The purpose of this audit was to review the Trust's compliance with the VPR standards, evidence and governance of this, we have thereby concluded a moderate design opinion and substantial design effectiveness opinion.*

The draft report provided to the Trust can be found Appendix 3.

Staff survey results

Below is the table of security related questions extracted from the staff survey.

Questionnaire Section	Question		20-21	21-22	22-23
YOUR HEALTH, WELL-BEING AND SAFETY AT WORK	Q13a	In the last 12 months how, many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public (Never).	86.00%	87.00%	85.20%
YOUR HEALTH, WELL-BEING AND SAFETY AT WORK	Q13b	In the last 12 months how, many times have you personally experienced physical violence at work from managers (Never).	100.00%	99.00%	99.40%
YOUR HEALTH, WELL-BEING AND SAFETY AT WORK	Q13c	In the last 12 months how, many times have you personally experienced physical violence at work from other colleagues (Never).	99.00%	98.00%	98.50%
YOUR HEALTH, WELL-BEING AND SAFETY AT WORK	Q13d	The last time you experienced physical violence at work, did you or a colleague report it (Yes).	47.00%	51.00%	66.90%

It is of note that a high percentage of staff are reporting they Never had events (85.2%) with regards to Q13a personally experienced physical violence, however it can be seen that the percentage is lower than that of the previous two years and acknowledge that some 25% of staff who completed the survey have experienced acts of physical violence at work in the past 12 months.

The reporting (Q13d) has improved on previous years although still relatively low. There is an action being taken to deliver a 'Security Road Show' to wards and departments. This is a short face to face session/s conducted by the Bournemouth, Accredited Security Management Specialist (ASMS) to update staff on security provision available or interventions that can be used alongside the 2222 security alert. It will also include a reminder of the importance of reporting incidents as they occur.

6. ASMS Work Update

Body Worn Cameras (BWC)

Following a successful trail period BWC have been introduced in a number of areas across UHD, these includes:

- Clinical site management

- Emergency Department
- Acute Medical Units
- Security Response Team

Feedback thus far is positive, reports from users indicate that the cameras have given Staff an increased confidence when having to deal with challenging situations.

UHD Documentation Review

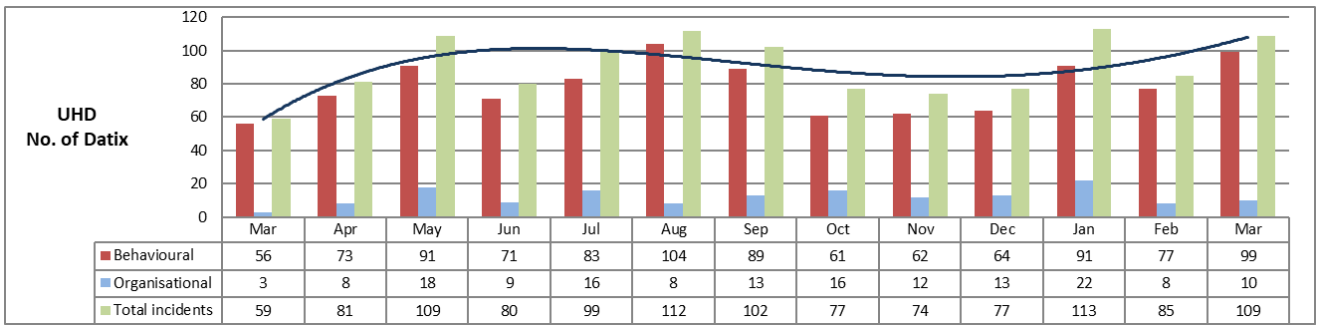
The following documentation has been reviewed and is now available on the Trust intranet policy page under Security;

- Security Management Policy
- Violence Prevention & Reduction Strategy
- Violence Prevention & Reduction Policy
- Lone Worker Policy
- Missing Person Procedure
- CCTV Policy

Appendix 1 - Datix reported incidents - UHD

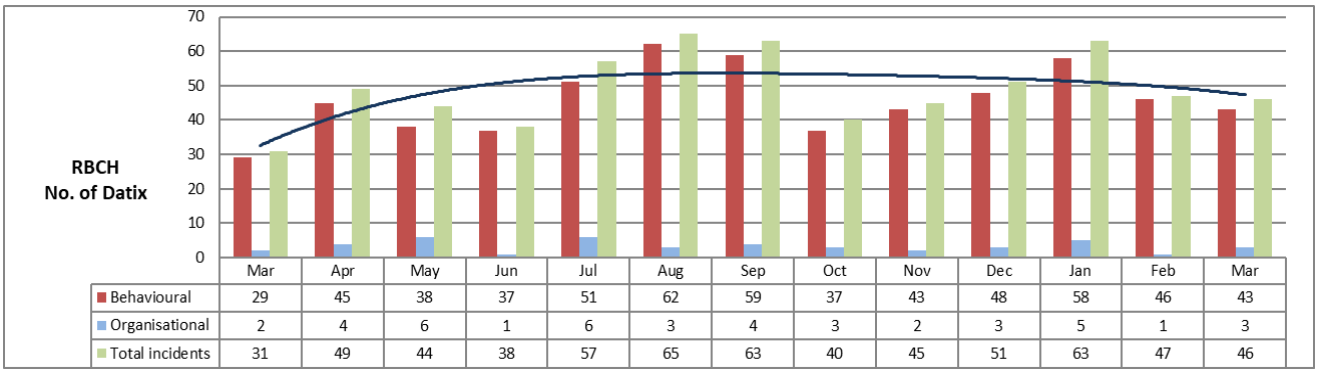
The graphs below illustrate the number of security related incidents reported by incident group and site.

UHD



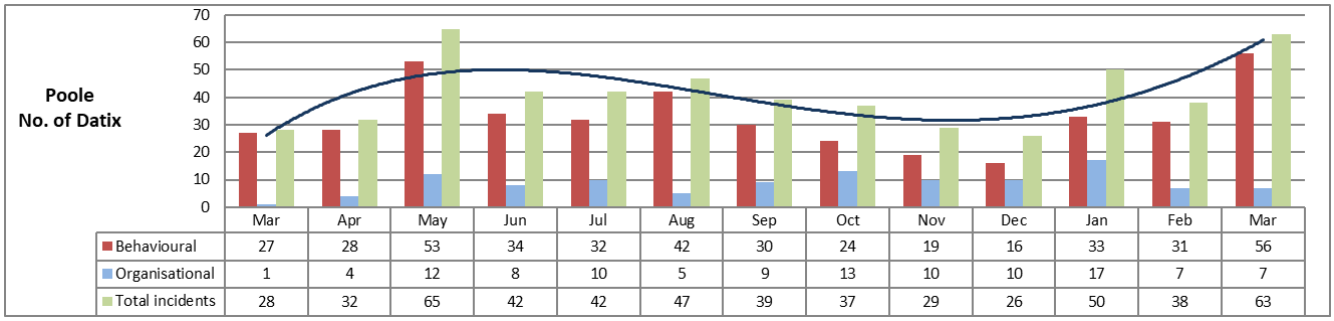
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Behavioural	56	73	91	71	83	104	89	61	62	64	91	77	99
Organisational	3	8	18	9	16	8	13	16	12	13	22	8	10
Total incidents	59	81	109	80	99	112	102	77	74	77	113	85	109

RBCH



	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Behavioural	29	45	38	37	51	62	59	37	43	48	58	46	43
Organisational	2	4	6	1	6	3	4	3	2	3	5	1	3
Total incidents	31	49	44	38	57	65	63	40	45	51	63	47	46

PH



	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Behavioural	27	28	53	34	32	42	30	24	19	16	33	31	56
Organisational	1	4	12	8	10	5	9	13	10	10	17	7	7
Total incidents	28	32	65	42	42	47	39	37	29	26	50	38	63

Appendix 2 - Top Reported Incidents

The tables below show the top reported incidents by type per quarter

Behavioural Incidents

UHD Behaviour Related Incidents	Q1	Q2	Q3	Q4	12 mnth
Inappropriate/Aggressive Behaviour by a Patient towards an Object/Structure	7	9	7	33	**541**
Inappropriate/Aggressive Behaviour towards a Patient by a Patient	18	24	16	10	**92**
Inappropriate/Aggressive Behaviour towards a Patient by a Visitor/Other	1	4	2	8	**79**
Inappropriate/Aggressive Behaviour towards a Patient by Staff	4	8	5	3	**68**
Inappropriate/Aggressive Behaviour towards Staff by a Visitor	135	172	84	150	**61**
Inappropriate/Aggressive Behaviour towards Staff by a Patient	18	16	6	21	**56**
Inappropriate/Aggressive Behaviour towards Staff by Staff	6	10	18	9	**33**
Inappropriate/Aggressive Behaviour towards Visitor by a Patient	1	0	7	4	**22**
Inappropriate/Aggressive Behaviour towards Visitor by a Visitor	0	0	12	0	**20**
Inappropriate/Aggressive Behaviour towards Visitor by Staff	0	0	2	0	**15**
Missing Patient (absconded/abducted patient)	25	22	13	19	**12**
Patient Restraint Processes	16	0	6	0	**12**
Persons Performing Unauthorised Acts	0	1	0	0	**2**
Use/Possession of Prohibited/Stolen Goods	4	10	9	10	**1**
Total	**235**	**276**	**187**	**267**	**965**

Organisational Incidents

UHD Organisational	Q1	Q2	Q3	Q4	12 mnth
Missing/Lost Property	18	28	31	28	**105**
Theft (proven, alleged or suspected)	7	2	2	3	**14**
Trespassing/Intrusion	6	2	1	4	**13**
Vandalism (proven, alleged or suspected)	4	2	1	1	**8**
Property Theft (proven, alleged or suspected)	0	2	2	2	**6**
Break in/Forced Entry (proven, alleged or suspected)	0	1	2	2	**5**
Other	0	0	1	0	**1**
Unconsented or Unauthorised use	0	0	1	0	**1**
Unauthorised access/disclosure	0	0	0	0	**0**
Unconsented or Unauthorised use of Property	0	0	0	0	**0**
Total	**270**	**314**	**277**	**307**	**1168**

Appendix 3 – BDO Audit Report VPR Standards

UHD - VPRS - Final Report.pdf

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 27 September 2023

Agenda item: 8.3.1

Subject:	Key Issues and Assurance Report to Board of the Finance and Performance Committee meeting held on 14 August 2023
Prepared by:	Philip Green, Chair of the Finance and Performance Committee
Presented by:	Philip Green, Chair of the Finance and Performance Committee

Key Issues/matters discussed by the Committee:	The Committee received the following: • Update from the ICS CFO • Update on BAF Strategic Risks 1,2,7 & 9 • Proposal to add new BAF Strategic Risk 10 relating to the EPR…supported • Update on risks rated 12 and above assigned to the committee • Operational Performance Report • Financial Performance Report M4 • Cost Improvement Report M4 • Update on Financial Risks and Mitigations • Contract Decision Timetable • Report on Estates Improvement and Premises Assurance Model • NHP Benefits Case • Update deep dive on Transformation • Cyber Securities and Vulnerabilities Report • Information Governance Report. The Committee: • Ratified its previous out of committee approval for CT Scanners Procurement • Approved proposal to increase spend on NHP Contract 8 from £750k to £1m and recommended to the Board that it approve the full contract value to £2.4m.
Significant issues for escalation to Board for action:	1) **Operations.** The Committee was alerted to performance against ED organizational standard in July was below trajectory due to challenges from implementation of the Agyle IT system;

	industrial action by junior doctors and workforce gaps. 2) **Operations.** The Committee was concerned that for #NOF only 36% of patients were operated on within 36 hours. This is a long-standing issue and suggested the Quality Committee might wish to undertake a deep dive. 3) **Finance.** At end of July the Trust reported a deficit of £8.5m v planned deficit of £4.7m due to energy cost inflation, industrial action, unfunded escalation costs and premium cost pay overspends. 4) **Finance.** Current savings plans total £18.4m, a shortfall of £15m against the full savings requirement of £33.3m. However, the recurrent shortfall is £21.7m. A significant issue is capacity of Care Groups to identify and action savings plans. A PMO is being set up and further resource provided. The Committee felt strongly that every attempt must be made to deliver savings within the Trust's control in the current year whilst looking to the Medium-Term Financial Plan to include the benefits of major transformational change at system and Trust level. 5) **Finance.** If identified mitigations are not achieved the Trust is at risk of a considerable outturn deficit 6) **Estates Improvement.** A five-year bottoms up capital plan has been developed for tackling the estates maintenance backlog which totals £71m. 7) **Information Governance.** The Trust was not able to submit a compliant Data Security and Protection Toolkit assessment in June as 10 of the mandatory assertions out of 112 remain incomplete.
Progress of Board Assurance Key Risks Assigned to Committee:	The risk scores for BAF Risks 1 (meeting constitutional standards for planned care) and BAF risk 2 (meeting constitutional standard for Emergency Care) remain at 20. It will be a challenge to achieve the target of 6. The risk score for BAF Risk 7 (returning to a financial surplus from 2026/27) remains at 16 with the target of 6. The risk score will be re-considered as part of the approval process for the medium-term financial plan. BAF risk 9 (integration and reconfiguration) is at 20 and it looks challenging to get to the target of 12 because of NHP.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 27 September 2023

Agenda item: 8.3.2

Subject:	Key Issues and Assurance Report to Board of the Finance and Performance Committee meeting held on 18 September 2023
Prepared by:	John Lelliott, Deputy Chair of the Finance and Performance Committee
Presented by:	John Lelliott, Deputy Chair of the Finance and Performance Committee

Key Issues/matters discussed by the Committee:	The Committee received the following: • Operational Performance Report • Financial Performance Report Month 5 • Medium Term Financial Plan • Cost Improvement Programme Report Month 5 • Contract Decision Timetable • Estates Improvement Report • New Hospitals Programme Update • Transformation Update • Private Patients Strategy Update The Committee received certain recommendation reports which it approved or endorsed with a recommendation for approval by the Board.
Significant issues for escalation to Board for action:	(1) **Operational performance:** The Committee continued to be alerted to cancelled activity (operations and outpatient clinics) impacting on elective performance and further industrial action having been announced in September and October 2023. Capacity also remained a challenge. (2) **Operational performance:** The Committee also received an alert in relation to forecasted decline in performance against the cancer Faster Diagnosis Standard having provisionally materialised in July 2023. This was due to an increase in referrals, the impact of industrial action, workforce gaps in certain areas and capacity challenges. The Committee was informed of the improvement actions in place with associated target dates. (3) **Finance:** At the end of August 2023, the Trust reported a deficit of £11.7 million against a planned deficit of £5.2 million, representing an adverse

	variance of £6.5 million. Key drivers for this as well as mitigants were reported to the Committee. The Committee requested an updated forecast and a focus upon achievement of the Cost Improvement Programme be presented to its October meeting. **(4) Medium Term Financial Plan:** A draft plan was presented, with it being acknowledged that there may be further revisions following discussion within the senior management team and with the Dorset Integrated Care Board. **(5) New Hospitals Programme:** An update was provided on the New Hospital Programme which would be discussed further by the Board at its Part 2 meeting. **(6) Estates Improvement:** It was noted that progress was being made in tackling the estates backlog, recognizing the budgetary implications. In terms of maintenance the focus was upon priority and risk areas. **(7) Private Patients Strategy Update:** The Committee received an update on progress. Further work was to be undertaken and presented at the December meeting of the Committee.
Progress of Board Assurance Key Risks Assigned to Committee:	The Board Assurance Framework was not presented to the September 2023 meeting of the Committee.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 27 September 2023

Agenda item: 8.1

Subject:	Estates Premises Assurance Model (PAM)
Prepared by:	Edwin Davies and Bernard Bhukal
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: (if applicable)	1260 – Compliance with SFG20 and associated legislation
Purpose of paper:	Assurance
Executive Summary:	The Premises Assurance Model (PAM) is a self-assessment that requires annual oversight at Board level. The Finance and Performance Committee (FPC) reviewed this in August 2023. The summary sheet is attached. The Board is asked to accept the PAM report. Overall the ratings are good for the systems and processes, with assurance given via Internal Audit and the ISO 9001 Quality Management Systems. The main area of requiring improvement is “maintenance.” Prompt question: are assets, equipment and plant adequately maintained? UHD has good systems to identify maintenance and compliance. However, the high level of estates backlog indicates “moderate improvement” required. Moderate is used as UHD is not an outlier overall in levels of backlog, this has estimated costings, and there are systems in place to prioritize funding. This though is in the context of an estimated £80m cost to remove Critical Infrastructure Risk (CIR) i.e. critical and high priority items. These are especially prevalent at Poole, as well as the electrical infrastructure at Bournemouth. PAM requires the Board to be aware of the costed plans to resolve this. The background section below provides further information. There is also a briefing note the FPC had as an aide memoire of the 10-year strategy to reduce backlog. This strategy has also been discussed at previous Board briefings on this topic.

Background:

Capital planning for backlog reduction

A 5 year "bottom up" capital plan has been developed for tackling the estates backlog. This uses local knowledge, including where NHP and other works are removing backlog already in the next 5 years. It is informed by where equipment and plant are breaking or maintenance is becoming excessive. It totals £71m.

Included within this are known issues, such as c£12m electrical infrastructure at RBH, which both provides resilience and enables decarbonization.

This first draft to inform the medium-term capital plan compliments the 2019 six facet survey which provides the more top down assessment with an estimated cost of £80m for the critical works.

The ability to access operational areas to meaningfully undertake major backlog works, plus the lead times for procuring and implementing, plus the scarcity of specialist contractors means several years planning is required.

Therefore, the table below is the first draft "need" for the next 5 years, but in reality the work is more likely to expand from 2026/27 when Poole site becomes more available.

	2024/25	2025/26	2026/27	2027/28	2028/29
RBH	6,750	4,705	4,550	11,665	5,485
Poole	9,135	7,810	7,035	5,885	5,785
Xch	50	225	475	100	250
Ald	382	635	-	-	-
Total	**16,317**	**13,375**	**12,060**	**17,650**	**11,520**
					70,922

The other major factor is that UHD's nationally set Capital Departmental Expenditure Limit (CDEL) availability limits expenditure. Thus within 2024/25 and 2025/26, this means c£5-6m may be the maximum expenditure allowed. Thus, the most pressing work will be prioritized. A step up from 2026/27 onwards would then focus on making in-roads into the wider backlog.

The Capital plan for 2023/24 and 2024/25 is focused on not deteriorating, with major inroads being planned from 2025/26 onwards with both the New Hospital Programme works, and a step up in Trust capital spent on backlogs. The medium-term capital plan that FPC and Board will consider shortly, will need to reflect this.

In year any capital slippage is being targeted towards the most urgent works, as the budgeted capital has been largely allocated for this year.

Work continues on improving estates compliance, identifying backlog and staff development. Staffing issues continue across the dept. with leavers exceeding joiners and high levels of sickness. Issues with estates staffing levels is now such that it is recommended that this risk is being added to the Trust risk register. This risk is being mitigated by use of external contractors, but this comes at a cost.

	PAM also covers facilities services, such as catering and security, and the summary report highlights the self-assessment of those services as well.
Key Recommendations:	To approve the Premises Assurance Model (PAM) annual submission to NHS England, based upon the self-assessment. To note the work on the medium-term capital plan, including the bottom-up budgeting using local knowledge which indicates a £71m expenditure required to remove critical infrastructure. This will feed into the process of prioritization and setting of capital plan.
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**
Monthly reports to FPC	14/08/2023	Noted

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

Annex – PAM Summary

NHS Premises Assurance Model (NHS PAM)

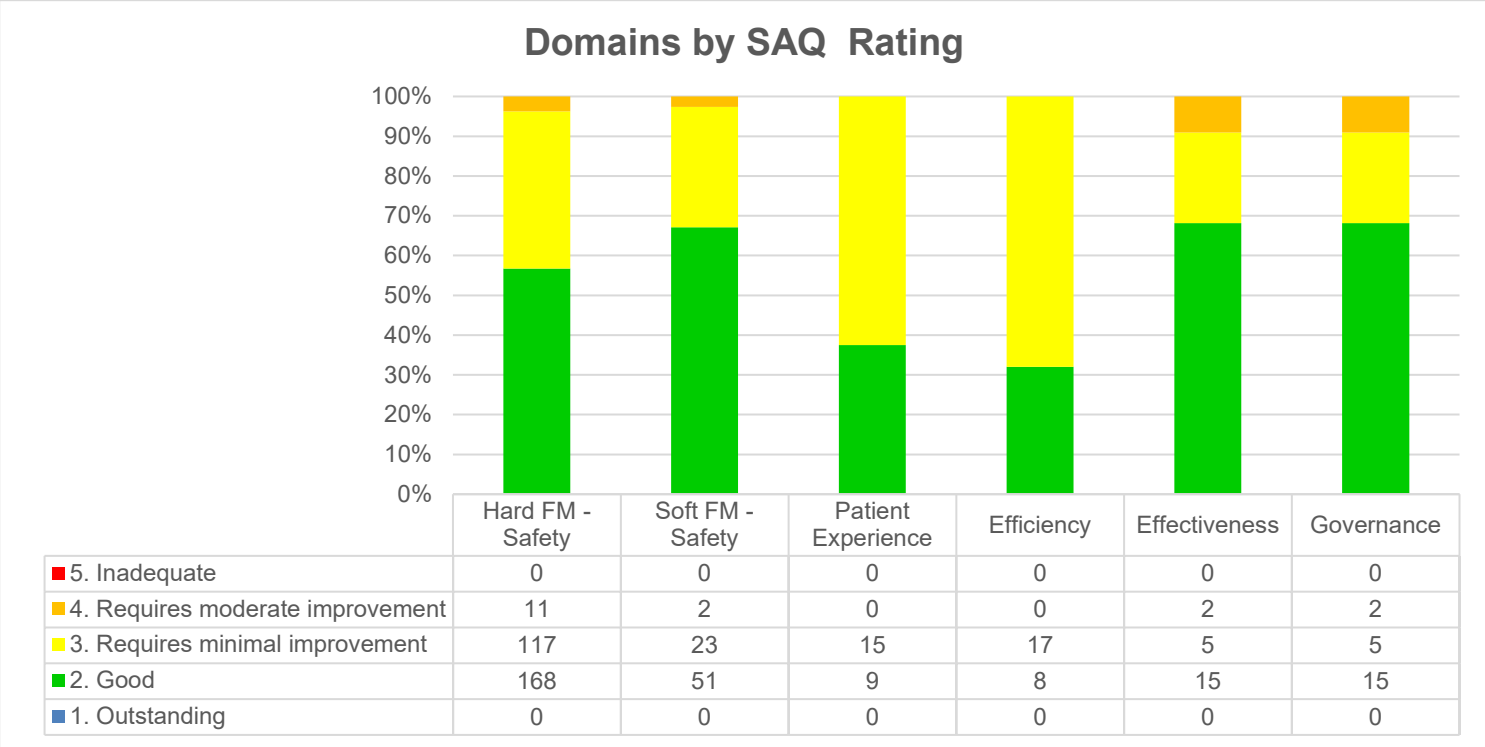
Self-Assessment Question Subject	1. Policy & Procedures	2. Roles and Resp.	3. Risk Assessment	4. Maintenance	5. Training and Dev	6. Resilience, Emergency & BCP	7. Review Process	8. Costed Action Plans	Capital	Revenue
Estates and Facilities Operational Management	3. Minimal	2. Good	3. Minimal	4. Moderate	3. Minimal	3. Minimal	3. Minimal	4. Moderate	0	**250,000**
Design, Layout and Use of Premises	3. Minimal	3. Minimal	2. Good	4. Moderate	2. Good	2. Good	2. Good	3. Minimal	0	0
Health & Safety at Work	2. Good	2. Good	3. Minimal	N/a	2. Good	3. Minimal	3. Minimal	3. Minimal	0	0
Asbestos	2. Good	3. Minimal	2. Good	N/a	3. Minimal	2. Good	2. Good	2. Good	0	0
Medical Gas Systems	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	0	0
Natural Gas and specialist piped systems	3. Minimal	3. Minimal	3. Minimal	2. Good	2. Good	2. Good	3. Minimal	3. Minimal	0	0
Water Safety Systems	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	3. Minimal	**7,070,675**	**5,000**
Electrical Systems	2. Good	2. Good	2. Good	4. Moderate	2. Good	3. Minimal	2. Good	3. Minimal	**4,500,000**	**175,000**

Mechanical Systems and Equipment	2. Good	2. Good	2. Good	4. Moderate	2. Good	3. Minimal	3. Minimal	3. Minimal	**150,000**	0
Ventilation, Air Conditioning and Refrigeration Systems	2. Good	2. Good	2. Good	4. Moderate	2. Good	3. Minimal	2. Good	3. Minimal	**8,372,134**	**10,000**
Lifts, Hoists and Conveyance Systems	2. Good	3. Minimal	2. Good	4. Moderate	2. Good	3. Minimal	2. Good	3. Minimal	**1358100**	**10,000**
Pressure Systems	2. Good	2. Good	2. Good	4. Moderate	2. Good	2. Good	2. Good	3. Minimal	**484,099**	**10,000**
Fire Safety	2. Good	3. Minimal	2. Good	4. Moderate	2. Good	4. Moderate	2. Good	2. Good	**6,160,000**	**75,000**
Medical Devices and Equipment	3. Minimal	2. Good	2. Good	3. Minimal	4. Moderate	3. Minimal	2. Good	2. Good	0	**151,000**
Resilience, Emergency and Business Continuity Planning	2. Good	2. Good	3. Minimal	3. Minimal	2. Good	N/a	2. Good	2. Good	0	0
Safety Alerts	2. Good	2. Good	2. Good	N/a	2. Good	2. Good	2. Good	2. Good	0	0
Catering services	2. Good	2. Good	2. Good	2. Good	3. Minimal	2. Good	2. Good	3. Minimal	0	0
Decontamination process	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	3. Minimal	**4,000,000**	0
Waste and Recycling Management	2. Good	2. Good	2. Good	2. Good	3. Minimal	3. Minimal	2. Good	3. Minimal	**50,000**	0

Cleanliness and Infection Control	3. Minimal	3. Minimal	3. Minimal	4. Moderate	2. Good	2. Good	3. Minimal	2. Good	0	0
Laundry and Linen Services	3. Minimal	2. Good	3. Minimal	N/a	2. Good	2. Good	2. Good	N/a	0	0
Security Management	3. Minimal	3. Minimal	3. Minimal	2. Good	2. Good	2. Good	2. Good	N/a	0	0
Transport Services	2. Good	2. Good	2. Good	2. Good	2. Good	3. Minimal	3. Minimal	N/a	**500,000**	0
Pest control	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	0	0
Portering services	3. Minimal	3. Minimal	4. Moderate	3. Minimal	2. Good	2. Good	3. Minimal	3. Minimal	0	0
Estates IT and BIM systems	3. Minimal	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	0	0

	1. Policy & Procedures	**2. Roles and Resp.**	**3. Risk Assessment**	**4. Maintenance**	**5. Contractor Compliance**	**6. Resilience, Emergency & BCP**	**7. Review Process**	**8. Costed Action Plans**		
Contractor Management for Soft and Hard FM services	3. Minimal	3. Minimal	3. Minimal	3. Minimal	3. Minimal	3. Minimal	3. Minimal	3. Minimal	0	0
	1. DMS in Place	**2. Approval of documents**	**3. Review of documents**	**4: Availability of documents**	**5. Legibility of Documents**	**6: Document Control**	**7. Obsolescence**	**8. Costed Action Plans**		

Estates and Facilities Document Management	3. Minimal	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	3. Minimal	0	**75,000**



	Hard FM - Safety	Soft FM - Safety	Patient Experience	Efficiency	Effectiveness	Governance
5. Inadequate	0	0	0	0	0	0
4. Requires moderate improvement	11	2	0	0	2	2
3. Requires minimal improvement	117	23	15	17	5	5
2. Good	168	51	9	8	15	15
1. Outstanding	0	0	0	0	0	0

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 27 September 2023

Agenda item: 8.4

Subject:	Key Issues and Assurance Report to Board of the Charitable Funds Committee meeting held on 07 August 2023
Prepared by:	John Lelliott, Chair of the Charitable Funds Committee
Presented by:	John Lelliott, Chair of the Charitable Funds Committee

Key Issues/matters discussed by the Committee:	The Committee received the following: • Investment Update for assurance • Review of Ethical Positioning, which was approved • Fundraising Report Q1 for assurance • Finance Report Q1 for assurance • Charity recharges, which were approved • Compliance with Reserves Policy report • NHS Charities Together Fund Allocation Update for assurance • Risk register for approval • UHD Charity Annual Report and Accounts which was endorsed with a recommendation to the Board to approve. The Committee also considered and endorsed/approved a number of business cases.
Significant issues for escalation to Board for action:	No significant issues to escalate to the Board for action arising from the August 2023 meeting.
Progress of Board Assurance Key Risks Assigned to Committee:	N/A

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 27 September 2023

Agenda item: 9.1

Subject:	Appointment of Senior Independent Director (SID)
Prepared by:	Yasmin Dossabhoy, Associate Director of Corporate Governance
Presented by:	Rob Whiteman, Trust Chair

Strategic themes that this item supports/impacts:	Systems working and partnership ☐ Our people ☒ Patient experience ☐ Quality: outcomes and safety ☐ Sustainable services ☐ Patient First programme ☐ One Team: patient ready for reconfiguration ☐
BAF/Corporate Risk Register: (if applicable)	N/A
Purpose of paper:	Decision/Approval
Executive Summary:	Caroline Tapster, Non-Executive Director, currently also holds the role of the Senior Independent Director (SID) of the Trust. Taking into account another role that she now holds, and the time commitment involved, Caroline Tapster will be step down as a Non-Executive Director of the Trust in December 2023. It is for the Board of Directors to appoint one of the Non-Executive Directors as the SID, following consultation with the Council of Governors. The Council of Governors was consulted in July 2023 about the appointment of Judy Gillow as the SID with effect from 1 October 2023 and for the period of her term of office as Non-Executive Director (unless otherwise determined), which was supported.
Background:	The Trust Constitution outlines the process for the appointment of the Senior Independent Director. *Annex 7 Clause 3.4 Appointment and Role of the Senior Independent Director* states the following: "3.4.2 The Board shall (following consultation with the Council of Governors) appoint one of the Non-Executive Directors as the SID for such a period not exceeding the

	remainder of the individual's term of office as a Non-Executive Director." The Board should note that Judy Gillow will commence the role of Chair of the Audit Committee from 1 October 2023.
Key Recommendations:	To consider and, if thought fit, approve the appointment of Judy Gillow as the Senior Independent Director.
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**
Council of Governors	27/07/2023	The appointment of Judy Gillow was endorsed by the Council of Governors.

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

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 27 September 2023

Agenda item: 9.2

Subject:	Terms of Reference
Prepared by:	Ewan Gauvin, Corporate Governance Manager Yasmin Dossabhoy, Associate Director of Corporate Governance
Presented by:	Rob Whiteman, Trust Chair

Strategic themes that this item supports/impacts:	Systems working and partnership ☒ Our people ☒ Patient experience ☒ Quality: outcomes and safety ☒ Sustainable services ☒ Patient First programme ☒ One Team: patient ready for reconfiguration ☒
BAF/Corporate Risk Register: (if applicable)	N/A
Purpose of paper:	Decision/Approval
Executive Summary:	**Summary of amendments:** Audit Committee • Senior Independent Director removed from those that are ineligible to be Committee Chair Quality/People & Culture/Finance & Performance Committees • Updated strategic vision aligned to each Committee Population Health & System Committee • Removed past strategic objective • Added Medical Director for Integrated Care to attendees Honours Group • Annual review of terms of reference
Background:	The terms of reference have been updated, as detailed in the executive summary.
Key Recommendations:	To approve the updated Terms of Reference for the Board Committees and Honours Group. To approve the next review date for the Terms of Reference for the Charitable Funds Committee and the

	Appointments Remuneration and Evaluation Committee being July 2024 to align with the other Board Committees.
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**
Honours Group	06/03/2023	Endorsed

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

TERMS OF REFERENCE

for the

University Hospitals Dorset NHS Foundation Trust

Audit Committee

~~January 2023~~July 2024

DOCUMENT DETAILS

Author:	Yasmin Dossabhoy
Job Title:	Associate Director of Corporate Governance
Signed:	
Date:	~~January~~September 2023
Version No: (Author Allocated)	2.~~0~~1
Next Review Date:	~~January~~July 2024

Approving Body/Committee:	Board of Directors
Chair:	Rob Whiteman
Signed:	
Date Approved:	~~25 January 2023~~
Target Audience:	Board of Directors

Document History

Date of Issue	Version No:	Next Review Date:	Date Approved:	Director responsible for Change	Nature of Change
October 2020	1	October 2021	July 2020	Company Secretary	New Document
October 2021	1.1	October 2022		Company Secretary	Deleted 9.1 Requirement for Committee minutes to be reported to the Trust Board Added 9.1 These minutes will be available to the Board fo Directors Remove a phrase at 11.4 i) Amend 11.6,
January 2023	2	January 2024	25 January 2023	Associate Director of Corporate Governance	Alignment of formatting with other Committee ToR; full review and update.
September 2023	2.1	July 2024		Associate Director of	Amended 3.3 to remove Senior Independent Director from those

				Corporate Governance	ineligible to be Committee Chair.

TABLE OF CONTENTS

INDIVIDUAL APPROVAL			
Job Title	N/A	Date	N/A
Print Name	N/A	Signature	
BOARD OF DIRECTORS / COMMITTEE APPROVAL			
If the Board / Committee has approved this document, please sign and date it and forward copies for inclusion on the Intranet.			
Name of approving body	Board of Directors	Date	~~25 January 2023~~
Print Name	Rob Whiteman	Signature of Chair	

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

AUDIT COMMITTEE

TERMS OF REFERENCE

1. PURPOSE

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

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

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

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

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

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

2. RESPONSIBILITIES

Governance, risk management and internal control

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

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

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

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

Counter-fraud

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

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

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

Internal Audit

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

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

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

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

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

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

External Audit

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

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

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

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

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

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

Financial reporting

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

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

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

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

2.5.3.2 Areas where judgment has been exercised;

2.5.3.3 Appropriateness and adherence to accounting policies and practices;

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

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

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

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

Freedom to speak up

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

Emergency Preparedness, Resilience and Response (EPRR)

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

3. MEMBERSHIP & ATTENDANCE

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

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

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

and others will attend as invited by the Committee Chair.

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

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

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

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

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

4. AUTHORITY

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

4.2 The Committee is authorised to approve its own governance cycle

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

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

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

5. CONDUCT OF BUSINESS

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

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

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

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

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

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

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

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

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

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

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

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

6. RELATIONSHIPS & REPORTING

6.1 The Committee shall be accountable to the Board.

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

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

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

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

7. MONITORING

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

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

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

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

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

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

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

8. REVIEW

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

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

APPENDIX A

ATTENDANCE AT AUDIT COMMITTEE MEETINGS

NAME OF COMMITTEE:	Audit Committee											
Present ***(including names of members present at the meeting)***	**Meeting Dates**											
Was the meeting quorate? Y/N *(Please refer to Terms of Reference)*												

University Hospitals Dorset
NHS Foundation Trust

TERMS OF REFERENCE

for the

University Hospitals Dorset NHS Foundation Trust

Quality Committee

~~May~~September 2023

We are caring one team listening to understand open and honest always improving inclusive

DOCUMENT DETAILS

Author:	Yasmin Dossabhoy and Ewan Gauvin
Job Title:	Associate Director of Corporate Governance and Corporate Governance Manager
Signed:	
Date:	~~May~~September 2023
Version No: (Author Allocated)	2.~~1~~2
Next Review Date:	~~January~~July 2024

Approving Body/Committee:	Board of Directors
Chair:	Rob Whiteman
Signed:	
Date Approved:	~~24 May 2023~~
Target Audience:	Board of Directors

Document History

Date of Issue	Version No:	Next Review Date:	Date Approved:	Director responsible for Change	Nature of Change
October 2020	1	October 2021	July 2020	Company Secretary	New document
May 2021	1.1	October 2021	26 May 2021	Assistant Company Secretary	Removed CEO as member of the committee at section 2.1 Added the CEO's attendance at section 2.4 Added CEO's receipt of papers at section 5.4
October 2021	1.2	October 2022	November 2021	Company Secretary	Added the Care Group Quality & Risk Groups to the reporting groups in sections 1.4 and 9.1 Added Associate Director of AHP/HCS as an attendee in section 2.2

					Added that the Clinical Lead for Clinical Audit is to attend for the Annual Audit Plan and Annual Report in section 2.2.
January 2022	1.3	January 2023		Corporate Governance Assistant	Changed "Quality Governance Group" to "Clinical Governance Group" in sections 1.4 and 9.1.
January 2023	2.0	January 2024	25 January 2023	Company Secretary	Full review and re-draft.
May 2023	2.1	January 2024	24 May 2023	Company Secretary	Membership of the Committee increased from three to four Non-Executive Directors
September 2023	2.2	July 2024		Company Secretary	Updated strategic objectives in 1.2.

TABLE OF CONTENTS

INDIVIDUAL APPROVAL			
Job Title	N/A	Date	N/A
Print Name	N/A	Signature	N/A
BOARD OF DIRECTORS/COMMITTEE APPROVAL			
If the Board/Committee has approved this document, please sign and date it and forward copies for inclusion on the Intranet.			
Name of approving body	Board of Directors	Date	~~24 May 2023~~
Print Name	Rob Whiteman	Signature of Chair	

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

QUALITY COMMITTEE

TERMS OF REFERENCE

1. PURPOSE

1.1 The Trust's vision is to positively transform its health and care services as part of the Dorset Integrated Care System. Its mission is to provide excellent healthcare for its patients and wider community and be a great place to work now and for future generations.

1.2 The purpose of the Quality Committee is to support the Trust in achieving its ~~strategic objective: "To enhance emergency care and hospital flow and continually improve the quality so that services are safe, compassionate, timely and responsive, achieving consistently good outcomes and an excellent patient experience".~~ vision of:

- All patients at UHD receive quality care, which results in a positive experience for them, their families and carers. Every team is empowered to make continuous improvement by engaging with patients in a meaningful way, using their feedback to make change.
- To be rated the safest Trust in the country and be seen by our staff, as an outstanding organisation for effectiveness (Hospitalised Standardised Mortality Ratios - SMR) and Patient Safety Incidents (PSIs)

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1.3 The Quality Committee will do this including through:

- Providing input and recommendations to the Board for the development of the Quality Strategy, Risk Management Strategy and Clinical Audit Strategy and the End of Life Care Strategy;
- Assisting the Trust's Board of Directors (Board) in its oversight of achievement of breakthrough objectives and strategic initiatives relating to the Quality domain;
- Ensuring robust clinical governance structures, systems and processes are in place across all services;
- Promoting a culture of learning and continuous improvement;
- Obtaining assurance on the implementation of the quality strategy; and
- Receiving and reviewing information and data relating to quality performance reporting to the Board.

1.4 The Committee serves to provide assurance that the Trust has an effective framework within which it can provide an effective patient experience by working to improve and assure the quality and safety of services it provides in a timely and cost-effective manner across the following areas: quality, patient experience, patient safety, clinical outcomes, risk management, health and safety, safeguarding (children and adults), infection prevention and control, medicines management, learning from deaths and end of life care.

1.5 The Committee acts as a means of internal assurance for compliance against the Care Quality Commission regulating and inspection compliance framework.

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

2. RESPONSIBILITIES

Quality Strategy and delivery of the Quality Agenda

2.1 To receive confirmation from the Board, on an annual basis, of:

- the relevant breakthrough objectives; and
- the relevant strategic initiatives;

which are to be held to account by the Committee.

2.2 To obtain assurance that the relevant breakthrough objectives and strategic initiatives for which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, appropriate challenge and escalating to the Board when required.

Risk Management

2.3.1 To oversee that the Trust has robust management systems and processes in place for ensuring high standards for quality of care.

2.3.2 To oversee that the Trust has an effective framework to support assurance regarding Trust systems relating to patient safety, patient outcome and patient experience.

2.3.2 To regularly review the Board Assurance Framework (including through in-depth review of specific risks) and to ensure that it reflects the assurances for which the Committee has oversight, with risks highlighted being appropriately reflected on the risk registers. This shall include, but not be limited to the Committee acting in accordance with Board approved risk appetite and risk tolerance levels when reviewing risks.

2.3.3 To be kept appraised of all new and current risks rated 12-25, clinical and non-clinical, identified on the risk register across the organisation and progress of action plans identified to mitigate these risks.

Assurance

2.4 Statutory requirements

2.4.1 To review the annual quality report.

2.4.2 To review the quarterly and annual mortality reports.

2.4.3 To review the annual adult and children safeguarding report and statement.

2.4.4 To review the annual reports on claims.

2.4.5 To review the annual infection prevention and control report and statement.

2.5 External reviews

2.5.1 To receive assurance from other significant assurance functions, both internal and external, on review of the findings of external reviews and consider the implications to the Trust. These will include, but not be limited to, regulators and inspectors.

2.5.2 To monitor the Trust's responses to relevant external assessment reports and the progress of their implementation, including the reports of the Care Quality Commission.

2.5.3 To receive and monitor the CQC Insight Model Report.

2.5.4 To receive and monitor the CQC in-patient survey reports and associated action plans.

2.6 Safe

2.6.1 To review reports on serious incidents, mortality, learning from deaths, never events, claims and inquests to receive assurance that appropriate thematic review, investigation and learning to reduce risk has been undertaken.

2.6.2 To receive reports including:

- identification of areas of concern and escalations; and
- in the context of quality risks and assurances over the Trust's system of internal control as reflected in the Board Assurance Framework;

from defined sub-groups of the Trust Management Group and/or Board Committees (including, as considered required, Safeguarding, Infection Prevention & Control, Radiation Protection, Medicines Governance, Health and Safety, Mortality Surveillance, Clinical Governance Group and Strategic Nursing Midwifery and Professions Group).

2.6.3 To review and monitor Quality Impact Assessments relating to cost improvement programmes and transformation programmes to obtain assurance that there will be no unforeseen detrimental impact on the quality of care for patients.

2.6.4 To obtain assurance that robust safeguarding structures, systems and processes are in place to safeguard children and adults.

2.6.5 To obtain assurance over the Trust's maternity services including receipt of reports from the Maternity Safety Champion and relevant maternity safety and performance dashboards.

2.6.6 To obtain assurance over the safe delivery of the Trust's palliative and end of life care services including receipt of the annual End of Life Care Report and Care of the Dying Audit.

2.6.7 To obtain assurance in relation to the safe delivery of the Trust's resuscitation services.

2.6.8 To obtain assurance in relation to the safe delivery of the Trust's children's services.

2.6.9 To obtain assurance in relation to the delivery of the Trust's falls and dementia services.

2.6.10 To review reports in relation to Getting It Right First Time.

2.6.11 To receive relevant reports from national bodies in relation to standards or practice of clinical care.

2.7 Effective

2.7.1 To ensure a comprehensive clinical audit programme is in place to support and apply evidence-based practice, implement clinical standards and guidelines and drive quality improvement. This shall include through monitoring progress against the Clinical Audit Strategy.

2.7.2 When requested by the Board, or where determined by the Committee, to monitor the implementation of action or improvement plans in relation to quality of care, particularly in relation to incidents and similar issues.

2.8 Caring

2.8.1 To consider reports from the Patient Advice & Liaison Service and other sources of feedback (such as Healthwatch) on formal and informal patient feedback and to consider action in respect of matters of concern.

2.8.2 To consider the results of issues raised and the trends in patient surveys of in-patients and out-patients activities and estate surveys such as PLACE that may impact on clinical quality, and to gain assurance of the development of suitable improvement and the completion of action to address the issues raised.

2.9 Well-Led

2.9.1 To receive and consider the Trust's clinical governance and risk management reports and review recommendations on actions for improvement.

2.9.2 To provide assurance reporting to the Board that the Care Quality Commission's fundamental standards for quality and safety are monitored and highlight any gaps in compliance, controls or assurance.

2.9.3 To review, make comment and provide assurance reporting to the Board on the care and safety issues which are subject to other regulatory scrutiny (for example, NICE).

2.9.4 To oversee, through receipt of periodic status reporting, the update of clinical policies.

2.10 Responsive

2.10.1 To identify key themes from complaints, PALS and patient engagement, good practice and learning and provide oversight on behalf of the Board.

2.10.2 To identify key themes from patient experience, quality indicators and provide oversight of action plans to attain assurance.

2.10.3 To receive, by exception, reports relating to patient experience following review at relevant groups.

2.11 ICS

To receive and review relevant reports of or relating to the Dorset integrated care system and provider collaborative.

3. MEMBERSHIP/ ATTENDANCE

3.1 Membership of the Quality Committee comprises of four Non-Executive Directors, one of whom will be a member of the Audit Committee, the Chief Nursing Officer, the Chief Medical Officer, the Chief Operating Officer and the Chief People Officer.

3.2 In addition, the following will attend the Committee to provide information and advice with prior agreement of the Committee Chair and/or to present a report to the Committee or a Chief Officer is unable to attend:

- Deputy Chief Nursing Officers;
- Deputy Chief Medical Officers;
- Director of Infection Prevention and Control;
- Care Group Medical Directors;

- Associate Director of Pharmacy;
- Associate Medical Director (Chair of CGG);
- Care Group Directors of Nursing;
- Associate Director of Quality Governance and Risk;
- Clinical Lead for Clinical Audit;
- IR(ME)R Lead/Chair of Radiation Group;
- Associate Director of Allied Health Professionals & Healthcare Scientists

and others as invited by the Committee Chair.

3.3 The Committee will be chaired by a Non-Executive Director of the Trust (other than the Chair of the Audit Committee or Finance and Performance Committee). A Non-Executive Deputy Chair (other than the Chair of the Audit Committee or Finance and Performance Committee) may be nominated. In the absence of the Chair and/or an appointed Deputy, the remaining members shall elect one of the Non-Executive Directors present to chair the meeting.

3.4 Subject to paragraphs 3.2 above and 3.6 below, only members of the Committee have the right to attend Committee meetings. If a standing member is unable to attend, they may exceptionally send a deputy to the meeting, but the deputy will not have voting rights at the meeting. The Chief Executive Officer will attend on an ad-hoc basis or as required.

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

3.6 Any member of the Board may attend any meeting of the Committee with prior agreement of the Committee Chair.

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

4. AUTHORITY

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

4.2 The Committee is authorised to approve its governance cycle.

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

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

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

5. CONDUCT OF BUSINESS

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

5.2 The Committee will normally meet on a monthly basis (and not less than 10 times in each financial year) and at such other times as the Committee Chair shall require.

5.3 Meetings of the Committee shall be quorate if there at least five members present, which will include the Chair (or a Non-Executive Director deputy), and two Executive Directors, one of whom must be the Chief Medical Officer or Chief Nursing Officer. For the avoidance of doubt, an Officer in attendance who has been formally appointed by the Board to act up for an Executive Director shall count towards the quorum.

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

5.5 Meetings of the Committee shall be called by the Company Secretary at the request of the Chair.

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

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

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

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

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

6. RELATIONSHIPS AND REPORTING

6.1 The Committee shall be accountable to the Board.

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

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

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

6.5 For the avoidance of doubt:

- the People and Culture Committee will have oversight of the development by the Trust of an effective staff structure and workforce operating model across the organisation; and
- the Population Health and System Committee will have oversight of health inequalities, work with system partners in establishing the Dorset ICS and the development of the Dorset provider collaborative.

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

7. MONITORING

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

7.2 The Trust's Annual Report will include attendance of members, frequency of meetings and whether meetings were quorate.

7.3 On an annual basis, the Committee will provide a self-assessment report to the Board detailing how the Committee has discharged its obligations as set out within its terms of reference, specifically incorporating an assessment of its effectiveness and making recommendations for improvement, where appropriate. This will form part of the assurances which support the Annual Governance Statement and the Trust's Annual Report disclosures.

8. REVIEW

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

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

APPENDIX A

ATTENDANCE AT QUALITY COMMITTEE MEETINGS

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

TERMS OF REFERENCE

for the

University Hospitals Dorset NHS Foundation Trust

People & Culture Committee

~~May~~September 2023

We are caring one team listening to understand open and honest always improving inclusive

DOCUMENT DETAILS

Author:	Yasmin Dossabhoy
Job Title:	Associate Director of Corporate Governance
Signed:	
Date:	~~May~~September 2023
Version No: (Author Allocated)	2.~~1~~2
Next Review Date:	~~January~~July 2024

Approving Body/Committee:	Board of Directors
Chair:	Rob Whiteman
Signed:	
Date Approved:	~~24 May 2023~~
Target Audience:	Board of Directors

Document History

Date of Issue	Version No:	Next Review Date:	Date Approved:	Director responsible for Change	Nature of Change
August 2020	1	August 2021	August 2020	Company Secretary	New document
October 2021	1.1	October 2022	24 November 2021	Company Secretary	Addition of two Groups at 9.1 Addition of an Attendee at 2.2
January 2023	2.0	January 2024	25 January 2023	Company Secretary	Full review and re-draft.
May 2023	2.1	January 2024	24 May 2023	Company Secretary	Membership of the Committee increased from three to four Non-Executive Directors
September 2023	2.2	July 2024		Company Secretary	Updated strategic objectives in 1.2.

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INDIVIDUAL APPROVAL			
Job Title	N/A	Date	N/A
Print Name	N/A	Signature	N/A
BOARD OF DIRECTORS/COMMITTEE APPROVAL			
If the Board/Committee has approved this document, please sign and date it and forward copies for inclusion on the Intranet.			
Name of approving body	Board of Directors	Date	~~24 May 2023~~
Print Name	Rob Whiteman	Signature of Chair	

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

PEOPLE & CULTURE COMMITTEE

TERMS OF REFERENCE

1. PURPOSE

1.1 The Trust's vision is to positively transform its health and care services as part of the Dorset Integrated Care System. Its mission is to provide excellent healthcare for its patients and wider community and be a great place to work now and for future generations.

1.2 The purpose of the People & Culture Committee is to support the Trust in achieving its ~~strategic objective: "To be a great place to work, by creating a positive and open culture, and supporting and developing staff across the Trust, so that they are able to realise their potential and give of their best".~~ vision of:

- To be a great place to work attracting and retaining the best talent. NHS Staff Survey results in top 20% within three years.
- To successfully and sustainably adopt the Patient First approach.

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1.3 The People & Culture Committee will do this through:

- Providing input and recommendations to the Trust's Board of Directors (Board) for the development of the People Strategy and the Equality, Diversity & Inclusion Strategy;
- Assisting the Board in its oversight of achievement of breakthrough objectives and strategic initiatives relating to the People & Culture domains;
- Obtaining assurance on the implementation of the People Strategy and Equality, Diversity & Inclusion Strategy; and
- Receiving and reviewing information and data relating to workforce reporting to the Board.

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

2. RESPONSIBILITIES

People Strategy and delivery of the People Agenda

2.1 To receive confirmation from the Board, on an annual basis, of:

- the relevant breakthrough objectives; and
- the relevant strategic initiatives;

which are to be held to account by the Committee.

2.2 To obtain assurance that the relevant breakthrough objectives and strategic initiatives for which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, appropriate challenge and escalating to the Board when required.

Risk Management

2.3.1 To regularly review the Board Assurance Framework (including through in-depth review of specific risks) and to ensure that it reflects the assurances for which the Committee has oversight, with risks highlighted being appropriately reflected on the risk registers. This shall include, but not be limited to the Committee acting in accordance with Board approved risk appetite and risk tolerance levels when reviewing risks.

2.3.2 To review the Trust's significant risks report and receive updates on directorate workforce risk issues, action plans or unresolved matters/concerns for escalation.

Oversight and Assurance

A great place to work

2.3.4 To review reports from the Guardian of Safe Working and Freedom to Speak Up Guardian as well as Safe Staffing reviews.

2.3.5 To consider reports on national and local surveys including the staff survey and GMC survey as they relate to workforce, monitoring the implementation of actions agreed to be taken to address areas of concern identified.

2.3.6 To obtain assurance that appropriate feedback mechanisms are in place for those raising incidents and that a culture of openness and transparency in respect of incident reporting is encouraged by supporting the Speaking Up agenda.

2.3.7 To oversee and monitor the implementation of the Equality, Diversity and Inclusion strategy.

2.3.8 To obtain assurance in relation to the Trust's security management - violence prevention and reduction strategy.

Compassionate inclusive leadership, focused on improvement of quality and efficiency of services for patients

2.3.9 To oversee the development by the Trust of an effective staff structure and workforce operating model across the organisation.

2.3.10 To monitor delivery of staff engagement plans to ensure there are clear communication channels across the organisation which provide staff with key information during the transformation of services.

2.3.11 To monitor organisational integration and cultural development and the implementation of action plans as necessary.

Building skills and capabilities

2.3.12 To receive reporting relating to changes in Professional Education and Essential Core Skills training to ensure compliance and continued provision of high quality care.

2.3.13 To monitor the provision of training and development and implementation of solutions which deliver a skilled, flexible modernised workforce improving productivity, performance and reducing health inequalities.

2.3.14 To obtain assurance that effective performance management systems are in place in support of delivery by the Trust of improving capability and capacity to provide high quality, safe patient care.

Strategic workforce planning

2.3.15 To monitor major workforce transformation programmes, including to obtain assurance that no such programme has an unforeseen adverse impact on workforce or on the performance of the Trust.

2.3.16 To receive and monitor workforce indicators including recruitment, retention/turnover, sickness, appraisals and training.

Mandated/Statutory requirements

2.3.17 To oversee and monitor progress against national NHS England workforce standards and reporting including the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).

2.3.18 To review the Trust's Equality and Diversity Monitoring Report.

2.3.19 To review the Gender Pay Gap Report.

2.3.20 To review the annual consultant revalidation report.

2.4 ICS

To receive and review relevant reports of or relating to the Dorset integrated care system and provider collaborative.

3. MEMBERSHIP/ATTENDANCE

3.1 Membership of the People & Culture Committee comprises of four Non-Executive Directors, the Chief People Officer, the Chief Medical Officer, Chief Nursing Officer and the Chief Operating Officer:

3.2 In addition, the following will attend the Committee to provide information and advice with the prior agreement of Committee Chair and/or to present a report to the Committee or a Chief Officer is unable to attend:

- Deputy to Chief People Officer x 2;
- Associate Director of Communications;
- Director of Organisational Development;
- Care Group Directors of Operations;
- Associate Director for Allied Health Professionals & Healthcare Scientists;

and others as invited by the Committee Chair.

3.3 The Committee will be chaired by a Non-Executive Director of the Trust (other than the Chair of the Audit Committee). A Non-Executive Deputy Chair may be nominated (other than the Chair of the Audit Committee). In the absence of the Chair and/or an appointed Deputy, the remaining members shall elect one of the Non-Executive Directors present to chair the meeting.

3.4 Subject to paragraphs 3.2 above and 3.6 below, only members of the Committee have the right to attend Committee meetings. If a standing member is unable to attend, they

may exceptionally send a deputy to the meeting, but the deputy will not have voting rights at the meeting.

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

3.6 Any member of the Board may attend any meeting of the Committee with prior agreement of the Committee Chair.

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

4. AUTHORITY

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

4.2 The Committee is authorised to approve its governance cycle.

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

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

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

5. CONDUCT OF BUSINESS

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

5.2 The Committee will normally meet on a quarterly basis and at such other times as the Chair of the Committee shall require.

5.3 Meetings of the Committee shall be quorate if there at least four members present, which will include at least one Non-Executive Director and one Executive Director. For the avoidance of doubt, an Officer in attendance who has been formally appointed by the Board to act up for an Executive Director shall count towards the quorum.

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

5.5 Meetings of the Committee shall be called by the Company Secretary at the request of the Chair.

5.6 The Company Secretary (or their nominee) is responsible for preparing the agenda for agreement by the Chair, with the Chair consulting with the Chief Nursing Officer, as

considered appropriate. The Company Secretary (or their nominee) shall collate and circulate papers to Committee members. Unless otherwise agreed, papers should be provided not less than seven working days before the meeting and the agenda and papers should be circulated not less than five working days before the meeting.

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

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

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

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

6. RELATIONSHIPS AND REPORTING

6.1 The Committee shall be accountable to the Board.

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

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

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

6.5 For the avoidance of doubt:

- the Finance and Performance Committee will have oversight of coordination and coherence of the entire transformation agenda;
- the Quality Committee will have oversight of quality and safety issues including private patient care as part of the quality governance process; and
- the Population Health and System Committee will have oversight of health inequalities, work with system partners in establishing the Dorset ICS and the development of the Dorset provider collaborative.

6.6 The Committee shall receive reports from sub-groups of the Trust Management Group and/or Board Committees that specify matters requiring escalation to the Committee. The Committee shall also receive, from time to time, such reports from such sub-groups

as it may require to provide it with assurance relating to matters within the scope of the Committee's responsibilities.

7. MONITORING

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

7.2 The Trust's Annual Report will include attendance of members, frequency of meetings and whether meetings were quorate.

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

8. REVIEW

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

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

APPENDIX A

ATTENDANCE AT PEOPLE & CULTURE COMMITTEE MEETINGS

NAME OF COMMITTEE:	People & Culture Committee								
	Meeting Dates								
Present (*include names of members present at the meeting)*									
In Attendance									
Was the meeting quorate? Y / N (*Please refer to Terms of Reference*)									

TERMS OF REFERENCE

for the

University Hospitals Dorset NHS Foundation Trust

Finance & Performance Committee

~~May~~September 2023

DOCUMENT DETAILS

Author:	Yasmin Dossabhoy and Ewan Gauvin
Job Title:	Associate Director of Corporate Governance, Corporate Governance Manager
Signed:	
Date:	~~May~~September 2023
Version No: (Author Allocated)	2.~~1~~2
Next Review Date:	~~January 2024~~July 2024

Approving Body/Committee:	Board of Directors
Chair:	Rob Whiteman
Signed:	
Date Approved:	~~24 May 2023~~
Target Audience:	Board of Directors

Document History

Date of Issue	Version No:	Next Review Date:	Date Approved:	Director responsible for Change	Nature of Change
2020	1	2021	29 07 2020	Company Secretary	New Document
2021	1.1	Oct 2021	26 05 2021	Assistant Company Secretary	Removed CEO as member of the committee at section 2.1 Added the CEO's attendance at section 2.3 Added CEO's receipt of papers at section 4.2
October 2021	1.2	October 2022		Company Secretary	'Excluding VAT' added to 8.3
January 2023	2.0	January 2024	25 January 2023	Company Secretary	Full review and redraft.
May 2023	2.1	January 2024	24 May 2023	Company Secretary	Membership increased from three to four Non-Executive Directors
September 2023	2.2	July 2024		Company Secretary	Updated strategic objectives in 1.2.

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If the Board / Committee has approved this document, please sign and date it and forward copies for inclusion on the Intranet.			
Name of approving body	Board of Directors	Date	~~24 May 2023~~
Print Name	Rob Whiteman	Signature of Chair	

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

FINANCE & PERFORMANCE COMMITTEE

TERMS OF REFERENCE

1. PURPOSE

1.1 The Trust's vision is to positively transform its health and care services as part of the Dorset Integrated Care System. Its mission is to provide excellent healthcare for its patients and wider community and be a great place to work now and for future generations.

1.2 The purpose of the Finance and Performance Committee is to support the Trust in achieving its ~~strategic objectives: "**To arrange our people and services to best address the planned care backlog, ensuring that all resources are used efficiently to establish financially and environmentally sustainable services and deliver key operational standards and targets**" and "**To transform and improve our services in line with the Dorset ICS Long Term Plan, by separating emergency and planned care and integrating our services with those in the community**".~~ vision of:

- To meet the patient national constitutional standards for Planned and Emergency care. supporting inequalities in outcome and access and improving productivity and value.
- To maximise value for money enabling further investment in our services to improve the timeliness and quality of care for our patients, and the working lives of our staff.
- To integrate teams and services, then to reconfigure, and so create the planned and emergency hospitals.

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1.3 The Finance and Performance Committee will do this including through:

- Providing input and recommendations to the Board for the development of the Annual Operating Plan, Productivity and Efficiency Plan (including savings opportunities and merger benefits realisation), Quality Improvement Strategy, Estates Strategy (Masterplan), Sustainability Strategy (Green Plan), Digital Strategy and Private Patients Strategy;
- Assisting the Trust's Board of Directors (Board) in its oversight of achievement of breakthrough objectives and strategic initiatives relating to finance, performance, digital, sustainability and transformation;
- Obtaining assurance on the implementation of the Annual Operating Plan, the Productivity and Efficiency Plan, Quality Improvement Strategy, Estates Strategy (Masterplan), Sustainability Strategy (Green Plan), Digital Strategy and Private Patients Strategy;
- Monitoring risks relating to the efficient use of resources (physical and financial, but excluding workforce which shall be reviewed by the People and Culture Committee), including financial performance;
- Monitoring implementation progress and obtaining assurance of:
  - Delivery of financial and non-financial benefits of merger integration and reconfiguration;

- all components of post-merger benefits realisation;
- the Clinical Services Review implementation; and
- Mitigations to climate change;

- Overseeing coordination and coherence of the entire transformation agenda, including both major programmes of changes, as well as creating a culture of empowerment and continuous quality improvement.

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

2. RESPONSIBILITIES

Strategies and delivery of the strategic agendas

2.1 To receive confirmation from the Board, on an annual basis, of:

- the relevant breakthrough objectives and
- the relevant strategic initiatives

which are to be held to account by the Committee.

2.2 To obtain assurance that the relevant breakthrough objectives and strategic initiatives, for which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, appropriate challenge and escalating to the Board when required.

2.3 Statutory requirements

2.3.1 To review the Trust's draft Annual Report and Accounts, in conjunction with the Audit Committee, and following satisfactory external audit, making recommendations jointly to the Board for approval, signature, submission and filing.

2.4 Financial and operational performance

2.4.1 To review for recommendation to the Board the annual plan and medium-term financial plans, including, to the extent necessary and relevant considering the wider Dorset system's annual plan.

2.4.2 To review and make comment to the Board on the long term strategic financial plans of the Trust, and to the extent necessary the wider Dorset system, including consideration of the level of capital investment and financial risk.

2.4.3 To review and make comment to the Board on the substance of the annual revenue and capital budgets of the Trust, and to the extent necessary the wider Dorset system, and to consider and make recommendations to the Board of Directors on tenders, contracts and business cases for capital and revenue schemes which exceed the Committee's delegated limits set out in the Schedule of Delegation of the Board.

2.4.4 To review the financial and operational performance and controls reporting of the Trust, and to the extent necessary the wider Dorset system, to include overall financial and operational performance, financial performance of each Care Group, cash flow, debtors and creditors, transformation, merger and cost improvement programmes, capital spend against plan and resources available.

2.4.5 To review and examine monthly and year to date financial management variances both revenue and capital and report to the Board.

2.4.6 To keep under review the quality, quantity and timeliness of financial, operational and analytical information provided to the Board and recommend any required changes, particularly in response to changes required to regain budget trajectory or in national requirements on a monthly or annual basis as appropriate.

2.4.7 In respect of major capital projects of the Trust, and to the extent necessary the wider Dorset system, to consider business cases in detail and where necessary advise on strengthening prior to making recommendations to the Board for its approval or otherwise. To monitor these projects post-approval and scrutinise any cost or time variances.

2.4.8 To review and make comment to the Board on borrowing against Prudential Borrowing Code and other ratios.

2.4.9 To monitor and recommend improvements to Treasury and Financial Systems, meeting the objectives of strengthening the use of financial resources.

2.4.10 To review and recommend individual investments of cash balances/cash advances.

2.4.11 To monitor banking arrangements, including approving tenders of banking services.

2.4.12 To support the Trust in fulfilling the requirements of its licence and commissioner contracts in relation to key performance indicators.

2.4.13 To keep the Board updated on any identified regulatory and statutory duties related to financial performance of the Trust and how this impacts delivery against the control total.

2.4.14 To consider the impact of accounting policies for external reporting, taking into account the requirements of NHS England and other appropriate bodies.

2.4.15 To review the estates strategy and Estates masterplan, providing input and recommendations to the Board, and to monitor progress against and risks associated with the strategy and monitoring other estates-related improvement plans.

2.4.16 To review the Private Patient Strategy, the Benefits Realisation Strategy and the Quality Improvement Strategy, providing input and recommendations to the Board and to monitor progress against and risks associated with such strategies.

2.4.17 To review the development and delivery of commercial strategies of the Trust, including partnership arrangements with other organisations, providing input and recommendations to the Board.

2.4.18 To review the Trust's procurement strategy including having regard to the priorities at national and integrated care system (ICS) level and challenges to the delivery of change and providing input to the Board.

2.5 Digital

2.5.1 To review the Digital Strategy and provide input and recommendations to the Board for approval.

2.5.2 To monitor the implementation of the Trust's information management, technology and digital plans as enablers to efficiency and transformation, receiving regular progress reports to scrutinise delivery and the meeting of key milestones.

2.5.3 To receive reporting in relation to cyber security including regular maintenance of critical systems and equipment and minimising impact on clinical services during downtime.

2.6 Sustainability

2.6.1 To review the Sustainability Strategy (Green Plan) and provide input and recommendations to the Board for approval.

(For this purpose, sustainability means meeting the needs of the current generation without compromising future generations of the ability to meet their needs, in social, economic or environmental terms. The Trust and the wider NHS are also assessing the health and wellbeing of the population for environmental changes, including the impacts of a warming planet, air quality and mitigations for these negative changes).

2.6.2 To monitor the implementation of the Trust's sustainability plans, receiving regular progress reports to scrutinise delivery and the meeting of key milestones.

2.6.3 To review the Trust's draft Annual Report prior to recommendation to the Board for matters of sustainability, climate adaptation and carbon reduction and related areas of corporate social responsibility.

2.7 ICS

2.7.1 To receive and review financial and other relevant reports of or relating to the Dorset ICS and provider collaborative.

Risk Management

2.8.1 To regularly review the Board Assurance Framework (including through in-depth review of specific risks) and to ensure that it reflects the assurances for which the Committee has oversight, with risks highlighted being appropriately reflected on the risk registers. This shall include, but not be limited to the Committee acting in accordance with Board approved risk appetite and risk tolerance levels when reviewing risks.

2.8.2 To be kept appraised of all new and current risks rated 12-25 applicable to the Committee's scope identified on the risk register across the organisation and progress of action plans identified to mitigate these risks.

3. MEMBERSHIP & ATTENDANCE

3.1 Membership of the Finance and Performance Committee comprises of four Non-Executive Directors (at least one of whom should have recent and relevant financial experience), the Chief Finance Officer, the Chief Strategy and Transformation Officer and the Chief Operating Officer.

3.2 In addition, the following will attend the Committee to provide information and advice with prior agreement of the Committee Chair and/or to present a report to the Committee or a Chief Officer is unable to attend:

- Deputy Chief Finance Officer;
- Head of Productivity & Efficiency;
- Group Directors of Operations;

Group Directors of Operations will attend on a quarterly basis and as invited, and others including, but not limited to:

- the Chair of the Medical Advisory Committee for Private Health UHD;
- the Chair of the Medical Advisory Committee for Dorset Heart Clinic;
- the Associate Director of Estates;
- the Trust Sustainability and Carbon Manager;
- a representative from Communications;
- a representative from Bournemouth, Christchurch and Poole Council;
- a representative from Bournemouth University
- the Director of Transformation;
- the Director of Improvement and Integration;
- the Director of Organisational Development;

as invited by the Committee Chair.

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

3.4 Subject to paragraphs 3.2 above and 3.5 and 3.6 below, only members of the Committee have the right to attend Committee meetings. If an executive director member is unable to attend, they may exceptionally send a deputy to the meeting, but the deputy will not have voting rights at the meeting. The Chief Executive Officer will attend on an ad-hoc basis or as required.

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

3.6 Any member of the Board of Directors may attend any meeting of the Committee with prior agreement of the Chair.

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

4. AUTHORITY

4.1 The Committee is authorised by the Board to investigate/review any activity within the Terms of Reference and to make decisions within its delegated authority limits.

4.2 The Committee is authorised to approve its own governance cycle

4.3 The Committee shall have delegated authority to approve or reject tenders, award contracts and approve business cases for capital and revenue schemes up to the value delegated to it by the Board.

4.4 The Committee is authorised to approve Treasury Management Policies and Investments.

4.5 The Committee is authorised to approve the policies and procedures for ensuring economy, efficiency and effectiveness in the use of resources.

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

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

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

5. CONDUCT OF BUSINESS

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

5.2 The Committee will normally meet on a monthly basis (and not less than 10 times in each financial year) and at such other times as the Committee Chair shall require.

5.3 Meetings of the Committee shall be quorate if there are at least three members present which will include two Non-Executive Directors and one Executive Director. For the avoidance of doubt, an Officer in attendance who has been formally appointed by the Board to act up for an Executive Director shall count towards the quorum.

In the absence of the Chief Finance Officer, his/her deputy must be present.

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

5.5 Meetings of the Committee shall be called by the Company Secretary at the request of the Chair or Chief Finance Officer.

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

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

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

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

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

6. RELATIONSHIPS & REPORTING

6.1 The Committee shall be accountable to the Board.

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

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

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

6.5 For the avoidance of doubt:

- the Quality Committee will have oversight of quality and safety issues including private patient care as part of the quality governance process; and
- the People and Culture Committee will have oversight of the development by the Trust of an effective staff structure and workforce operating model across the organisation; and
- the Population Health and System Committee will have oversight of health inequalities, work with system partners in establishing the Dorset ICS and the development of the Dorset provider collaborative.

6.6 The governance of Private Health UHD is within the Surgical Care Group and Dorset Heart Clinic within the Medical Care Group. There are operational management groups for these, who report via the Care Group management governance.

6.7 The Committee shall receive reports from sub-groups of the Trust Management Group and/or Board Committees that specify matters requiring escalation to the Committee. The Committee shall also receive, from time to time, such reports from

such sub-groups as it may require to provide it with assurance relating to matters within the scope of the Committee's responsibilities.

7. MONITORING

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

7.2 The Trust's Annual Report will include attendance of members, frequency of meetings and whether meetings were quorate.

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

8. REVIEW

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

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

APPENDIX A

ATTENDANCE AT FINANCE AND PERFORMANCE COMMITTEE MEETINGS

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

University Hospitals Dorset
NHS Foundation Trust

TERMS OF REFERENCE

for the

University Hospitals Dorset NHS Foundation Trust

Population Health and System Committee

March 2023

We are caring one team listening to understand open and honest always improving inclusive

DOCUMENT DETAILS

Author:	Yasmin Dossabhoy
Job Title:	Associate Director of Corporate Governance
Date:	~~March~~September 2023
Version No: (Author Allocated)	1.~~0~~1
Next Review Date:	~~March 2024~~July 2023

Approving Body/Committee:	Board of Directors
Chair:	Rob Whiteman
Signed:	
Date Approved:	~~27 March 2023~~
Target Audience:	Board of Directors

Document History

Date of Issue	Version No:	Next Review Date:	Date Approved:	Director responsible for Change	Nature of Change
March 2023	1	March 2024	27 March 2023	Associate Director of Corporate Governance	New document
September 2023	1.1	July 2024		Associate Director of Corporate Governance	Addition of Medical Director for Integrated Care in section 3.2

TABLE OF CONTENTS

INDIVIDUAL APPROVAL			
Job Title	N/A	Date	N/A
Print Name	N/A	Signature	N/A
BOARD OF DIRECTORS/COMMITTEE APPROVAL			
If the Board/Committee has approved this document, please sign and date it and forward copies for inclusion on the Intranet.			
Name of approving body	Board of Directors	Date	~~27 March 2023~~
Print Name	Rob Whiteman	Signature of Chair	

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

POPULATION HEALTH AND SYSTEM COMMITTEE

TERMS OF REFERENCE

1. PURPOSE

1.1 The Trust's vision is to positively transform its health and care services as part of the Dorset Integrated Care System. Its mission is to provide excellent healthcare for its patients and wider community and be a great place to work now and for future generations.

~~1.2 The purpose of the Population Health and System Committee is to support the Trust in achieving its strategic objective: **"To transform and improve our services in line with the Dorset ICS Long Term Plan, by separating emergency and planned care and integrating our services with those in the community".**~~

1.~~2~~3 The Population Health and System Committee will ~~do this including through~~:

- Provid~~e~~ing oversight of the implementation by the Trust of its responsibilities pursuant to the Our Dorset strategic plan for population health and health inequalities;
- Assist~~ing~~ the Trust's Board of Directors (Board) in its oversight of achievement of breakthrough objectives and strategic initiatives relating to population health and health inequalities;
- Receiv~~e~~ing ~~and review~~ing ~~information~~ and data relating to population health and health inequalities reporting to the Board.

1.~~3~~4 The Committee is a committee of the Board and has no executive powers other than those specifically delegated in these terms of reference.

2. RESPONSIBILITIES

Our Dorset Strategic Plan and Trust's objectives and initiatives for Population Health and Health Inequalities

Formatted: Underline

2.1 To receive confirmation from the Board, on an annual basis, of:

- the relevant breakthrough objectives; and
- the relevant strategic initiatives;

which are to be held to account by the Committee.

2.2 To obtain assurance that the relevant breakthrough objectives and strategic initiatives for which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, appropriate challenge and escalating to the Board when required.

Population Health and Health Inequalities

2.3 **Strategic development, monitoring and review**

2.3.1 To develop the architecture to support outcomes-based population health improvement and measurement.

2.3.2 To consider key population health/pathway issues and commission work from clinical groups within the Trust as appropriate, reviewing re-engineered pathways and outcomes.

2.4 **Assurance**

2.4.1 To obtain assurance that the Trust's delivery plan aligns with the Dorset Integrated Care Board strategy and/or relevant aspects of the Core 20 plus 5 approach.

2.4.2 To obtain assurance that the Trust has efficient processes to identify variation in outcomes, incorporating those with protected characteristics and other vulnerable groups.

2.4.3 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.

2.5 **ICS**

2.5.1 To receive and review relevant reports of or relating to the Dorset integrated care system and provider collaborative.

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2.6 **Learning and innovation**

2.6.1 To consider and review, as appropriate, available good practices and learning from other organisations.

3. MEMBERSHIP/ ATTENDANCE

3.1 Membership of the Population Health and System Committee comprises of three Non-Executive Directors, the Chief Medical Officer and the Chief Informatics and IT Officer.

3.2 In addition, ~~others~~the following will attend the Committee to provide information and advice with prior agreement of the Committee Chair and/or to present a report to the Committee or if a Chief Officer is unable to attend~~.~~:

- Medical Director for Integrated Care

and others as invited by the Committee Chair.

3.3 The Committee will be chaired by a Non-Executive Director of the Trust. A Non-Executive Deputy Chair may be nominated. In the absence of the Chair and/or an appointed Deputy, the remaining members shall elect one of the Non-Executive Directors present to chair the meeting.

3.4 Subject to paragraphs 3.2 above and 3.6 below, only members of the Committee have the right to attend Committee meetings. If a standing member is unable to attend, they may exceptionally send a deputy to the meeting, but the deputy will not have voting rights at the meeting. The Chief Executive Officer may attend on an ad-hoc basis or as required.

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

3.6 Any member of the Board may attend any meeting of the Committee with prior agreement of the Committee Chair.

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

4. AUTHORITY

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

4.2 The Committee is authorised to approve its governance cycle.

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

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

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

5. CONDUCT OF BUSINESS

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

5.2 The Committee will normally meet on a quarterly basis and at such other times as the Committee Chair shall require.

5.3 Meetings of the Committee shall be quorate if there at least two members present, which will include the Chair (or a Non-Executive Director deputy). For the avoidance of doubt, an Officer in attendance who has been formally appointed by the Board to act up for an Executive Director shall count towards the quorum.

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

5.5 Meetings of the Committee shall be called by the Company Secretary at the request of the Chair.

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

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

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

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

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

6. RELATIONSHIPS AND REPORTING

6.1 The Committee shall be accountable to the Board.

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

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

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

6.5 For the avoidance of doubt:

- the People and Culture Committee will have oversight of the development by the Trust of an effective staff structure and workforce operating model across the organisation; and
- the Quality Committee will have oversight of quality and safety issues including private patient care as part of the quality governance process.

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

7. MONITORING

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

7.2 The Trust's Annual Report will include attendance of members, frequency of meetings and whether meetings were quorate.

7.3 On an annual basis, the Committee will provide a self-assessment report to the Board detailing how the Committee has discharged its obligations as set out within

its terms of reference, specifically incorporating an assessment of its effectiveness and making recommendations for improvement, where appropriate.

8. REVIEW

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

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

APPENDIX A

ATTENDANCE AT POPULATION HEALTH AND SYSTEM COMMITTEE MEETINGS

NAME OF COMMITTEE:	Population Health and System Committee								
	Meeting Dates								
Present (*include names of members present at the meeting)*									
In Attendance									
Was the meeting quorate? Y / N (*Please refer to Terms of Reference*)									

University Hospitals Dorset
NHS Foundation Trust

TERMS OF REFERENCE

for the

University Hospitals Dorset NHS Foundation Trust

Honours Group

January 2023

DOCUMENT DETAILS

Author:	Yasmin Dossabhoy / Ewan Gauvin
Job Title:	Associate Director of Corporate Governance / Corporate Governance Manager
Signed:	
Date:	March 2023
Version No: (Author Allocated)	2.0
Next Review Date:	March 2024

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

Document History

Date of Issue	Version No:	Next Review Date:	Date Approved:	Director responsible for Change	Nature of Change
January 2021	1	January 2022	25 February 2021	Company Secretary	New document
September 2021	1.1	September 2022	29 September 2021	Company Secretary	Addition of Director of Organisational Development at item 2.1
March 2023	2.0	March 2024		Company Secretary	Aligned with the new Terms of References of the Board Committees.

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

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

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

HONOURS GROUP

TERMS OF REFERENCE

1. PURPOSE

1.1 The Honours Group is an independent group that meets under the chairmanship of a Non-Executive Director to agree nominations from the Trust for national honours, royal garden parties and other such events.

1.2 The primary purpose of the Group is to receive, scrutinise and agree nominations.

2. RESPONSIBILITIES

2.1 The Group shall:

- Request nominations for honours in accordance with the guidance issued by the Department of Health and Social Care;
- Review and submit nominations for both the Birthday and New Year Honours Lists;
- Review and submit nominations to Royal Garden Parties and other such events;
- Provide support and guidance to staff making nominations.

3. MEMBERSHIP/ ATTENDANCE

3.1 Membership of the Honours Group comprises of:

- A Non-Executive Director (other than the Trust Chair);
- Chief Nursing Officer;
- Chief People Officer;
- Chief Medical Officer;
- Director of Organisational Development;
- Associate Director of Communications.

3.2 Only members of the Group have the right to attend Group meetings. Others may attend as invited by the Chair.

3.3 The Group will be chaired by a Non-Executive Director. In the absence of the Chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

4. AUTHORITY

4.1 The Group is authorised to assist the Board of Directors in carrying out its functions.

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

5. CONDUCT OF BUSINESS

5.1 The Group will normally meet twice yearly and at such other times as the Chair shall require.

5.2 Meetings of the Group shall be quorate if there are at least two members present, one of whom must be a Non-Executive Director. Meetings shall not proceed if inquorate. For the avoidance of doubt, an Officer in attendance who has been formally appointed by the Board to act up for an Executive Director shall count towards the quorum.

5.3 Meetings of the Group shall be called by the Company Secretary at the request of the Chair.

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

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

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

5.7 Proceedings and decisions made will be formally recorded by the Company Secretary team in the form of notes, which will be submitted to the next meeting of the Group for approval.

6. RELATIONSHIPS & REPORTING

6.1 The Chair will draw to the attention of the Board any issues that require disclosure or further action.[1]

7. MONITORING

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

8. REVIEW

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

[1] Removed reference to the minutes of each meeting being available to the Board of Directors due to the Group being "an independent group".

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

APPENDIX A

ATTENDANCE AT HONOURS GROUP MEETINGS

NAME OF GROUP:	Honours Group								
	Meeting Dates								
Present (*include names of members present at the meeting)*									
In Attendance									
Was the meeting quorate? Y / N (*Please refer to Terms of Reference*)									

University Hospitals Dorset - Board Governance Cycle 2024

Agenda Item	Part 1	Part 2	Jan	Mar	May	July	Sept	Nov	Lead
Standing reports									
Patient Story	X		X	X	X	X	X	X	CNO
Update from the Council of Governors	X		X			X			Lead Governor
Minutes	X	X	X	X	X	X	X	X	Chair
Matters Arising - Action List	X	X	X	X	X	X	X	X	Chair
Trust Chair's Update		X	X	X	X	X	X	X	Chair
Chief Executive Officer's Update (to include ICB minutes)	X	X	X	X	X	X	X	X	CEO
Integrated Quality, Performance, Workforce, Finance and Informatics	X		X	X	X	X	X	X	Exec Leads
Committee Chair's Key Issues & Assurance Report	X		X	X	X	X	X	X	Committee Chairs
Escalations from Committee Chairs (not already covered in Part 1)		X	X	X	X	X	X	X	Committee Chairs
Risk Register: new risks 12 and above	X		X	X	X	X	X	X	Exec Leads
Patient Safety Incident Response Framework		X	X	X	X	X	X	X	CNO
Recommendation Reports		X	X	X	X	X	X	X	CFO
Maternity Safety Champion	X		X	X	X	X	X	X	Director of Midwifery

University Hospitals Dorset - Board Governance Cycle 2024

Quarterly reports									
Mortality Report	X			X	X		X	X	CMO
Quality Impact Assessment Overview Report	X			X	X		X	X	CNO
Guardian of Safe Working Hours Report	X		X	X			X*	X	Guardian of Safe Working Hours
Bi-annual reports									
Board Assurance Framework	X				X			X	Exec Leads
7 Day Services Board Assurance Framework	X				X			X	CMO
Nursing Establishment Review	x			X			X		CNO
Freedom to Speak Up Guardian Report	x			X			X*		Freedom to Speak Up Guardian
Maternity Staffing Report	x			X			X		CNO/ Director of Midwifery
Annual reports									
Annual Safeguarding Report and Statement	x						X		CNO
Annual Infection Prevention Control and Statement	x						X		CNO
Annual Mixed Sex Accommodation Statement and Declaration	x						X		CNO
Annual Complaints Report	x					X			CNO
Quality Account		x			X *(May/June)*				CNO
Maternity Incentive Scheme - draft		x						X	CNO/ Director of Midwifery

University Hospitals Dorset - Board Governance Cycle 2024

Maternity Incentive Scheme - final	X		X				CNO/ Director of Midwifery
Annual Health and Safety Report	X					X	CPO
Staff Survey Report and Action Plan	X			X			CPO
Gender Pay Report	X				X		CPO
Annual Security Report	X					X	COO
Workforce Race Equality Standards Report and Action Plan	X					X	CPO
Workforce Race Disability Equality Standards Report and Action Plan	X					X	CPO
Annual Equality Diversity and Inclusion Report	X					X	CPO
Quality Assurance for Responsible Officers and Revalidation	X					X	CMO
Procurement Strategy Review	X			X			CFO
Operational Budget		X		X			CFO
Going Concern Statement	X				X		CFO
Key Areas of Judgment and Estimation within the Annual Accounts	X				X		CFO
Annual Operational Plan	X				X		CSTO
Annual Accounts - draft		X			X		CFO
Annual Report and Accounts - final (including representation letter and auditors' opinion)		X			X *(May/June)*		CSTO/CFO
Annual Certificates: availability of resources; training of governors		X			X *(May/June)*		CFO/Chair

University Hospitals Dorset - Board Governance Cycle 2024

Sustainability Strategy - Green Plan	X				X			CSTO
Annual SIRO Report	X					X		CIO
Premises Assurance Model	X					X		CSTO
Annual Winter Plan	X						X	COO
Local Clinical Excellence Awards		X					X	CMO
Code of Governance	X			X				CEO/CoSec
Register of Compliance with Licence Conditions	X			X				CEO/CoSec
Independence of Non-Executive Directors	X			X				CoSec
Annual Governance Statement		X						CEO/CNO
Seal of Documents Register	X		X					CoSec
Emergency Preparedness Reslience and Response	X						X	COO
Gifts and Hospitality Register	X				X			CoSec
Register of Directors' Interests	X	X			X *(May/June)*			CoSec
Board Committee Terms of Reference	X				X			CoSec
Board Committees - Effectiveness Reviews	X				X			Committee Chairs
Board Governance Cycle	X					X		CoSec
Board Effectiveness Review	X					X		Chair/Co Sec
Board Meeting Schedule	X			X				CoSec

By exception/when published						
National Inpatient and Outpatient Survey Results	X					CNO
Annual CQC Report	X					CNO
Estates Strategy	X					CSTO
Private Patients Strategy	X					COO
Benefits Realisation Strategy	X					CSTO
Quality Improvement Strategy	X					CNO
Digital Strategy (2024)	X		X			CIO
Regulatory exception reports e.g. Health and Safety Executive, Care Quality Commission	X					Exec Lead
Code of Conduct (October 2025)	X					Chair/Co Sec
Constitution (3 yearly) - Council of Governors to approve	X				X	Chair/Co Sec
Standing Financial Instructions	X					CFO
Scheme of Reservation and Delegation (By June 2026)	X					CEO/Co Sec
UHD Charity - Annual Report and Accounts	X			X		CFO
Strategic Plan (5 year) and supporting strategies	X					CSTO

*Includes annual report

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 27 September 2023

Agenda item: 9.4

Subject:	Board and Committee Meeting Dates 2024
Prepared by:	Yasmin Dossabhoy, Associate Director of Corporate Governance Ewan Gauvin, Corporate Governance Manager
Presented by:	Rob Whiteman, Trust Chair

Strategic themes that this item supports/impacts:	Systems working and partnership ☒ Our people ☒ Patient experience ☒ Quality: outcomes and safety ☒ Sustainable services ☒ Patient First programme ☒ One Team: patient ready for reconfiguration ☒
BAF/Corporate Risk Register: (if applicable)	N/A
Purpose of paper:	Decision/Approval
Executive Summary:	The purpose of this paper is to present the revised proposed meeting dates for the Board and its Committees for 2024.
Background:	The proposed calendar of meeting dates for the Board and its Committees for 2024 was approved by the Board in November 2022. A number of the dates have since been reviewed and are proposed to be updated.
Key Recommendations:	To consider and, if thought fit, approve the revised proposed dates for meeting of the Board and its Committees for 2024 (noting that there may be subsequent minor modifications to such date at the discretion of the Trust Chair and, for the Committee meetings, the Committee Chairs in consultation with the Committee members)..
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	30/11/2022	Approval of the draft schedule presented to the Board in November 2022 (subsequently updated by this paper).

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

University Hospitals Dorset NHS Foundation Trust

Board of Directors and Committee Meetings Schedule 2024 - DRAFT

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
BOARD OF DIRECTORS PART 1 *(1st Wednesday, other than Jan)*	10/01/2024 9:00 (V)	-	6/03/2024 9:30 (F)	-	1/05/2024 9:30 (V)	-	3/07/2024 9:30 (V)	-	4/09/2024 9:30 (F)	-	6/11/2024 9:30 (V)	-
BOARD OF DIRECTORS PART 2 *(1st Wednesday, other than Jan)*	10/01/2024 11:15 (V)	7/02/2024 9:30 *(confidential/ urgent only)* (V)	6/03/2024 11:45 (F)	3/04/2024 9:30 (V)	1/05/2024 11:45 (V)	5/06/2024 9:30 (V)	03/07/2024 11:45 (V)	-	4/09/2024 11:45 (F)	2/10/2024 9:30 (V)	6/11/2024 11:45 (V)	-
BOARD DEVELOPMENT *(1st Wednesday, other than Jan)*	-	7/02/2024 11:00 (F)	-	3/04/2024 11:00 (F)	-	5/06/2024 11:00 (F)	-	-	-	2/10/2024 11:00 (F)	-	
BOD/COG DEVELOPMENT *(1st Wednesday, other than Jan)*	-	7/02/2024 13:30 (F)	-	3/04/2024 13:30 (F)	-	5/06/2024 13:30 (F)	-	-	-	2/10/2024 13:30 (F)	-	-
AUDIT	18/01/2024 9:00 (F)	-	21/03/2024 9:00	-	23/05/2024 9:00 (F)	-	18/07/2024 9:00	-	-	17/10/2024 9:00 (F)	-	-
FINANCE & PERFORMANCE	22/01/2024 9:00	26/02/2024 9:00	25/03/2024 9:00	22/04/2024 9:00	29/05/2024 9:00	24/06/2024 9:00	29/07/2024 9:00	28/08/2024 9:00	23/09/2024 9:00	28/10/2024 9:00	25/11/2024 9:00	16/12/2024 9:00
PEOPLE AND CULTURE	-	14/02/2024 11:00 (F)	-	10/04/2024 11:00	-	-	10/07/2024 11:00	-	11/09/2024 11:00 (F)	-	-	11/12/2024 11:00
POPULATION HEALTH & SYSTEM	24/01/2024 14:00	-	13/03/2024 9:00	-	-	12/06/2024 9:00	-	14/08/2024 9:00	-	9/10/2024 9:00	-	-
QUALITY	23/01/2024 13:00	27/02/2024 13:00 (F)	26/03/2024 13:00	16/04/2024 13:00 (F)	28/05/2024 13:00	25/06/2024 13:00 (F)	30/07/2024 13:00	27/08/2024 13:00 (F)	24/09/2024 13:00	29/10/2024 13:00 (F)	26/11/2024 13:00	17/12/2024 13:00 (F)
CHARITABLE FUNDS	-	5/02/2024 9:00	-	-	8/05/2024 9:00	-	-	5/08/2024 9:00	-	-	4/11/2024 9:00	-
TRUST MANAGEMENT GROUP	9/01/2024 23/01/2024 14:00	6/02/2024 20/02/2024 14:00	5/03/2024 19/03/2024 14:00	2/04/2024 16/04/2024 30/04/2024 14:00	14/05/2024 14:00	4/06/2024 18/06/2024 14:00	2/07/2024 16/07/2024 30/07/2024 14:00	13/08/2024 14:00	3/09/2024 17/09/2024 14:00	1/10/2024 22/10/2024 14:00	5/11/2024 19/11/2024 14:00	3/12/2024 17/12/2024 14:00

University Hospitals Dorset NHS Foundation Trust
Council of Governors Meetings Schedule 2024 - DRAFT

COUNCIL OF GOVERNORS PART 1	11/01/2024 16:30	-	-	4/04/2024 16:30	-	-	4/07/2024 16:30	-	-	3/10/2024 16:30	-	-
COUNCIL OF GOVERNORS PART 2	11/01/2024 18:15	-	-	4/04/2024 18:15	-	-	4/07/2024 18:15	-	-	3/10/2024 18:15	-	-
NOMINATIONS, REMUNERATION AND EVALUATION	3/01/2024 10:00	-	27/03/2024 10:00	-	-	26/06/2024 10:00	-	-	25/09/2024 10:00	-	-	-
INFORMAL GOVERNOR BRIEFINGS	-	8/02/2023 14:00	-	-	2/05/2023 14:00	-	-	-	-	-	-	-
COUNCIL OF GOVERNOR DEVELOPMENT SESSIONS	-	-	7/03/2024 14:00	-	-	6/06/2024 14:00	-	-	5/09/2024 14:00	-	7/11/2024 14:00	-

Key
Green text indicates known school holidays

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 27 September 2023

Agenda item: 9.5

Subject:	Anti-Fraud, Bribery and Corruption Policy Update
Prepared by:	Kim Hampson, Anti-Crime Specialist, TIAA
Presented by:	Pete Papworth, Chief Finance Officer

Strategic themes that this item supports/impacts:	Systems working and partnership ☐ Our people ☐ Patient experience ☐ Quality: outcomes and safety ☐ Sustainable services ☒ Patient First programme ☐ One Team: patient ready for reconfiguration ☐
BAF/Corporate Risk Register: (if applicable)	None
Purpose of paper:	Decision/Approval
Executive Summary:	The Trusts Anti-Fraud, Bribery and Corruption Policy has been reviewed with the following updates made/ proposed: • Addition of Appendix 4 – Joint working and parallel sanction protocol • Reference to NHSCFA Strategy 2023-2026 • Reference to Counter Fraud Champion role • Minor changes to Appendix 3 • Addition that subject of investigation not aware of criminal investigation (8.3.4) In addition, a new Anti-Fraud, Bribery and Corruption Statement has been drafted for consideration and approval.
Background:	The Anti-Fraud, Bribery and Corruption Policy has been in place for many years and have been the subject of a scheduled review to ensure compliance with NHSCFA requirements.
Key Recommendations:	The Board is asked to approve the updates Anti-Fraud, Bribery and Corruption Policy and Statement.
Implications associated with this item:	Council of Governors ☐ Equality and Diversity ☐ Financial ☒

	Operational Performance	☐
	People (inc Staff, Patients)	☐
	Public Consultation	☐
	Quality	☐
	Regulatory	☒
	Strategy/Transformation	☐
	System	☐
CQC Reference:	Safe	☐
	Effective	☐
	Caring	☐
	Responsive	☐
	Well Led	☒
	Use of Resources	☒

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Audit Committee	13/07/2023	Recommended for approval (Note that the Board statement has been drafted following Audit Committee approval of the policy so has not been considered by the Committee prior to presentation to the Board).

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

University Hospitals Dorset NHS Foundation Trust

ANTI-FRAUD, BRIBERY & CORRUPTION POLICY

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

University Hospitals Dorset NHS Foundation Trust

A) SUMMARY POINTS
• Policy and procedure for ensuring the Trust has a zero-tolerance approach to all fraud, bribery and corruption.
• Guidance to help staff understand what fraud, bribery and corruption is and how to identify and report it effectively.
ASSOCIATED DOCUMENTS
• Values and Aims of The Trust
• Managing Conflicts of Interest
• Declaration of Gifts, Hospitality and/or Sponsorship
• Staff Discipline Procedure

B) DOCUMENT DETAILS	
Author:	Kim HampsonHeather Greenhowe
Job title:	Counter Fraud Specialist
Directorate:	Finance
Version no:	32
Target audience:	All Staff
Approving committee / group:	Board of Directors
Chairperson:	Rob Whiteman
Review Date:	Juneanuary 2024

C) CONSULTATION PROCESS			
Version No.	**Review Date**	**Author**	**Level of Consultation**
1	10/09/2021	Heather Greenhowe	Chief Finance Officer and Trust Secretary
2	05/01/2023	Heather Greenhowe	Audit Committee
3	13/06/2023	Kim Hampson	Audit Committee

D) VERSION CONTROL						
Date of Issue	**Version No.**	**Date of Review**	**Nature of Change**	**Approval Date**	**Approval Committee**	**Author**
Oct 21	1		New policy for UHD		Audit Committee	Heather Greenhowe. Local Counter Fraud Specialist -
Jan 2023	2	Jan 24	Updated reference in 5.4 from Director of Finance to Chief	25/01/2023	Board of Directors	Heather Greenhowe Local Counter Fraud

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June 2023	3	June 2024	Addition of Appen 4 Reference to NHSCFA Strategy 2023-2026 Reference to Counter Fraud Champion Minor changes to Appendix 3 Addition - subject of counter fraud investigation not normally aware (8.3.4)		Board of Directors	Kim Hampson Local Counter Fraud Specialist- TIAA

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Foreword by the Chief Finance Officer

This Trust is committed to eliminating fraud, bribery and corruption within the NHS, freeing up public resources for better patient care.

To this end, the Trust employs a specialist counter-fraud service to undertake a comprehensive programme against fraud, bribery and corruption which is overseen by the Trust's Audit Committee.

We operate a zero-tolerance approach to fraud, bribery and corruption. Staff are reminded that it is a criminal offence to give, promise or offer a bribe, and to request, agree to receive, or accept a bribe. We expect this policy to be complied with by all staff, patients, contractors and suppliers.

Although the Bribery Act permits hospitality, all staff are required to consider, on an individual basis, whether accepting any hospitality offered is appropriate and should they then elect to take it, to record it within the Trust's Hospitality register (in line with the Receipt of Hospitality, Gifts and Inducements policy) so that it has been fully disclosed.

It is also important that all of our contractors and agents comply with our policies and procedures. When entering into contracts with organisations, the Trust follows the NHS standard terms and conditions of contract for the purchase of goods and supplies. For more information see http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121260

We ask all who have dealings with the Trust, as employees, agents, trading partners, stakeholders and patients, to help us in our fight against fraud, bribery and corruption. If you have any concerns or suspicions we need to know about, the Trust's Local Counter Fraud Specialist can be contacted in confidence and their details can be found on the staff intranet counter fraud page. Any suspicions of fraud and corruption can also be reported to the NHS Fraud and Corruption Reporting Line on Freephone 0800 028 40 60, again in strict confidence.

Chief Finance Officer

1 Introduction

1.1 General

1.1.1 This policy has been produced in conjunction with the Local Counter Fraud Specialist (LCFS) and is intended as a guide for all employees on counter fraud work within the NHS.

1.1.2 One of the basic principles of public sector organisations is the proper use of public funds. Any fraud committed is wholly unacceptable and ultimately leads to a reduction in the resources available for patient care.

1.1.3 The Local Counter Fraud Service carries out work in accordance with guidance issued by the Government and NHS Counter Fraud Authority (CFA).

1.1.4 The Counter Fraud Authority has responsibility for all policy and operational matters relating to the prevention, detection and investigation of fraud and corruption and the management of security in the NHS. All instances where fraud is suspected are properly investigated until their conclusion by staff trained by the NHS CFA. Any investigations will be handled in accordance with the *NHS Counter Fraud and Corruption Manual*.

1.1.5 As a Trust we encourage anyone that has reasonable suspicions of fraud to report them. All employees, patients and contractors can be confident that they will not suffer in any way as a result of reporting reasonably held suspicions of fraud. For these purposes “reasonably held suspicions” shall mean any suspicions other than those which are raised maliciously and found to be groundless.

1.1.6 The Trust has a zero-tolerance approach to any fraud or corruption and will commit to investigate all concerns raised

1.2 Generic Areas of Action

1.2.1 The Trust is committed to taking all necessary steps to counter fraud and corruption. To meet its objectives, the LCFS ensures that the Trust complies with the Government Functional Standards 0:13, part of which involves an annual self-assessment and submission to NHS CFA. The assessment covers 13 requirements which include planning and governance, training and awareness, proactive detection and investigations.

1.3 Aims and Scope

1.3.1 This policy relates to all forms of fraud, bribery and corruption and is intended to provide direction and help to employees who may identify suspected fraud. It provides a framework for responding to suspicions of fraud, advice and

information on various aspects of fraud and implications of an investigation. It is not intended to provide a comprehensive approach to preventing and detecting fraud and corruption. The overall aims of this policy are to:

- improve the knowledge and understanding of everyone in the Trust, irrespective of their position, about the risk of fraud, bribery and corruption and its unacceptability;
- assist in promoting a climate of openness and a culture and environment where staff feel able to raise concerns sensibly and responsibly;
- set out the Trust's responsibilities in terms of the deterrence, prevention, detection and investigation of fraud, bribery and corruption; and
- ensure the appropriate sanctions are considered following an investigation, which may include any or all of the following:
    - criminal prosecution
    - civil prosecution
    - internal/external disciplinary action.

This policy applies to all employees of the Trust, regardless of position held, as well as consultants, vendors, contractors, and/or any other parties who have a business relationship with the Trust; it will be brought to the attention of all employees and form part of the induction process for new staff.

2 Definitions

2.1 Fraud

2.1.1 There are three main offences under the Fraud Act 2006:

1) Fraud by false representation (s.2) – lying about something using any means, e.g. by words or actions

2) Fraud by failing to disclose (s.3) – not saying something when you have a legal duty to do so

3) Fraud by abuse of a position of trust (s.4) – abusing a position where there is an expectation to safeguard the financial interests of another person or organisation.

2.1.2 Within the Fraud Act it is not always necessary to prove that a person has been deceived. The focus is on the dishonest behaviour of the suspect and their intent to make a gain or cause a loss.

2.1.3 It should be noted that all offences under the Fraud Act 2006 occur where the act or omission is committed dishonestly and with intent to cause gain or loss. The gain or loss does not have to succeed, so long as the intent is there. For

guidance on examples of types of fraud please refer to the Trust's Counter Fraud web pages.

2.1.4 The full Act can be viewed at https://www.legislation.gov.uk/ukpga/2006/35/contents

2.2 Corruption / Bribery

2.2.1 This can be broadly defined as the offering or acceptance of inducements, gifts, favours, and payment or benefit-in-kind which may influence the action of any person. Corruption does not always result in a loss. The corrupt person may not benefit directly from their deeds; however, they may be unreasonably using their position to give some advantage to another.

2.2.2 Under the Bribery Act 2010 it is an offence to offer/ give / accept / agree to accept a financial of other benefit in return for performing an improper function.

2.2.3 Under section 7 of the Bribery Act 2010 it is an offence for organisations to fail to prevent persons associated with them from giving, offering, receiving or agreeing to receive bribes.

2.2.4 The Trust must be able to prove it has adequate procedures in place to prevent persons associated with it from bribing to have a defence to the section 7 offence.

2.2.5 To protect themselves from the risk of receiving a gift or hospitality that may be perceived as a bribe staff must ensure compliance with the Receipt of Hospitality, Gifts and Inducements policy.

2.3 Employees

2.3.1 For the purposes of this policy, 'employees' includes the Trust staff, as well as board, executive, non-executive members (including co-opted members), governors, third party providers and honorary members.

2.3.2 The Receipt of Hospitality, Gifts and Inducements policy extends also to anyone working in any capacity on behalf or representing the Trust, such as bank and agency staff or contractors.

3 Codes of Conduct

3.1.1 The codes of conduct for NHS boards and NHS managers set out the key public service values. They state that high standards of corporate and personal conduct, based on the recognition that patients come first, have been a requirement throughout the NHS since its inception. These values are summarised as:

- *Accountability* Everything done by those who work in the authority must be able to stand the tests of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.
- *Probity* Absolute honesty and integrity should be exercised in dealing with NHS patients, assets, staff, suppliers and customers.
- *Openness* The health body's activities should be sufficiently public and transparent to promote confidence between the authority and its staff and the public.

3.1.2 In addition, all those who work for, or are in contract with the Trust, should exercise the following 'Nolan Principles' when undertaking their duties:

Selflessness	Should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family or their friends.
Integrity	Should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.
Objectivity	Should, in carrying out public business, (including making public appointments, awarding contracts, or recommending individuals for rewards and benefits), make choices on merit.
Accountability	Are accountable for their decisions and actions to the public and must submit them to whatever scrutiny is appropriate to their office.
Openness	Should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest demands.
Honesty	Have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.
Leadership	Should promote and support these principles by leadership and example.

These standards are national benchmarks that inform local policies and procedures. The arrangements made in this policy have been designed to ensure compliance with the national standards.

3.1.3 All staff should be aware of and act in accordance with these values.

4 Fraud Strategy

4.1.1 Through our day-to-day work, we are in the best position to recognise any specific risks within our own areas of responsibility. We also have a duty to ensure that those risks – however large or small – are identified and eliminated. Where staff believe the opportunity for fraud exists, whether because of poor procedures or oversight, they should report it to the LCFS, Director of Finance or the NHS Fraud and Corruption Reporting phone line (see Appendix 1).

4.1.2 The Trust will take all necessary steps to counter fraud and corruption in accordance with this policy, the *NHS Counter Fraud and Corruption Manual*, the policy statement '*Applying Appropriate Sanctions Consistently'* and any other relevant guidance or advice issued by the NHS CFA, including the *Government Functional Standards*.

4.1.3 The Trust will implement the seven generic areas of counter fraud action outlined below. Adherence to these areas will assist with compliance against the 13 principles of the *Functional Standards under areas for* planning and governance, training and awareness, proactive detection and investigations.

4.1 The Creation of An Anti-Fraud Culture

4.1.1 The Trust will use Counter Fraud publicity material to persuade those who work in the Trust that fraud and corruption is serious and takes away resources from important services. Such activity will demonstrate that fraud and corruption is not acceptable and is being tackled.

4.1.2 The trust has a zero-tolerance approach to fraud and bribery. The Trust also has a duty to ensure that it provides a secure environment in which to work, and one where people are confident to raise concerns without worrying that it will reflect badly on them. This extends to ensuring that staff feel protected when carrying out their official duties and are not placed in a vulnerable position. If staff have concerns about any procedures or processes that they are asked to be involved in, the Trust has a duty to ensure that those concerns are listened to and addressed.

4.2 Maximum Deterrence of Fraud

4.2.1 Deterrence is about increasing the expectation that someone will be caught if they attempt to defraud – this is more than just tough sanctions. The Trust will

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introduce such measures to minimise the occurrence of fraud, bribery and corruption.

4.3 Successful Prevention of Fraud That Cannot Be Deterred

4.3.1 The Trust has policies and procedures in place to reduce the likelihood of fraud, bribery and corruption occurring. These include a system of internal controls, Standing Financial Instructions and documented procedures, which involve physical and supervisory checks, financial reconciliations, segregation and rotation of duties, and clear statements of roles and responsibilities. Where fraud, bribery or/ and corruption has occurred, the Trust will ensure that any necessary changes to systems and procedures take place immediately to prevent similar incidents from happening in the future.

4.4 Prompt Detection of Fraud Which Cannot Be Prevented

4.4.1 The Trust will develop and maintain effective controls to prevent fraud, bribery and corruption and to ensure that if it does occur, it will be detected promptly and referred to the LCFS for investigation.

4.5 Professional Investigation of Detected Fraud

4.5.1 The LCFS is professionally trained and accredited to carry out investigations into suspicions of fraud, bribery and corruption to the highest standards. In liaison with NHS CFA, the LCFS will professionally investigate all suspicions of fraud and corruption to prove or disprove the allegation.

4.5.2 The Trust are committed to preventing and detecting fraud by all available means and so shall make available any Trust data as necessary to allow the LCFS to identify and evidence any frauds that have occurred.

4.6 Effective Sanctions

4.6.1 Following the conclusion of an investigation, if there is evidence of fraud, available sanctions will be considered in accordance with the guidance issued by NHS CFA – 'Applying Appropriate Sanctions Consistently'. This may include criminal prosecution, civil proceedings and disciplinary action, as well as referral to a professional or regulatory body.

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4.7 Effective Methods for Seeking Redress in Respect of Money Defrauded

4.7.1 Recovery of any losses incurred will also be sought through civil proceedings if appropriate, to ensure losses to the Trust and the NHS are returned for their proper use.

5 Roles, Responsibilities, Sanctions and Redress

5.0.1 All employees, contractors, providers and members of the public have a responsibility to protect the assets of the Trust, including all buildings, equipment and monies from fraud, theft, bribery or corruption. Any concerns should be reported to the LCFS, Chief Finance Officer , or to the NHS Counter Fraud Authority (NHSCFA) via the Fraud and Corruption Reporting Line or via their online form. Details of these reporting methods can be found in the Fraud and Bribery Policy and/ or the counter fraud pages of the intranet.

The following are those tasked with financial redress and sanctions at the Trust:

5.1 The Chief Finance Officer

5.1.1 The Trust's Executive Board has overall responsibility for the effective operation of all Trust activities and is liable to be called to account for specific failures in the Trust's control systems. The Chief Finance Officer will ensure adequate controls are implemented to safeguard the resources and operations of the Trust, staff receive training and support in the use of these resources and controls and adequate measures are employed to prevent, detect and deter fraud, bribery and corruption. The Chief Finance Officer will monitor and ensure compliance with this policy, monitor and record the progress of recoveries and report progress to the Audit Committee. In addition, the Chief Finance Officer will;

- Meet with the LCFS/NHSCFA and a legal advisor to seek appropriate advice and guidance before deciding on a course of action for recovery.
- Agree an appropriate course of action for recovery.
- Ensure that the Trust is effective in recovering any losses incurred to fraud, bribery and corruption.
- Ensure that civil redress is progressed effectively through the Finance department.

5.2 Audit Committee

5.2.1 The Audit Committee will support the Board of Directors to deliver the Trust's responsibilities for the conduct of public business and the stewardship of funds; to be responsible for providing assurance to the Board that appropriate systems of internal control and risk management are in place covering all corporate and clinical areas of the Trust.

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5.2.2 The Committee shall seek to ensure that business is conducted in accordance with the law and proper standards; public money is safeguarded and properly accounted for; Financial Statements are prepared in a timely manner and give a true and fair view of the financial position of the Trust for the period in question; services are managed so as to secure economic, efficient and effective use of resources; and that reasonable steps are taken to prevent and detect fraud and other irregularities.

5.2.3 The committee will authorise the proposed work plans of the internal audit and counter fraud teams, ensuring that the proposed work meets the Trust's strategy and aims in identifying and reducing fraud. The committee will meet regularly with auditors to receive updates on the progress of their plans. The committee will be apprised of all current fraud investigations, any losses identified, and the measures being implemented to safeguard against further occurrences.

5.3 Managers

5.3.1 Managers must be vigilant and ensure that procedures to guard against fraud and corruption are followed. They should be alert to the possibility that unusual events or transactions could be symptoms of fraud and corruption. If they have any doubts, they must seek advice from their nominated LCFS.

5.3.2 Managers must instil and encourage an anti-fraud and anti-corruption culture within their team and ensure that information on procedures is made available to all employees.

5.3.3 The LCFS will proactively assist the encouragement of an anti-fraud culture by undertaking work that will raise fraud awareness.

5.3.4 All instances of actual or suspected fraud or corruption which come to the attention of a manager must be reported immediately. It is appreciated that some employees will initially raise concerns with their manager. However, in such cases, **managers must not attempt to investigate the allegation themselves**; they have the clear responsibility to refer the concerns to their nominated LCFS as soon as possible.

5.3.5 Line managers at all levels have a responsibility to ensure that an adequate system of internal control exists within their areas of responsibility and that controls operate effectively. The responsibility for the prevention and detection of fraud and corruption therefore primarily rests with managers but requires the co-operation of all employees. As part of that responsibility, line managers need to:

- inform staff of the Trust 's code of business conduct and counter fraud and corruption policy as part of their induction process, paying particular attention to the need for accurate completion of personal records and forms

- ensure that all employees for whom they are accountable are made aware of the requirements of the policy
- assess the types of risk involved in the operations for which they are responsible
- ensure that adequate control measures are put in place to minimise the risks. This must include clear roles and responsibilities, supervisory checks, staff rotation (particularly in key posts), separation of duties wherever possible so that control of a key function is not invested in one individual, and regular reviews, reconciliations and test checks to ensure that control measures continue to operate effectively
- ensure that any use of computers by employees is linked to the performance of their duties within the Trust
- be aware of the Trust 's Counter Fraud Policy and the rules and guidance covering the control of specific items of expenditure and receipts
- identify financially sensitive posts
- ensure that controls are being complied with
- contribute to their director's assessment of the risks and controls within their business area, which feeds into the Trust's and the Department of Health Accounting Officer's overall statements of accountability and internal control.

5.4 Employees

5.4.1 The Trust's Standing Orders, Standing Financial Instructions, policies and procedures place an obligation on all employees and non-executive directors to act in accordance with best practice. Employees are expected to act in accordance with the standards laid down by their professional institutes, where applicable, and have a personal responsibility to ensure that they are familiar with them. This includes, but is not limited to, the Trust's Freedom to Speak Up Policy.

5.4.2 Employees also have a duty to protect the assets of the Trust, including information, goodwill and property. In addition, all employees have a responsibility to comply with all applicable laws and regulations relating to ethical business behaviour, procurement, personal expenses, conflicts of interest, confidentiality and the acceptance of gifts and hospitality. This means, in addition to maintaining the normal standards of personal honesty and integrity, all employees should always:

- avoid acting in any way that might cause others to allege or suspect them of dishonesty

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- behave in a way that would not give cause for others to doubt that the Trust 's employees deal fairly and impartially with official matters
- be alert to the possibility that others might be attempting to deceive

5.4.3 All employees have a personal responsibility to protect the assets of the Trust, including all buildings, equipment and monies from fraud, theft, or bribery. All employees have a duty to ensure that public funds are safeguarded, whether or not they are involved with cash or payment systems, receipts or dealing with contractors or suppliers.

5.4.4 If an employee suspects that there has been fraud or corruption, or has seen any suspicious acts or events, they must report the matter. This can be done directly to the LCFS, or to the Chief Finance Officer or Freedom to Speak up Guardian.

5.5 Internal and External Audit

5.5.1 Any incident or suspicion that comes to internal or external audit's attention will be passed immediately to the nominated LCFS. The outcome of the investigation may necessitate further work by internal or external audit to review systems.

5.6 The Local Counter Fraud Specialist (LCFS):

5.6.1 The LCFS a~~A~~dvises the Trust on the evidence available to be able to seek recovery of funds. Ensures that all records are of sufficient quality to be able to support the recovery process. Liaises with the NHS CFA to obtain guidance and advice as appropriate and inform the Trust. Seeks agreement with the Chief Finance Officer on the most appropriate course of action (or the CEO if the Chief Finance Officer is implicated). Liaises with the relevant line manager and payroll manager to facilitate any deductions from salaries. In addition the LCFS will;

- Liaise with the police and/or NHS CFA for cases being sent to CPS (either via the police or via the NHS CFA)
- Liaise with HR when parallel criminal (LCFS) and disciplinary (HR) investigations are being conducted to ensure one does not prejudice the other.
- Maintain decision logs on NHS CFA case management system regarding sanctions and redress. This will include reasons for and against the pursuance of such action.
- Upon the provision of details of sanctions/recoveries applied, this will be recorded on the NHS CFA case management system within 20 working days of such a decision.
- Where appropriate, publicise proven cases of fraud and bribery within the Trust with details of sanctions and redress.

5.7 NHS Counter Fraud Authorities (NHS CFA) 1~~4~~:

The NHSCFA's 2023-2026 strategy document sets out their approach to fighting fraud and other economic crime. The full document is available on the corporate publications page of their website: https://cfa.nhs.uk/about-nhscfa/corporate-publications

~~5.7~~

- Provide a centralised investigation capacity for complex economic crime matters in the NHS and investigate the most serious, complex and high-profile cases of fraud, and work closely with the LCFS, Chief Finance Officer, police and the Crown Prosecution Service to bring offenders to justice.
- Provide specialist financial investigators to recover NHS money lost to fraud.
- Approve submission of cases to the CPS where the LCFS has not conducted the investigation jointly with the police.
- Report progress back to the Trust where a case has been adopted.

5.8 Human Resources

The LCFS will seek an agreement with the Chief People Officer (or nominated deputy) to ensure that all potential investigations of fraud are reviewed as per the detailed flow chart in appendix 3. Appendix 4 is the protocol for joint working and parallel investigations between the Local Counter Fraud Speciaist and HR.

- Reviews instances of staff conduct, behaviour, and incident to establish whether there has been a breach of policy, procedure, or legislation.
- Ensures that all records are of sufficient quality to be able to support the recovery process.
- Seeks agreement with the Chief People Officer on the most appropriate course of action (or the CEO if the Chief People Officer is implicated).
- Liaises with the relevant line manager and payroll manager to facilitate any deductions from salaries.
- Liaise with the LCFS when parallel criminal (LCFS) and disciplinary (HR) investigations are being conducted to ensure one does not prejudice the other.
- Provide details of any sanctions/recoveries applied to the LCFS within 20 working days for recording purposes.

5.9 Payroll

Liaise with HR, the relevant line manager and LCFS to facilitate any deductions from salaries. Implement agreements reached on the amount and timescale of any timescale of repayments.

[1] The NHS CFA is a specialist Health Authority tasked with leading the fight against fraud, bribery and corruption in the NHS

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5.10 Finance Team

Where invoices need to be raised: Agree with the individual the amount and timescale of any repayments. Ensure that invoices are raised and followed up on a timely basis.

5.11 Disciplinary Panels

Provides a panel of staff that may consist of Directors, Managers and HR staff to establish what sanctions and/or redress may be applied from a disciplinary perspective. Ensures that all records are of sufficient quality to be able to support the disciplinary process and decision made. Provide details of any sanctions/recoveries applied to the LCFS within 20 working days for recording purposes.

5.12 Counter Fraud Champion

The role of the Counter Fraud Champion forms part of the Trust's counter fraud provision and having a Counter Fraud Champion is a requirement of the Government Functional Standard GovS 013: Counter Fraud. The main role of the Counter Fraud Champion is to promote and raise awareness of fraud, bribery and corruption across the Trust.

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6 Sanctions and Redress

6.1.1 The Trust will always seek to apply appropriate sanctions in response to financial crime perpetrated against the NHS. The range of available sanctions which may be pursued by the relevant decision makers includes:

- criminal prosecution (potentially resulting in fine, imprisonment, community penalty, confiscation and/or compensation order) or out-of-court disposal
- civil action, including action to preserve assets and recover losses
- disciplinary action by the Trust
- regulatory action by a relevant regulatory body (e.g. GMC, GDC, NMC). Each case will be considered individually on its own facts and merits; however, applying a consistent and thorough approach in all cases will ensure that:
- the most effective investigations are undertaken, including the gathering and assessment of all relevant material which may form evidence of fraud, bribery, corruption, misconduct and/or unfitness to practise
- the most appropriate sanction or combination of sanctions is sought where fraud, bribery, corruption or related misconduct is identified.

6.1 Financial Redress:

6.1.1 The Trust has an obligation to safeguard public funds. As such, the Trust will seek financial redress wherever possible due to losses to fraud, bribery or corruption. Financial redress can take the form of:

- a confiscation and/or compensation orders in accordance with the Proceeds of Crime Act.
- a civil order for repayment

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- a local agreement between the organisation and offender to repay any monies Actions which may be taken when considering seeking redress include:

- no further action
- penalty charges (falsely claiming assistance with NHS Health Charges)
- criminal investigation
- civil recovery
- disciplinary action
- confiscation order under the Proceeds of Crime Act 2002
- provisions available under Anti-money laundering (AML) legislation
- recovery sought from ongoing salary payments or pensions.

6.2 Criminal Sanctions:

6.2.1 The LCFS and the NHS CFA may conduct a criminal investigation with a view to submitting a case to the Crown Prosecution Service for a decision regarding prosecution for any number of reasons, for example:

- The case is serious and/or extensive.
- If a prosecution took place it would help to challenge beliefs about fraud, bribery and corruption and how and when they can occur.
- If a prosecution took place it would help to prevent or deter financial crime.
- If a prosecution took place it would demonstrate to potential offenders and the public that those who commit crimes against the NHS will be held to account. This list is non-exhaustive; the NHS CFA and health bodies reserve complete discretion to conduct a criminal investigation in any case and to carry out investigations across a range of offences.

  Actions which may be taken when considering seeking a criminal sanction include:

- no further action
- fine
- suspended sentence
- custodial sentence
- community penalty
- confiscation and/or compensation orders

6.3 Civil Sanctions:

6.3.1 A civil claim with the objective of financial recovery can be brought where financial redress via the criminal route is not thought to be appropriate, or where a health body was not (fully) compensated following a criminal conviction. If successful the claimant is entitled to seek enforcement by various means, including the forced transfer of assets, the forced sale of property to realise capital, or insolvency proceedings.

6.4 Disciplinary Sanctions:

6.4.1 As per the Disciplinary Policy, there are a number of actions that may be taken when considering disciplinary sanctions, including:

- no further action
- verbal warning

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- written warning
- dismissal
- recovery of any losses via payroll
- referral to regulatory body

6.5 Regulatory Body Sanctions:

6.5.1 In certain cases where the conduct of an individual contravenes their regulatory body's Code of Conduct, the Trust may refer the matter to the regulatory body, for example the GMC, GDC, and NMC. It is the responsibility of the Chief Finance Officer to make or direct such referrals.

Following an investigation by the regulatory body the following sanctions may include:

- no further action
- restrictions to licence
- being struck off by the regulatory body (i.e. no longer being able to practice profession)

In addition, NHS England may suspend or remove doctors, dentists, and ophthalmic medical practitioners from performers lists comprising those who may provide NHS services. Where clear evidence exists that a healthcare professional has been involved in fraud or corruption, there is likely to be a strong public interest in informing NHS England to enable it to undertake enquiries regarding the allegations and to take action where appropriate. In making its decision, NHS England may consider whether the instances of fraud in question, as well as any current or past investigations relating to the professional, justify such action. The duty to protect patients is a major factor in deciding what action is necessary.

7 Process

7.1.1 Once the loss has been identified and all investigations have been fully undertaken and reported to the Audit Committee, the Chief Finance Officer and LCFS will consider all recovery of losses options in line with the Fraud and Bribery Policy.

The Chief Finance Officer will authorise the appropriate recovery method considering the advice and guidance of the LCFS. The chosen method of recovery will be reported to the Audit Committee.

Appropriate action in relation to the recovery of the loss will be applied by the relevant staff of the Trust liaising with the LCFS.

7.1.2 The ongoing monitoring and recovery of the loss will be regularly reported to the Audit Committee within part 2 of the meeting. The reporting of the outstanding loss will be reported until full recovery has been accomplished or if the Audit Committee decide to write off the debt. The writing off of the debt will be in line with the Losses and Special Payments/Debt Recovery policy.

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7.1.3 This process applies to:

- all employees and prospective employees of the Trust, regardless of position held;
- agency staff;
- consultants;
- vendors;
- contractors and subcontractors;
- service users;
- committee, sub-committee and advisory group members (who may not be directly employed or engaged by the Trust) members of organisations funded by the Trust
- employees and principals of partner organisations; and/or
- any other parties who have a business relationship with the Trust.

8 Reporting Fraud, Bribery or Corruption

8.1.1 This section outlines the action to be taken if fraud, bribery or corruption is discovered or suspected.

8.1.2 If an employee has any of the concerns mentioned in this document, they must inform the nominated LCFS or the Trust's Chief Finance Officer immediately, unless the Chief Finance Officer or LCFS is implicated. If that is the case, they should report it to the Chair or Chief Executive, who will decide on the action to be taken. As stated in section 4.10.4 above, **managers must not attempt to investigate the allegation themselves**.

8.1.3 ***Appendix 1*** provides a reminder of the key contacts and a checklist of the actions to follow if fraud, bribery and corruption, or other illegal acts, are discovered or suspected. Managers are encouraged to copy this to staff and to place it on staff notice boards in their department.

8.1.4 An employee can contact any executive director of the Trust to discuss their concerns if they feel unable, for any reason, to report the matter to the LCFS or Chief Finance Officer.

8.1.5 Employees can also call the NHS Fraud and Corruption Reporting Line on Freephone 0800 028 40 60. This provides an easily accessible route for the reporting of genuine suspicions of fraud within or affecting the NHS. It allows NHS staff that are unsure of internal reporting procedures to report their concerns in the strictest confidence. All calls are dealt with by experienced trained staff and any caller who wishes to remain anonymous may do so.

8.1.6 Anonymous letters, telephone calls, etc are occasionally received from individuals who wish to raise matters of concern, but not through official channels. While the suspicions may be erroneous or unsubstantiated, they may also reflect a genuine cause for concern and will always be taken seriously.

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8.1.7 The LCFS will make sufficient enquiries to establish whether or not there is any foundation to the suspicion that has been raised. If the allegations are found to be malicious, they will also be considered for further investigation to establish their source.

8.1.8 Staff should always be encouraged to report reasonably held suspicions directly to the LCFS. They can do this by filling in the NHS Fraud and Corruption Referral Form (***Appendix 2***) or by contacting the LCFS by telephone or email using the contact details supplied on the Trust's intranet site.

8.1.9 The Trust wants all employees to feel confident that they can expose any wrongdoing without any risk to themselves. In accordance with the provisions of the Public Interest Disclosure Act 1998, The Trust has produced a whistleblowing policy. This procedure is intended to complement the Trust's Anti-Fraud, Bribery and Corruption Policy and code of business conduct and ensures there is full provision for staff to raise any concerns with others if they do not feel able to raise them with their line manager/management chain.

8.1 Disciplinary Action

8.1.1 The disciplinary procedures of the Trust must be followed if an employee is suspected of being involved in a fraudulent or otherwise illegal act.

8.1.2 It should be noted, however, that the duty to follow disciplinary procedures will not override the need for legal action to be taken (e.g. consideration of criminal action). In the event of doubt, legal statute will prevail.

8.2 Police Involvement

8.2.1 In accordance with the *NHS Counter Fraud and Corruption Manual*, the Chief Finance Officer, in conjunction with the LCFS, will decide whether or not a case should be referred to the police. Any referral to the police will not prohibit action being taken under the local disciplinary procedures of the Trust.

8.3 Managing the Investigation

8.3.1 The LCFS, in consultation with the Director of Finance will investigate an allegation in accordance with procedures documented in the *NHS Counter Fraud and Corruption Manual* issued by NHS Counter Fraud Authority.

8.3.2 Staff under investigation that could lead to disciplinary action have the right to be represented at all stages. In certain circumstances, evidence may best be protected by staff member is suspended from duty. The Trust will make a decision based on HR advice on the disciplinary options, which include suspension.

8.3.3 The Trust will follow its disciplinary procedure if there is evidence that an employee has committed an act of fraud or corruption.

~~8.3.3~~8.3.4 Staff under investigation by counter fraud are not made aware of the criminal investigation, although there can be exceptions to this.

8.4 Gathering Evidence

8.4.1 The LCFS will take control of any physical evidence, and record this in accordance with the procedures outlined in the *NHS Counter Fraud and Corruption Manual*.

8.4.2 The LCFS may speak to any staff member and will take written statements of evidence where necessary.

8.4.3 The LCFS may be provided any data collected or held by the Trust, which assists in proving or disproving the allegations made. This may, include but is not limited to, swipe card records, CCTV, system access reports, payslips, application forms, references, personnel documentation and rosters.

8.4.4 The LCFS may conduct interviews under caution of those suspected of committing frauds against the Trust in accordance with the Police and Criminal Evidence Act 1984 (PACE). Any staff member being interviewed will be informed in writing and invited to attend voluntarily. They will also be entitled to have legal representation present at the interview.

8.4.5 The application of the Counter Fraud and Corruption Policy will at all times be in tandem with all other appropriate Trust policies, e.g. Standing Financial Instructions (SFIs).

8.5 Parallel Sanctions

8.5.1 In line with NHS Counter Fraud Authority guidance, the conduct of a counter fraud investigation will not preclude either an internal or civil investigation, or disciplinary process from taking place. Appendix 4 is the protocol for joint working and parallel investigations between the Local Counter Fraud Specialist and HR.

8.6 Recovery of Losses Incurred to Fraud, Bribery and Corruption

8.6.1 The seeking of financial redress or recovery of losses will always be considered in cases of fraud, bribery or corruption that are investigated by either the LCFS or NHS Counter Fraud Authority where a loss is identified. As a general rule, recovery of the loss caused by the perpetrator should always be sought. The decisions must be taken in the light of the particular circumstances of each case.

8.6.2 Redress allows resources that are lost to fraud and corruption to be returned to the NHS for use as intended, for provision of high-quality patient care and services.

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8.7 Reporting the Results of the Investigation

8.7.1 The investigation process requires the LCFS to review the systems in operation to determine whether there are any inherent weaknesses. Any such weaknesses identified should be corrected immediately.

8.7.2 If fraud, bribery or corruption is found to have occurred, the LCFS should prepare a report for the Chief Finance Officer and the next Trust Audit Committee meeting, setting out the following details:

- the circumstances
- the investigation process
- the estimated loss
- the steps taken to prevent a recurrence
- the steps taken to recover the loss.

This report should also be available to the Trust's board.

8.8 Action to be taken

8.8.1 Sections 10 and 11 of the *NHS Counter Fraud and Corruption Manual* provide in-depth details of how sanctions can be applied where fraud, bribery and corruption is proven and how redress can be sought. To summarise, local action can be taken to recover money by using the administrative procedures of the NHS Trust or the civil law.

8.8.2 In cases of serious fraud and corruption, it is recommended that parallel sanctions are applied. For example: disciplinary action relating to the status of the employee in the NHS; use of civil law to recover lost funds; and use of criminal law to apply an appropriate criminal penalty upon the individual(s), and/or a possible referral of information and evidence to external bodies – for example, professional bodies – if appropriate.

8.8.3 NHS Counter Fraud Authority can also apply to the courts to make a restraining order or confiscation order under the Proceeds of Crime Act 2002 (POCA). This means that a person's money is taken away from them if it is believed that the person benefited from the crime. It could also include restraining assets during the course of the investigation.

8.8.4 Actions which may be taken when considering seeking redress include:

- no further action

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- criminal investigation
- civil recovery
- disciplinary action
- confiscation order under POCA
- recovery sought from ongoing salary payments.

8.8.5 In some cases (taking into consideration all the facts of a case), it may be that the Trust, under guidance from the LCFS and with the approval of the Chief Finance Officer, decides that no further recovery action is taken.

8.8.6 Criminal investigations are primarily used for dealing with any criminal activity. The main purpose is to determine if activity was undertaken with criminal intent. Following such an investigation, it may be necessary to bring this activity to the attention of the criminal courts (magistrates' court and Crown court). Depending on the extent of the loss and the proceedings in the case, it may be suitable for the recovery of losses to be considered under POCA.

8.8.7 The civil recovery route is also available to the Trust if this is cost effective and desirable for deterrence purposes. This could involve a number of options such as applying through the Small Claims Court and/or recovery through debt collection agencies.

8.8.8 Each case needs to be discussed with the Director of Finance to determine the most appropriate action.

8.8.9 The appropriate senior manager, in conjunction with the HR department, will be responsible for initiating any necessary disciplinary action. Arrangements may be made to recover losses via payroll if the subject is still employed by the Trust. In all cases, current legislation must be complied with.

8.9 Timescales

8.9.1 Action to recover losses should be commenced as soon as practicable after the loss has been identified. Given the various options open to the Trust, it may be necessary for various departments to liaise about the most appropriate option.

8.10 Recording

8.10.1 In order to provide assurance that policies were adhered to, the Chief Finance Officer will maintain a record highlighting when recovery action was required

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and issued and when the action taken. This will be reviewed and updated on a regular basis.

9 Review of The Policy

9.1 This policy will be reviewed annually by the LCFS in conjunction the CFO and senior management and in accordance with relevant guidance, best practice and legislation.

10 Associated Internal Policies and Procedures

- Anti-Bribery Statement
- Disciplinary Policy
- Managing Conflicts of Interest in the NHS
- Secondary employment Policy
- Raising Concerns (Whistle-blowing) Policy
- Standing Financial Instructions
- Standing Orders
- Protocol for the Acceptance of Gifts, Hospitality, Sponsorship and Donations
- Code of Conduct (*If separate to any of the above policies)*
- Alcohol and Substance Misuse Policy

11 Associated External Policies and Procedures

- NHS Counter Fraud Authority guidance - *Parallel criminal and disciplinary investigations policy statement*.
- NHS Counter Fraud Authority guidance - *Parallel criminal and disciplinary investigations guidance for Local Counter Fraud Specialists*.
- Sanctions and Redress Guidance Note

University Hospitals Dorset NHS Foundation Trust

APPENDIX 1

NHS FRAUD AND CORRUPTION: DOS AND DON'TS - A DESKTOP GUIDE

FRAUD is the dishonest intent to obtain a financial gain from, or cause a financial loss to, a person or party through false representation, failing to disclose information or abuse of position.
CORRUPTION is the deliberate use of bribery or payment of benefit-in-kind to influence an individual to use their position in an unreasonable way to help gain advantage for another.

DO	***DO NOT***
Note your concerns Record details such as your concerns, names, dates, times, details of conversations and possible witnesses. Time, date and save your notes **Retain Evidence** Retain any evidence that may be destroyed, or make a note and advise your LCFS **Report your suspicions** Confidentiality will be respected – delays may lead to further financial loss Complete a fraud report and submit in a sealed envelope marked 'Restricted – Management' and 'Confidential' for the personal attention of the LCFS	**Confront the suspect or convey concerns to anyone other than those authorised, as listed below** **Attempt to question a suspect yourself; this could alert a fraudster or accuse and innocent person** **Try to investigate, or contact the police directly** **Attempt to gather evidence yourself unless it is about to be destroyed; gathering evidence must take in to account legal procedures in order for it to be useful. Your LCFS can conduct an investigation in line with the legislation.** **Be afraid of raising your concerns** The Public Interest Disclosure Act 1998 protects employees who have reasonable concerns. You will not suffer discrimination or victimisation by following the correct procedures.

If you suspect that fraud against the NHS has taken place, you must report it immediately, by:

- directly contacting the Local Counter Fraud Specialists, contact details to be found on the staff intranet page.
- phoning the NHS Fraud and Corruption Reporting Line on 0800 028 40 60. (All calls will be treated in confidence and investigated by professionally trained staff), or
- Visiting: https://cfa.nhs.uk/reportfraud
- contacting the Chief Finance Officer.

~~***Do you have concerns about a fraud taking place in the NHS?*** If so, any information can be passed to the NHS Fraud and Corruption Reporting Line:~~

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University Hospitals Dorset NHS Foundation Trust

APPENDIX 2

NHS FRAUD AND CORRUPTION REFERRAL FORM

All referrals will be treated in confidence and investigated by professionally trained staff

Note: ***Referrals should only be made when you can substantiate your suspicions with one or more reliable pieces of information. Anonymous applications are accepted but may delay any investigation.***

1. Date

2. Is this an anonymous referral? <Delete as appropriate>
Yes (If 'Yes' go to section 6) or No (If 'No' complete sections 3–5)

3. Your name

4. Your organisation/profession

5. Your contact details

6. ***Suspicion***

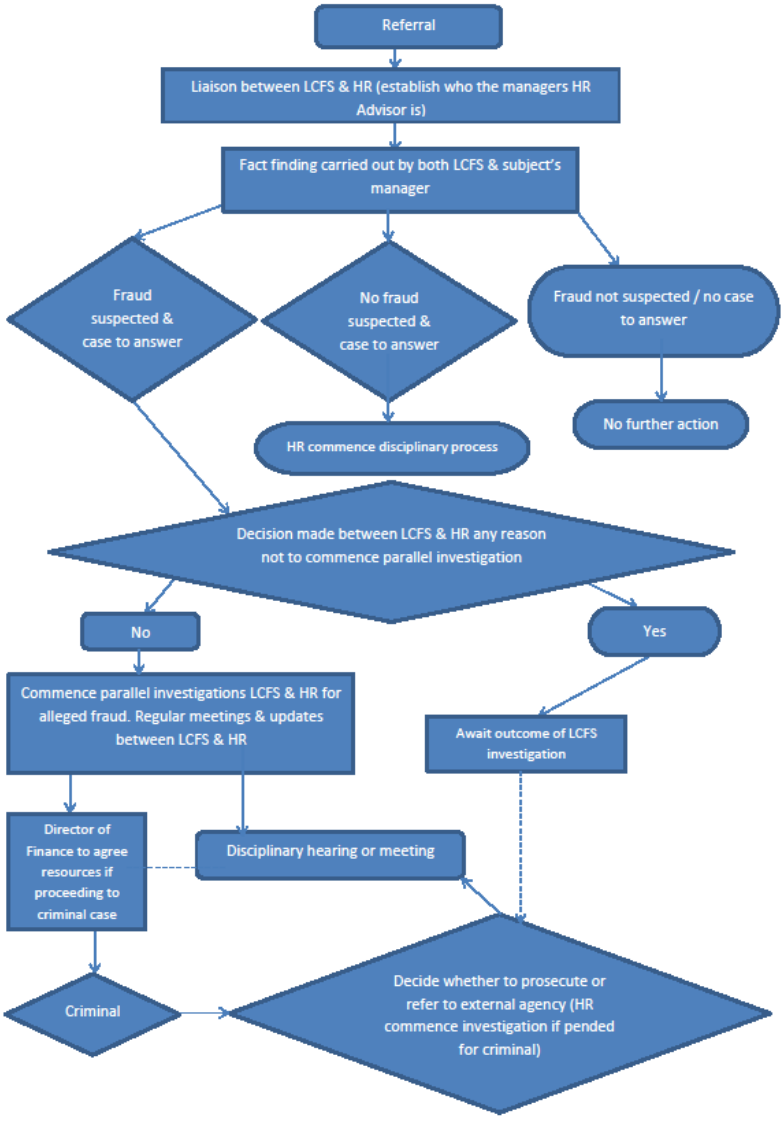
7. Please provide details including the name, address and date of birth (if known) of the person to whom the allegation relates.

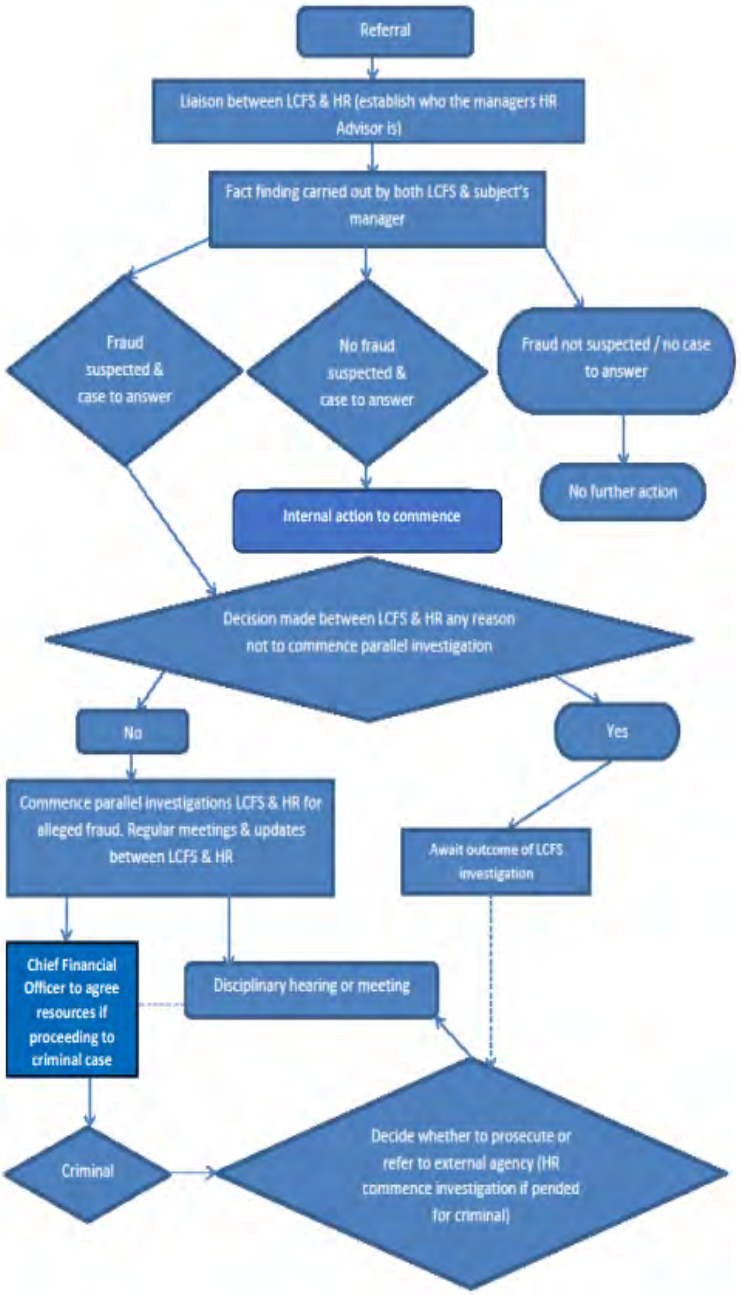
8. Possible useful contacts

9. **Please attach any available additional information**.

APPENDIX 3

LCFS REFERRAL / HR INVESTIGATION FLOW CHART




Referral
Liaison between LCFS & HR (establish who the managers HR Advisor is)
Fact finding carried out by both LCFS & subject's manager
Fraud suspected & case to answer
No fraud suspected & case to answer
Fraud not suspected / no case to answer
No further action
Internal action to commence
Decision made between LCFS & HR any reason not to commence parallel investigation
No
Yes
Commence parallel investigations LCFS & HR for alleged fraud. Regular meetings & updates between LCFS & HR
Await outcome of LCFS investigation
Chief Financial Officer to agree resources if proceeding to criminal case
Disciplinary hearing or meeting
Criminal
Decide whether to prosecute or refer to external agency (HR commence investigation if pended for criminal)

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Appendix 4

Protocol for joint working and parallel investigations between the Local Counter Fraud Specialist and HR

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This appendix sets out a Joint Working Protocol which is designed to enable effective interaction between the LCFS and HR department whenever an incident of Fraud, Bribery or Corruption is suspected and investigated, with appropriate flexibility and discretion based on the specific circumstances of each case.

The objectives of this protocol are;

- To enable regular interaction and joint working between the LCFS and HR at all times.
- To ensure close and supportive interaction and lawful information sharing between the LCFS and HR where a potential fraud has been highlighted and is investigated.
- To ensure that criminal and disciplinary investigations are carried out effectively and in accordance with relevant legal frameworks.
- To help deter future incidents of fraud by allowing sanctions to be pursued effectively, where appropriate.

GENERAL PRINCIPLES

A number of general principles should be adhered to when implementing this protocol around segregation of duties and information sharing.

Separate Processes

The criminal and disciplinary investigations will be conducted separately and by different people. The two investigations have different purposes, standards of proof in determining guilt, and different outcomes, and therefore it is not appropriate for one process to cover both.

Criminal investigations conducted by the LCFS must be in accordance with the Police and Criminal Evidence Act 1984 (PACE), the Criminal Procedure and Investigation Act 1996 (CPIA), and other relevant legislation. The LCFS will not conduct disciplinary investigations. If the LCFS were to act as investigator in both the criminal and disciplinary investigations, this may risk undermining the integrity of both processes in relation to the way evidence has been gathered.

Disciplinary investigations are a management function, assisted by HR, and must be carried out in accordance with the Trust disciplinary procedure.

The criminal investigation may be given precedence over the disciplinary investigation, if there is a risk of serious prejudice to the former from running the two processes concurrently. However, there may be a compelling public/clinical interest in suspending or removing an individual from their post before the conclusion of the criminal case. In this situation, the LCFS and HR will discuss the specific circumstances.

The criminal process may determine the actions and timing of related disciplinary investigations, particularly where there is a risk of prejudice to the criminal case. However, there may be other circumstances where sanctions are pursued concurrently, so that the public interest is protected

and disciplinary proceedings are heard in a just and timely way. All relevant personnel should be made aware of the parallel proceedings.

Information Sharing

Information may be shared between the criminal and disciplinary investigation by the LCFS and HR where and when it is lawful and appropriate, subject to the Data Protection Act 2018, and any local policy and contractual agreements.

JOINT WORKING PROTOCOL

Regular liaison between the LCFS and HR

The LCFS will meet with the Trust's HR function as and when required to provide and receive an update with ongoing cases. These updates will also be shared with the relevant HR officer within the Trust to maintain a flow of information (where lawful and appropriate) in relation to any specific investigation. An accurate record will be made on CLUE (The NHS Counter Fraud Authority case management system) regarding the precise nature of the update meetings and of any information that is being shared and the reasons why it is being shared.

Fraud/Bribery referrals

All referrals received by HR that have an element of suspected Fraud, Bribery or Corruption must be reported immediately to the LCFS and/or Chief Finance Officer.
HR will liaise closely with managers and the LCFS from the outset if an employee is suspected of being involved in fraud and/or corruption.
The LCFS will acknowledge receipt of suspected fraud referrals from HR and arrange to meet with an appropriate HR representative to discuss them.

The LCFS will ensure that the Chief Finance Officer is notified at the earliest opportunity about all referrals/cases, and HR are advised where an allegation concerns a current Trust employee. The LCFS will undertake a timely initial review to establish the validity of any allegation.
Initial enquiries by the LCFS following a referral may result in one of the following outcomes and action will be taken in conjunction with HR;

- no case to answer (no evidence of fraud)
- no evidence of fraud found but system weaknesses identified
- no evidence of fraud found but breach of policy or other disciplinary issues identified
- Reasonably held suspicion or evidence of suspected fraud identified, requiring criminal investigation.

Investigation

The LCFS, in consultation with the Trust's Chief Finance Officer, will investigate allegations in accordance with procedures documented in the *NHS Counter Fraud Manual* issued by the NHS Counter Fraud Authority. The investigation will be conducted in line with the Trust's Anti-Fraud,

Bribery and Corruption Policy which outlines the process for criminal investigation by the LCFS; as well as internal HR processes relating to disciplinary investigation.

The criminal and disciplinary investigations will be conducted separately by the LCFS and the Trust respectively. Disciplinary investigations will be undertaken by the investigating officer appointed by the Trust.

The criminal investigation will usually be given precedence over the disciplinary investigation, if there is a risk of serious prejudice to the former from running the two processes concurrently.

The criminal process may determine the actions and timing of related disciplinary investigations, particularly where there is a risk of prejudice to the criminal case. However, there may be other circumstances where sanctions are pursued concurrently, so that the public interest is protected and disciplinary proceedings are heard in a just and timely way. All relevant personnel should be made aware of the parallel proceedings.
The circumstances of a case may be such that HR wish to delay disciplinary proceedings until the LCFS has secured all evidence for use in the criminal inquiry.
Where an investigation by the LCFS relates to a case in which a breach of policy and/or procedures may have occurred, an HR officer will meet with the LCFS to discuss the case and receive documents or other materials (where lawful to do so), in order to establish if disciplinary action is required.
The LCFS and HR department will keep each other informed about the progress of their respective investigation.

Concluding reports will be issued at the closure of any investigation undertaken by the LCFS in accordance with the requirements outlined in the NHS Counter Fraud Manual. These may include agreed recommendations to strengthen controls in identified areas of weakness in order to prevent future fraud. The recommendations may need to be actioned by line management and/or HR; the LCFS will therefore ensure they are clearly communicated to the relevant Manager / HR advisers, and will check that they are duly implemented.

Information sharing
All information sharing between the LCFS and HR will be considered on a case-by-case basis with no routine or blanket information exchange. Whenever information is exchanged it will be recorded on the NHS CFA case management system (CLUE), along with the reasons for sharing and the legal principals considered.

HR may share information obtained during a disciplinary investigation with the LCFS to help further a criminal investigation. This includes the outcome of any disciplinary hearing. The LCFS may normally share with HR information or material, which belongs to the Trust or is freely available (e.g. emails).

However, discretion may be required for disclosure of certain types of data or information, or if it originates from a third party, for example;

- transcripts, CD's or tapes from an interview under caution (IUC)
- witness statements
- personal data obtained from a third party
- material seized during a search
- other material collected during the course of a criminal investigation.

Where there are overriding public interest issues, such as patient safety concerns, which may require the disclosure of confidential information to HR and/or other bodies, a case conference,

comprising the LCFS, Chief Finance Officer and legal input (e.g. from a solicitor), will be held in exceptional circumstances for full consideration. Issues related to the timing of disclosure of such material will also be discussed – for example, where a criminal case is ongoing but significant risks to patient safety remain. The case conference may seek advice from the NHS Counter Fraud Authority as appropriate.

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Information sharing will take account of relevant legislation, such as PACE, CPIA and DPA/GDPR, and guidance from the ICO and NHS Counter Fraud Authority.

Each piece of information will be considered individually before deciding whether it can be shared between the two parties.

Pursuing sanctions

Sanctions and redress, and recoveries of monies lost are covered in Section 6 of the main policy. Further information regarding pursuing sanctions is in the NHS Fraud Counter Fraud Manual. There will be close liaison between the LCFS and HR to ensure that any parallel sanctions are applied effectively and in a coordinated manner and that staff are at all times treated in accordance with the Trust's values.

The LCFS is responsible for informing HR of any criminal sanctions applied.

HR are responsible for keeping the LCFS updated on the application/outcome of disciplinary sanctions.

Action to recover losses will be commenced as soon as practicable after the loss has been identified.

Actions arising will be recorded by the LCFS on the CLUE system.

Anti-Fraud, Bribery and Corruption Statement

University Hospitals Dorset NHS Foundation Trust is committed to eliminating fraud, bribery and corruption within the NHS, protecting public resources for health and care. Fraud is an act of deception that is intended to make a financial gain or to cause a loss to another party. Bribery is generally defined as the giving or receiving of a financial or other advantage in exchange for improperly performing a relevant function or activity.

The Trust employs a specialist counter-fraud service to provide a comprehensive programme against fraud, bribery and corruption which is overseen by the Trust's Chief Finance Officer and the Audit Committee.

The Trust has a zero-tolerance approach to fraud, bribery and corruption and is committed to applying the highest standards of ethical conduct and behaviour, as well as having robust controls in place to prevent fraud and corruption. As well as staff, the Trust also expects its suppliers to adhere to the same high standards.

Our dedicated policies and procedures set out our expectations and guidance for staff, contractors and anyone else working with or for the Trust with regards to preventing fraud, bribery and corruption, and raising concerns.

We ask all who have dealings with the Trust, as employees, agency staff, trading partners (contractors/suppliers), stakeholders and patients, to help us in our fight against fraud and corruption and to contact us immediately if any concerns arise. No individual will suffer any detrimental treatment as a result of reporting reasonably held suspicions. The success of the Trust's anti-fraud and corruption measures depends on everyone playing their part.

The Trust's Counter Fraud Specialist can be contacted in confidence:

Kim Hampson
Counter Fraud Specialist

- by phone on 07881 840869
- or by e-mail kim.hampson@nhs.net

All genuine suspicions of fraud and corruption can also be reported in confidence to the NHS Fraud and Corruption Reporting Line on free phone 0800 028 40 60 or at: https://cfa.nhs.uk/reportfraud

Pete Papworth

Chief Finance Officer

Appendix - Attendance at Part 1 Board Meetings

Part 1		24 May 2023	26 July 2023				
Present	Karen Allman						
	Pankaj Dave						
	Peter Gill						
	Judy Gillow	A					
	Philip Green						
	Siobhan Harrington						
	John Lelliott						
	Stephen Mount						
	Mark Mould						
	Pete Papworth						
	Sharath Ranjan						
	Richard Renaut						
	Cliff Shearman						
	Paula Shobbrook						
	Caroline Tapster						
	John Vinney	A					
	Rob Whiteman						
	Peter Wilson						
In Attendance (excl Governors, members of public and	James Donald						
	Yasmin Dossabhoy						
	Ewan Gauvin						
	Sarah Locke						
	Judith May						
	Helena McKeown						
	Claire Whitaker						
Was the meeting quorate?		Y	Y				

Key

	Not in Attendance			In attendance
A	Apologies			N/A
D	Delegate Sent			