University Hospitals Dorset
NHS Foundation Trust

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

BOARD OF DIRECTORS – PART 1 MEETING

Wednesday 3 July 2024

9:30 – 12:15

via Microsoft Teams

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

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

BOARD OF DIRECTORS – PART 1 HELD IN PUBLIC

The next meeting of the University Hospitals Dorset NHS Foundation Trust Board of Directors Part 1 will be held at 9:30 on Wednesday 3 July 2024 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

9:30 on Wednesday 3 July 2024

Time	Item		Method	Purpose	Lead
9:30	**1**	Welcome, Introductions, Apologies & Quorum	**Verbal**		**Chair**
9:32	**2**	Declarations of Interest	**Verbal**		**Chair**
9:35	**3**	Patient Story	**Verbal**	**Discussion**	**CNO**
9:50	**4**	Poole Africa Link	**Verbal**	**Discussion**	**PAL**
10:00	**5**	Update from the Council of Governors	**Verbal**	**Discussion**	**Lead Governor**
10:10	**6**	**MINUTES**			
10:10	**6.1**	For Accuracy and to Agree: Minutes of the Board of Directors Meeting held on 1 May 2024	**Paper**	**Approval**	**Chair**
10:12	**6.2**	Matters Arising - Action List *(none outstanding)*	**Verbal**	**Review**	**Chair**
10:15	**7**	**TRUST CHAIR AND CHIEF EXECUTIVE UPDATES**			
10:15	**7.1**	Trust Chair's Update	**Verbal**	**Information**	**Chair**
10:20	**7.2**	Chief Executive Officer's Report • ICB minutes	**Paper**	**Information**	**CEO**
10:30	**8**	**RISK AND PERFORMANCE**			
10:30	**8.1**	Integrated Quality, Performance, Workforce, Finance and Informatics Report *Introduced by triumvirate*	**Paper**	**Assurance**	**Execs**

10:50	**8.2**	Quality Committee – Chair's Report – May and June 2024 • Maternity Safety Champions Report *(to be presented by Director of Midwifery)* • Complaints Annual Report	**Paper** **Paper** **Paper**	**Assurance** **Assurance** **Assurance**	**Committee Chair**
11:00	**8.3**	Finance and Performance Committee – Chair's Report – May and June 2024	**Paper**	**Assurance**	**Committee Chair**
11:05	**8.4**	People and Culture Committee – Chair's Report – July 2024 • Safe Staffing Report - Nursing • Quality Assurance for Responsible Officers and Revalidation • Annual Security Report • Freedom to Speak Up Report • Guardian of Safe Working Hours Report	**Verbal** **Paper** **Paper** **Paper** **Paper** **Paper**	**Assurance** **Assurance** **Assurance** **Assurance** **Assurance** **Assurance**	**Committee Chair**
11:15	**8.5**	Population Health and System – Chair's Report – June 2024	**Paper**	**Assurance**	**Committee Chair**
11:20	**8.6**	Audit Committee – Chair's Report – May and June 2024 • Clinical Audit Plan	**Paper** **Paper**	**Assurance** **Approval**	**Committee Chair**
11:30	**8.7**	Transforming Care Together – Chair's Report – June 2024	**Paper**	**Assurance**	**Chair**
11:35	**8.8**	Charitable Funds Committee – Chair's Report – May 2024	**Paper**	**Assurance**	**Committee Chair**
11:40	**8.9**	Risk Register: review of significant risks; new risks rated 12 and above	**Paper**	**Assurance**	**Execs**
11:45	**9**	**ITEMS FOR APPROVAL**			
11:45	**9.1**	Board Committee Effectiveness Review	**Paper**	**Approval**	**Chair/ CoSec**
	9.2	Annual Operating Plan	**Paper**	**Approval**	**CSTO**
11:50	**10**	Any Other Business	**Verbal**	**Discussion**	**Chair**
	11	Reflections on the Board Meeting	**Verbal**	**Discussion**	**Chair**
	12	Questions from the Council of Governors and Public arising from the agenda.			

		Governors and Members of the public are requested to submit questions relating to the agenda by no later than noon on Sunday 30 June 2024 to company.secretary-team@uhd.nhs.uk			
	13	**Date and Time of Next Board of Directors Part 1 Meeting:** Board of Directors Part 1 Meeting on Wednesday 4 September 2024 at 9:30.			
	14	**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.			
12:15	**15**	**Close**	**Verbal**		**Chair**

* Late paper
R Associated item in Reading Room

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

Items for Next Board Part 1 Agenda

Standing Reports

- Patient Story
- Trust Chair's Update
- Chief Executive Officer's Report
- Committee Chair's Key Issues & Assurance Report
- Integrated Performance Report
- Risk Register Report
- Maternity Safety Champions Report

Quarterly Reports

- Mortality Report
- Quality Impact Assessment Overview Report

Bi-annual/Annual Reports

- Nursing Establishment Review
- Maternity Staffing Report
- Annual Safeguarding Report and Statement
- Annual Infection Prevention Control and Statement
- Annual Mixed Sex Accommodation Statement and Declaration
- Annual Health and Safety Report
- Workforce Race Equality Standards Report and Action Plan
- Workforce Race Disability Equality Standards Report and Action Plan
- Annual Equality Diversity and Inclusion Report
- Annual SIRO Report
- Premises Assurance Model
- UHD Charity – Annual Report and Accounts
- Board Governance Cycle
- Board Effectiveness Review

- Board Meeting Schedule

Ad hoc

- Risk Management Strategy
- Committee Terms of Reference

AGENDA – PART 2 PRIVATE MEETING

12:30 on Wednesday 3 July 2024

Time	Item		Method	Purpose	Lead
12:30	**16**	Welcome, Introductions, Apologies & Quorum	**Verbal**		**Chair**
	17	Declarations of Interest	**Verbal**		**Chair**
12:32	**18**	**MINUTES AND ACTIONS**			
12:32	**18.1**	For Accuracy and to Agree: Minutes of the Board of Directors Meeting held on 5 June 2024 and 17 June 2024	**Paper**	**Approval**	**Chair**
12:33	**18.2**	Matters Arising – Action List	**Paper**	**Review**	**Chair**
12:35	**19**	**UPDATES**			
12:35	**19.1**	Chief Executive Officer's Update	**Verbal**	**Information**	**CEO**
12:55	**19.2**	Escalations from Committee Chairs (not already covered in Part 1)	**Verbal**	**Information**	**Committee Chairs**
13:10	**19.3**	Feedback from Service Visits	**Verbal**	**Information**	**All**
13:20	**19.4**	Cybersecurity	**Paper**	**Assurance**	**CFO**
13:25	**19.5**	Joint working with UHS	**Paper**	**Information**	**CSTO**
13:30	**20**	**QUALITY AND PEOPLE**			
13:30	**20.1**	Serious Incident Report	**Paper**	**Review**	**CMO**

13:35	**21**	**FINANCE**			
13:35	**21.1**	Efficiency Improvement Programme	**Paper**	**Assurance**	**CFO**
13:45	**22**	**ITEMS FOR APPROVAL**			
13:45	**22.1**	DSP Toolkit	**Paper**	**Ratification**	**CFO**
	22.2	Bournemouth site energy	**Paper**	**Approval**	**CSTO**
	22.3	Car parking	**Paper**	**Approval**	**CSTO**
	22.4	NHP – contracts	**Paper**	**Approval**	**CSTO**
	22.5	Private Patients	**Paper**	**Approval**	**CSTO**
	22.6	Lease - telecoms site at Poole Hospital	**Paper**	**Approval**	**CSTO**
	23	Any Other Business	**Verbal**		**Chair**
	24	Reflections on the Board Meeting	**Verbal**		**Chair**
	25	**Date and Time of Next Standing Board of Directors Part 2 Meeting:** Board of Directors Part 2 Meeting on Wednesday 4 September 2024 at 12:30.			
14:00	**26**	**Close**	**Verbal**		**Chair**

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Items for Next Standing Board Part 2 Agenda

Standing Reports

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

Bi-annual/Annual Reports

- N/A

Ad Hoc

- Digital Strategy
- Workforce Strategy

List of abbreviations:

Officer titles

CPO – Chief People Officer
CFO – Chief Finance Officer
CSTO – Chief Strategy and Transformation Officer
CEO – Chief Executive Officer
CNO – Chief Nursing Officer
CoSec – Associate Director of Corporate Governance

Other abbreviations

CDEL – Capital Delegated Expenditure Limit
CIP – Cost Improvement Programme
ED – Emergency Department
HSMR – Hospital Standardised Mortality Ratio
ICB – Integrated Care Board
SHMI – Summary Hospital-Level Mortality Indicator
SMR – Standardised Mortality Ratio
SWAST – South West Ambulance Service NHS Foundation Trust

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

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 1 May 2024 at 9:30 via Microsoft Teams.

Present:	Rob Whiteman	Trust Chair *(Chair)*
	Pankaj Davé	Non-Executive Director
	Judy Gillow	Non-Executive Director
	Siobhan Harrington	Chief Executive
	Fiona Hoskins	Acting Chief Nursing Officer
	John Lelliott	Non-Executive Director
	Helena McKeown	Non-Executive Director
	Pete Papworth	Chief Finance Officer
	Richard Renaut	Chief Strategy and Transformation Officer
	Sharath Ranjan	Non-Executive Director
	Cliff Shearman	Non-Executive Director
	Tina Ricketts	Chief People Officer
	Claire Whitaker	Non-Executive Director
In attendance:	Colin Blebta	Public Governor
	Annie Bush	Ward Sister, Ward 1
	Robert Bufton	Public Governor
	Sharon Collett	Public Governor
	Samantha Dean	Deputy Sister
	Jamie Donald	Associate Director of Communications
	Yasmin Dossabhoy	Associate Director of Corporate Governance *(minutes)*
	Rob Flux	Staff Governor
	Ewan Gauvin	Acting Deputy Company Secretary
	Paul Hilliard	Appointed Governor
	Elizabeth McDermott	Public Governor
	Keith Mitchell	Public Governor
	Jeremy Scrivens	Public Governor
	Diane Smelt	Public Governor
	Carrie Stone	Public Governor
	Lorraine Tonge	Staff Governor
	Kani Trehorn	Project Manager
	Michaela Turton	Public Governor
	Michele Whitehurst	
	(Three *members of the public in attendance and a patient's husband for the Patient Story)*	

BoD101/24	**Welcome, Introductions, Apologies & Quorum** Rob Whiteman welcomed everyone to the meeting. Apologies had been received from the following Board member: • Helena McKeown, Non-Executive Director. In addition, apologies had been received from David Broadley, Medical Director – Integrated Care and John Vinney, Associate Non-Executive Director. The meeting was declared quorate.
BoD102/24	**Declarations of Interest** No existing interests in the matters to be considered were declared. Rob Whiteman declared that he was soon to retire from his executive career at the Chartered Institute of Public Finance and Accountancy. He would be joining a university board and a theatre board, which were covered in the register of directors' interests being presented later in the meeting. Subject to this, no further interests were declared.
BoD103/24	**Patient Story** Fiona Hoskins introduced the Patient Story, outlining that it reflected upon the Trust's objective in relation to improving patient experience through listening and acting. It was a story from 2019 relating to a bereavement and the relationship that had built up between a bereaved partner and the ward team. Introducing Annie Bush and Russell – husband of Alison - Fiona Hoskins referenced it being a very moving story. Annie Bush commented upon the relationship they had built up; they had been co-working on a special service improvement project that had been created on ward 1 (gastroenterology) at Bournemouth hospital. Russell shared his and Alison's story. Alison had been diagnosed with cancer 5 years ago. He shared their journey from then, including them getting married and how special it was with all the staff support. Two days after they were married, Alison had passed away. He shared his personal journey after then and the questions he had to which he needed answers. He met with Annie Bush at the hospital and worked through with her and the consultant the answers he needed. This helped him feel differently by the end of the meeting and achieve peace of mind that there was nothing he could have done. Following this, they discussed a similar service being offered to all relatives who had a loved one pass away on ward 1. A card was now being given to all family members and loved ones offering the service up to six months after the death of someone on the ward. This was launched in November 2023, with consultant colleagues having been supportive and it having been very well received so far. Expressing condolences on the passing of his wife, Rob Whiteman thanked Russell for sharing. It was important for the Board to hear and listen to what he had needed for closure and his own help. He thanked Annie Bush, with it being reassuring to hear about the efforts being made to support in circumstances beyond medical care. Siobhan Harrington commented upon the significant messages in relation to communication. Annie Bush had exemplified caring. She asked what the plans were to share this more widely across the Trust. Responding to this, Fiona Hoskins confirmed that it was her intention to connect Annie Bush with Laura Northeast, Head of Patient Experience to achieve this personal touch being rolled out through the organisation.

	Thanking Russell for sharing his moving story and helping the Trust to further improve what it did to support people, Judy Gillow suggested that this could be a training tool for development in the Trust, not only for communication but also compassionate, personalised care. Sharath Ranjan highlighted his observations that patient care was not only about the patient, but also families. Claire Whitaker commented upon there being capacity issues within the Trust and enquired whether there were opportunities for a joined up approach mobilising internal Trust resources, but also external information. Adding to this, Siobhan Harrington considered that it may be positive to have a bereavement strategy. Russell highlighted that after Alison passed away, it was not only an opportunity for him to get answers, but also an opportunity for him to say thank you to Annie Bush and the team. The Board NOTED the Patient Story.
BoD 104/24	**For Accuracy and to Agree: Minutes of the Part 1 Meeting of the Board of Directors held on 6 March 2024** The minutes of the Part 1 meeting of the Board of Directors held on 6 March 2024 were APPROVED as an accurate record.
BoD 105/24	**Matters Arising – Action List** It was noted that there were no outstanding actions.
BoD 106/24	**Trust Chair's Update** Rob Whiteman presented the Trust Chair's Update highlighting that: • He had been pleased to be involved in local and regional meetings with partners since the last Board meeting, including a meeting of the integrated care partnership. • He had also visited services at the Trust. • There had been an interesting Board Development Session, with discussions having taken place in relation to further improvements that could be made to governance and the timeliness of reports being produced and therefore when the meeting materials were published. Efforts would continue to be made, with good practical discussions having taken place. • It was the time of year for Board member appraisals and he had been involved in a number of conversations with his Non-Executive Director colleagues about these. In addition, the Fit and Proper Persons process was on the agenda for discussion later in the meeting. • Non-Executive Director colleagues had been pleased to carry out a number of service visits. In the Part 2 meeting of the Board, they would reflect on any observations that they wanted to draw out. Moving on to the Board assurance sections of the meeting, colleagues would also bring in the insight that they find from those visits to help triangulate what was seen in reports. • Siobhan Harrington would speak about Wessex Fields in her report. The Board NOTED the Trust Chair's Update.
BoD 107/24	**Chief Executive Officer's Report** Siobhan Harrington introduced the Chief Executive Officer's Report, highlighting:

	• Her thanks to everyone across the Trust. The Trust had performed well in many areas, with the year having been quite challenging with 12 rounds of industrial action. • There were improvements in urgent and emergency pathways and waiting times for patients, albeit that there was still more to do. • Staff surveys and patient surveys were extremely important. • While the Trust had met its financial plan, more needed to be done in relation to recurrent savings. • The current financial year would continue to be a challenge. • The organisation was undergoing considerable change and it would be important to bring staff, patients and communities on the journey. • There would be continued focus upon patient safety and looking after staff. • There were a number of national updates included within her report, which she highlighted including the visit from Sir Julian Hartley and Amber Jabbal. • There were a number of actions that trusts would be taking to improve the working lives of staff, including doctors in training. • She referenced the maternity incident in September 2023 that had recently been reported in the media regarding a baby that was handed to the incorrect mother. The Trust was sorry for any distress caused and an investigation had been instigated into what happened at the time. Since her report, a meeting had taken place with the woman concerned. The investigation was being concluded and would be reported through to the Quality Committee. Any learning would be brought back through the Board and its Committees. • In relation to Wessex Fields, she referenced it having been positive that the full Council meeting in April 2024 had recommended the sale to the Trust. Noting media coverage that week, she wanted to reassure everyone that there was not a discount applied to the market value and some of the reporting in the Echo newspaper had been factually inaccurate. Adding to this, Richard Renaut stated that the Echo had since apologised to the Trust and BCP, which would be corrected. They had asked those who had commented upon or tweeted the story to reflect upon it. • Solar panels had been installed at Poole hospital, which was positive for the environment and sustainability. Adding to this, Richard Renaut referenced that one and a half tonnes of carbon had already been saved. • A position was being reached where from 1 June 2024, the Treatment Investigation Unit would be at Poole. A meeting with patients had taken place the previous evening, which was lively, with some very strong feelings from patients. Some of the very specific needs of patients used to being treated at Bournemouth were being considered. • The Pathology Hub was opening towards the end of May 2024. • The Patient First improvement programme was continuing at some pace. It would take time to be implemented. Wave One teams were having regular improvement huddles. The scorecard being implemented would begin to influence how everyone, including the Board, worked. Peter Wilson was now the senior responsible officer for the programme. • Thanking Fiona Hoskins for being Interim Chief Nursing Officer, she referenced that Sarah Herbert would start at the Trust on 13 May 2024.

	Agreeing that considerable progress had been made in many key areas, Pankaj Davé enquired whether the Trust was generally in the middle of the pack from a national perspective and not an outlier. Responding to this, Siobhan Harrington gave the example that for urgent and emergency care, the Trust was 19th in the country for most improved, therefore being slightly above middle of the pack. The Trust had also come out of Tier 2 for elective care, with this being an improvement and positive. There was more work to do on financial delivery, particularly the delivery of recurrent savings. On the staff survey, the Trust was in the upper half, of which she was very proud. In relation to the maternity incident, Sharath Ranjan reflected upon being proactive about the culture of when things went wrong, putting the support in place. Responding to this, Siobhan Harrington confirmed that it was important to drive an improved culture about engaging with people who may not have had the care they should have received and engaging with them sooner rather than it becoming a formal complaint. Using the specific maternity incident as an example, she observed that it was interesting that at the time, there had not been a formal complaint. It was important that people felt comfortable to escalate and to complete a DATIX form. There was still opportunity for improvement within the Trust. Rob Whiteman commented upon the importance of inclusivity, indicating that sometimes it was the more confident individuals who felt that they could complain. Adding to the conversation, Lorraine Tonge commented upon processes and systems to give assurance to the Board about maternity safety overall. With closure of escalation beds, Cliff Shearman asked whether there were particular consequences which would put pressure on already finely tuned services. Siobhan Harrington commented upon her having been on call over the weekend. The bed base in Poole was slightly tighter than it had been for some time, but flow had been well maintained during the weekend. While there were a number of variables, there had been a shift across the organisation, in terms of a feeling of responsibility for those aspects within the Trust's control across the flow pathway. Inviting Mark Mould to comment, he added that an extensive piece of work had been undertaken on the bed capacity plan, understanding the work needing to be done internally and progress to be made externally. This would be discussed at the Trust Management Group, with a subsequent briefing to the Finance and Performance Committee and if appropriate, escalated to the Board. It was recognised that this was not only about flow, but other matters such as cancelled operations and getting people out of critical care on time. All those factors were considered in the decisions made to open and close beds. Claire Whitaker commended Siobhan Harrington's approach to public consultation. Reflecting on the Patient Story and her own lived experience of losing somebody suddenly to cancer, she supported there being a joined up approach with other services relating to bereavement, for example with district nurses and palliative care. The experience was not only in the hospital. Her own experience had been mixed. Siobhan Harrington commented that Dorset was carrying out a review related to palliative care. The Board NOTED the Chief Executive Officer's Report.
BoD 108/24	**Board Assurance Framework and Risk Register: review of significant risks; new risks rated 12 and above** Rob Whiteman outlined that usually, the agenda would move next to the Integrated Performance Report. However, at the recent Board Development Session which he had mentioned in his introduction, Executive Director colleagues had considered that it would be beneficial to have the Board

Assurance Framework first, to provide an overview of the risks being managed and whether the Trust was on target to achieve its objectives.

Fiona Hoskins presented the Board Assurance Framework report adding that:

- The majority of the risk ratings had remained the same.
- In relation to BAF Risk 4 – making improvements using patient feedback – the improvement noted at the previous meeting had remained stable.
- BAF Risk 1 had decreased from 16 to 9. Mark Mould explained that a number of aspects had been considered including:
    - There had been a 6% reduction in waiting list.
    - Maintaining the number of people seen within 18 weeks.
    - The reduction in the number of people over 78 weeks and 65 weeks in terms of waiting.
    - The validation patient engagement programme, asking whether people still needed their treatment.

  He considered that when the new strategic objective was considered, the BAF risk would be updated for the next meeting.

In relation to BAF Risk 10 – Electronic Patient Record, Judy Gillow sought assurance about the comment that because there may be an affordability issue, that may delay the programme. She was cognisant that the timeframe was critical for the Trust. Responding to this, Pete Papworth confirmed that completion of the outline business case was on track and would be presented to the May 2024 meetings of the Finance and Performance Committee and the Board. The affordability was a challenge. A meeting would be taking place the following day with external financial partners to run through the economic model in further detail. If there were a residual gap, engagement would take place with the regional digital team about any potential for additional frontline digitisation funding. He would circulate a note to the Board the following day with an update.

Siobhan Harrington proposed that in relation to BAF Risk 9, relating to reconfiguring services, aspects connected to internal and external communications and engagement should be strengthened. Agreeing with this, Richard Renaut added that although the headline risk number had not changed, there was a very active risk management process. There were some risks decreasing and others increasing, contributing to the headline rating remaining constant. Progress had been made on the funding and the staffing, particularly the Staff Ready Group. Decision making processes were being reviewed to support decisions being made ahead of the critical path, including the appropriate amount of consultation.

Fiona Hoskins presented the risk register – including the three new risks - which had been through its usual governance and highlighted the two reduced risks related to industrial action and maternity staffing. In relation to the Older Persons' Services medical staffing, Peter Wilson outlined the work in progress with Tina Ricketts and the Care Groups in relation to recruitment, review of templates, job plan. Referencing Cliff Shearman's earlier question, he commented upon the impact of having four wards plus TIU and SDEC over winter creating quality and safety issues.

Pankaj Davé enquired about the ability to use the Beales centre for glaucoma monitoring or partnerships with opticians. Mark Mould explained that the Beales facility was in use; the challenge was with the medical capacity associated with reviews of those people that needed to be seen by a medic. A number of people – working to protocol – were being seen by technicians where they did not need to be seen by a consultant. The opthamology team were working on attracting as well as retaining medical workforce. Peter

	Wilson confirmed that non-consultant staff were being trained. The locum had been extended. From 1 May 2024, extra virtual clinics had been added to manage the backlog. There was currently no evidence of harm coming to patients. It was hoped that within two to three months, the risk would be reduced. Judy Gillow commented that she was surprised to see the long gap in recruitment to restorative dentistry. Although there was a locum, the delay in having a permanent appointment was a concern. She enquired what steps were being taken to get a substantive in post and why there had been such a delay. Peter Wilson explained that it was not a Dorset specific issue, with there being a national shortage. There was not a gap in recruitment, but there was a rolling attempt to recruit that had not been met. The Chief Dental Officer for the southwest region had been actively involved to mitigate and resolve, with mitigations being in place. One of the key issues was that having a small team did not attract people easily. In response to a question from Rob Whiteman about the timeline to resolve this, Peter Wilson responded that he was unable to provide this, but innovative options were being considered including joint appointments. He would go back to the region, from where the support was needed, about this. The Board NOTED the Board Assurance Framework and APPROVED the Risk Register.
BoD 109/24	**Integrated Performance Report (IPR)** Rob Whiteman invited Mark Mould, Peter Wilson and Fiona Hoskins to provide an initial introduction to the Trust's performance and key issues. Mark Mould highlighted the significant achievement by the Trust's people during the past year including less patients waiting and how long people waited having reduced. This was despite the industrial action, lost activity and a year of significant change. There had been services moves between the hospital sites and new facilities developed. Overall, the report highlighted the progress made. While there was considerably more to do, on behalf of the Board, it was important to thank the Trust's people and teams for all they had achieved in 2023/2024. Judy Gillow reinforced this, positively pleased when she had undertaken a clinical visit a few weeks prior and had looked at orthopaedic pathways at Poole hospital. She had been impressed with the staff, trying hard to improve pathways for patients and look at different ways of doing things. Presenting quality aspects in the IPR, Fiona Hoskins highlighted the positive progress in relation to patient feedback. In addition: • Care hours per patient day placed the Trust in a good position when benchmarked against other organisations. • Red flags were in the moment staffing concerns where patients, a member of the public or staff could raise a concern about the staffing levels. The Trust then had an opportunity to respond. All such flags had been mitigated. • While the materials referenced a new safeguarding practitioner commencing, unfortunately that person had withdrawn from the post. In relation to mortality, Peter Wilson outlined that this continued to improve, but the Hospital Standardised Mortality Ratio (HSMR) was quite volatile. Through the strategy deployment review process within the Care Groups, each Care Group was looking at its mortality. Deep dives were commencing in areas where there were perceived to be issues. He outlined a particular issue in relation to coding on palliative care and the impact that would have on HSMR if it were removed.

	Peter Wilson also highlighted that LERNs were being moved onto the Learn from Patient Safety Events (LFPSE) system. Commending the positive progress, Rob Whiteman asked Mark Mould, as he had done at Quality Committee, for a flavour of what more there was to do and a summary of what the Trust most wanted to achieve in the months and year coming forward. In response to this, Mark Mould referenced: • A more joined up place to work, with Patient First providing a springboard for that. • Decision making moving forward on quality, finance and operations being together at the same pace and with the same priority. This would, though, bring some challenges. • Continuing to build on the performance in 2023/24 and landing the reconfiguration well. Siobhan Harrington expressed an aspiration to achieve the best performance possible in relation to urgent and emergency care and being in the top decile for the staff survey and patient survey. Pete Papworth presented the financial aspects from the IPR. Judy Gillow commented upon the positive year end result from a financial perspective, while balancing this with the importance of how this was communicated within the Trust to continue to galvanise people to contribute to savings. This would be key in the coming year to achieve the financial challenge. Pete Papworth referenced that this discussion had taken place among the Executive Team and at the Trust Management Group. More focus on discussion of the recurrent underlying deficit rather than the in-year position was needed. Also, a focus on the medium term financial plan and the financial plan associated with the reconfiguration. Rob Whiteman commented that he was reassured to hear that Peter Papworth considered the Trust was building its capability to build recurrent cost improvements and enquired whether there was anything that Pete Papworth needed from the Board or colleagues to deliver. Responding to this, Pete Papworth confirmed that he was optimistic that the position was moving in a positive direction. However, the financial challenge was considerable. A plan to fully deliver everything that needed to be achieved to get to the break even position was not yet in place, but the numbers were improving. He considered that he had the support he needed from the Executive Team through Siobhan Harrington's leadership and Patient First. Going forward, there may be changes to risk appetite needed to deliver within the Trust's financial plan. These would go through the quality impact assessment process. Referencing the multiple discussions that had taken place at the Finance and Performance Committee about achieving the budget and focusing upon the medium term, John Lelliott emphasised that it was important to understand and create a framework for difficult decisions to be taken. This included the financial implication of decisions to keep escalation beds open, but also the financial information being received. Adding to this, Richard Renaut explained that the ask was to take 5% out of operating costs, improve the productivity by 5% at the same time and manage a large number of cost pressures. The size and scale of the ask was extensive. Pankaj Davé commended the approach by the organisation of doing the right thing by patients, for example, opening up unfunded beds despite the associated financial pressures that created. However, this did create challenges.

	Siobhan Harrington commented upon the opportunity for waste reduction if standard models were driven across the organisation. However, there were also issues that needed to be resolved by working across Dorset together. The Board NOTED the Integrated Performance Report.
BoD110/24	**Quality Committee – Chair's Report – March and April 2024** Rob Whiteman introduced the Committee Chairs assurance reports, Cliff Shearman, Chair of the Quality Committee, outlined that: • The Quality Impact Assessment had been discussed at the most recent meeting of the Quality Committee, although there was more work to be undertaken in relation to it. This would therefore be coming back to the Board in future. • He considered that there had been a considerable change in the Quality Committee. This included with the quality of the reporting having improved as well as there being more honest and open discussions. There was also increased time for discussion. • At the March 2024 meeting, the Learning Disabilities Mortality Review had been presented. At the time, there was an article in the media which had caused concern. The report presented had been positively re-assuring, looking at people with learning disabilities who had passed away in the organisation and the learning. • The Patient Led Assessment of the Care Environment had also been received, with extremely positive outcomes. • At the April 2024 meeting, the Committee had considered in some detail: o The IPR, with the Committee being impressed, considering the pressures, with the performance. Fractured neck of femur had continued to improve. o An update in relation to the Electronic Patient Record, with the organisation carrying some risk until this was embedded. However, the mitigations had been considered. o The mortality report had been received, which went into detail about the reporting mechanisms, coding systems and inclusion of palliative care. This gave strong assurance about the data and the improvement being seen. o The CQC update was provided monthly, following the CQC visit. There had been a robust discussion, with most of the actions now having been addressed. o The National Standards for Healthcare Food and Drink report had showed an improvement in all of the eight key performance standards. <u>Maternity Safety Champions Report</u> Lorraine Tonge presented the Maternity Safety Champions Report. Judy Gillow had concluded her maternity safety walkabout. She had attended the Maternity Champions meeting and triangulated some key alert areas by speaking with staff. The senior staff and staff in the clinical areas that she attended were very focused upon improvement areas and seeking to get consistency; with an example being in translating to serve the needs of the mother. She had been impressed with their motivation and enthusiasm to improve. In response to a question from Sharath Ranjan about the maternity incentive scheme, Lorraine Tonge confirmed that six out of thirteen in the south west had achieved the standards in year five. Alterations had been made in year

	six, which looked more promising. The mid-point would be known in July 2024. Mortality Report Peter Wilson confirmed that he did not have anything to add to the earlier presentation but was happy to receive questions. Quality Impact Assessment report Siobhan Harrington explained that this was being withdrawn from the meeting as the detail was discussed at the Quality Committee the previous week, but the cost improvement programme plans were still being finalised. Cliff Shearman added that it was a detailed report, with Fiona Hoskins working on it further to refine the usage. The Board NOTED the Quality Committee Chair's Report, Mortality Report and the Maternity Safety Champions Report.
BoD111/24	**People and Culture Committee – Chair's Report – April 2024** Pankaj Davé outlined the reports that had been presented to the Committee, a number of which were on the agenda for discussion at the Board meeting. Echoing Cliff Shearman's comments about the increased efficiency at the Quality Committee, he reflected that this was also the case for the People and Culture Committee. He highlighted that: • One of the key risks related to retention and recruitment of staff. Tina Ricketts and her team were undertaking more work to address that. • Tina Ricketts was also leading efforts on agency spend improvements. • Mental health was becoming more of an area of challenge for both staff and patients. • The Committee had received a report in relation to the current leadership and talent programme, with this having been linked to Patient First. • Good progress was being made on the Sexual Safety Charter with a further update to be provided at the next meeting of the Committee. Guardian of Safe Working Hours Report In the absence of the Guardians, Peter Wilson presented the report. He emphasised that doctors in training were encouraged to put forward exception reporting, particularly if they believed it related to patient safety. All patient safety concerns had been mitigated; this had been reflected in surveys coming through from the GMC. There would be three deputy medical education directors within the Care Groups - apart from education, they would support rota co-ordinators in relation to safety. He considered that there was now a strong junior doctors' forum - he and the Deputy Chief Medical Officer attended this regularly. The Board NOTED the People and Culture Committee Chair's Report and the Guardian of Safe Working Hours Annual Report.
BoD112/24	**Finance and Performance Committee – Chair's Report – March and April 2024** John Lelliott presented the Finance and Performance Committee Chair's report, noting: • As discussed earlier in the meeting, the progress in relation to finance and operational performance. The focus now would be upon looking forward. • Not only was revenue important, but also the capital aspects, particularly concerning the transformation.

	• Especially in relation to Estates, the quality of the reporting had improved. The implications of the Build Safety Act had been noted and which could impact on some of the Trust's capital programmes. • The Committee had discussed Wessex Fields; Build Ready and Service Ready in the context of the transformation; Digital; and the Annual Accounts. <u>Annual Plan</u> Richard Renaut outlined that the Annual Plan had been developed and discussed with the Council of Governors and the Board. Feedback had been received through Governors and others, which had been incorporated or explanation provided where the context of the questions was quite specific. The Annual Plan was being presented and would be shared more widely. Efforts would be made to align around the five objectives. The Board NOTED the Finance and Performance Committee Chair's Report and the Annual Plan.
BoD113/24	**Population Health and System Committee – Chair's Report – March 2024** Rob Whiteman explained that Helena McKeown was on a fundraising expedition and the report would be taken as read. The Board NOTED the Population Health and System Committee Chair's Report.
BoD114/24	**Audit Committee – Chair's Report – 'April 2024** Judy Gillow presented the Audit Committee – Chair's Report, adding that: • Particularly with changes to reporting including a more streamlined IPR, confidence in data quality would be important. It had been agreed that this would be on the Annual Audit Plan. • The Annual Audit Plan had been approved, with some areas to be added. These included Service Ready and Capital Funding. A request was made for a review of whether IT infrastructure or parts of it should be included in the plan. • A number of reports were considered and endorsed with a recommendation to the Board to approve. These included the draft provider licence compliance report, the Code of Governance compliance report, draft annual governance statement and going concern. The Board NOTED the Audit Committee Chair's Report and APPROVED the annual certificates.
BoD115/24	**Transforming Care Together – Chair's Report – April 2024** Rob Whiteman explained the purpose of the Transforming Care Together Group highlighting that: • Build Ready was in a good position. • There were discussions about the rationalisation of the estate and assumptions being made about the ability to use some buildings for warehousing. It would be important to look at the detail of all items being reflected in plans including the budget. • In relation to Service Ready, bids for resources which were not necessarily consistent with the funding assumptions with the Clinical Service Review were being seen. It was important to be clear on those cases where there may be resource requirements and those where greater efficiencies needed to be seen.

	There had also been a discussion about the need for proactive communications in the run up to people being asked to move. It was important to have the capacity to deliver all of the change. A positive paper in relation to horizon scanning on parking had been received. This included options related to how parking issues may be alleviated. Richard Renaut confirmed that there would be linkage with the Council of Governors and others to inform and engage in relation to those options. The Board NOTED the Transforming Care Together Group Chair's Report.
BoD116/24	**Staff Survey** Presenting the Staff Survey results, Tina Ricketts outlined that these had been considered in detail at the People and Culture Committee. Thanking her for the report, John Lelliott noted that one of the lower elements related to individuals being able to make improvements in their area of work. He raised concern with this, given the discussions earlier in the meeting about the need for efficiencies. Tina Ricketts responded by explaining that this was a potential consequence of people not feeling empowered to make changes; Patient First would help to address this, which would change the culture of the organisation. Siobhan Harrington commented that she had attended the session where the survey providers gave feedback, highlighting that the Trust should be proud of the results. Rob Whiteman praised Siobhan Harrington for leading from the front in relation to the Staff Survey. Adding to this, Peter Wilson gave an example from his recent visit to the intensive care unit of how change and staff engagement was being managed with Patient First huddles. Cliff Shearman enquired about how the results could be used at a more granular level going forward and about the proposed change in approach for those groups that had not contributed as widely. Responding to this, Tina Ricketts confirmed that the results showed a fairly consistent level of response to a percentage of the staff group in the organisation. She considered the heatmap to be an important tool as this showed individual team and service area results to help facilitate conversations. Line managers would be encouraged to use these to help inform local team meetings, discussions and action plans. She also explained the assurance that would be received through the Patient Frist strategy deployment reviews. Additionally, she would be putting in place a culture steering group with representation from various stakeholders across the organisation. The Board NOTED the Staff Survey Report.
BoD117/24	**Gender Pay Report** Tina Ricketts presented the Gender Pay Report, including actions to be taken to improve. The Board NOTED the Gender Pay Report.
BoD118/24	**Freedom to Speak Up Guardian Report and Strategy** Helen Martin presented the Freedom to Speak Up Guardian Report and Strategy, including an infographic. Thanking Helen Martin for the report, John Lelliott enquired about the level of seniority of individuals where there were complaints, noting the importance of tone from the top. She outlined that this would be collected over the coming months as well as the underlying attitudes and behaviours.

	Judy Gillow enquired about how middle managers could be supported with coaching and mentorship. Tina Ricketts outlined that a refreshed management and leadership development plan was being worked upon. Work was also being undertaken on a behaviour framework. It would also be important to have a charter, explicit for patients, public and visitors about behaviours expected on the Trust's sites. Siobhan Harrington updated the Board on the recent national appreciation of administrators. At relatively short notice, a webinar had been organised by the Trust, with 254 members of staff joining for an hour and people really speaking up. The Board NOTED the Freedom to Speak Up Guardian Report and APPROVED the Freedom to Speak Up Strategy.
BoD119/24	**Fit and Proper Persons Policy** Yasmin Dossabhoy presented the Fit and Proper Persons Policy, adding that further work was in progress in relation to the Leadership Competency Framework. The Fit and Proper Persons Policy was APPROVED by the Board.
BoD120/24	**Independence of Non-Executive Directors; Register of Directors' Interests; Membership of Board Committees, Board's balance, completeness and appropriateness statement** The Board APPROVED: • Independence of Non-Executive Directors; • Register of Directors' Interests; • Membership of Board Committees; and • Board's balance, completeness and appropriateness statement.
BoD121/24	**Any Other Business** No further items were raised.
BoD122/24	**Reflections on the meeting** Rob Whiteman commented that it had ben a good meeting and thanked everyone for their contributions, summarising the discussions.
BoD123/24	**Questions from the Council of Governors and Public arising from the agenda** No questions had been received from the Council of Governors or members of the public.
BoD124/24	**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. There being no further business, the meeting was closed.
	The date and time of the next Standing Board of Directors Part 1 Meeting was announced as Wednesday 3 July 2024 at 9:30 via Microsoft Teams.

CHIEF EXECUTIVE'S REPORT
JULY 2024

As we emerge from another round of industrial action, my first thought, as ever is our staff who continue to work to keep our patients safe during these periods and to support their colleagues. I would like to thank them for their continuing resilience. The country is about to go to the polls and decide on the next government on 4 July which will potentially have an impact on the NHS whichever party is elected. We are already through our first quarter of 2024-25 and continue to work to meet our contracted obligations whilst managing challenging activity levels and financial targets, there is significant work ongoing to ensure that we again achieve our plans.

We are now in full summer and whilst the weather has not been as reliable as we expect in the sunny south, I am enjoying being in such a beautiful part of the country. I encourage my colleagues across the Trust to embrace that local beauty and aim to achieve a good work life balance during these coming months.

1. NATIONAL UPDATES

Martha's Rule

1.1 143 hospital sites across the NHS will test and roll out Martha's Rule in its first year. I am pleased to report that UHD is one of the sites who have adopted the rule. The purpose of Martha's Rule is to provide a consistent and understandable way for patients and families to seek an urgent review if their or their loved one's condition deteriorates and they are concerned this is not being responded to.

The scheme is named after Martha Mills, who died from sepsis aged 13 in 2021, having been treated at a London hospital, due to a failure to escalate her to intensive care and after her family's concerns about her deteriorating condition were not responded to. We are very happy to be chosen as one of the Trusts who has committed to providing this additional safety process for our patients and their families.

Infected Blood

1.2 On 20 May 2024 the National Infected Blood Inquiry Report was published. This long-awaited report identifies the key failings and lessons to be learned for the future. The level of suffering and loss identified in the report is very distressing to anyone who works within the NHS and my heart goes out to the families who suffer and continue to feel the consequences many decades later.

2. DORSET

Five-Year Forward Plan – Refresh

2.1 The five-year forward plan has been refreshed and updated at the beginning of June ICB meeting and will be published shortly.

Operational Plan 2024-25

2.2 Our Dorset ICS operational plan for 2024-25 has now been reviewed by NHS England and following a detailed and constructive meeting, has been accepted subject to some minor amendments. Most notably, this includes a marginal improvement to the financial plan following final confirmation of the Elective Recovery Fund thresholds

resulting in an ICS aggregate planned deficit of £20 million.

Electronic Health Record (EHR)

2.3 The Outline Business Case for the Dorset and Somerset Electronic Health Record has been completed and approved by all organisations Boards. This will be submitted to NHS England to commence the regional review and recommendation on for national and Cabinet Office approval which is expected by October.

FBC Approval

2.4 The new hospital program business case has been formally signed off and the Memorandum of Understanding setting out the details has been agreed. This was completed prior to the dissolution of Parliament. Works have started, most visibly in the demolition of the old kitchens on the Bournemouth site to make way for the new ward block.

Provider Collaborative

2.5 The Dorset Provider Collaborative met on 12 June 2024. Four areas of focus were:

- Community Ophthalmology Services and Ophthalmology Surgery Capacity (cataracts)
- Shared services: procurement
- Pan-Dorset bank services
- Acute networking.

3. QUALITY & SAFETY

Royal Bournemouth Treatment and Investigation Unit (TIU)

3.1 TIU Bournemouth merged with TIU Poole on 1 June 2024, moving to Lilliput ward on the Poole site. This strategic move is part of our commitment to enhancing services and optimising patient care. Consolidating our TIU services at Poole Hospital is designed to streamline access to care - with the entire TIU team available to support patients seamlessly throughout their treatment.

While we recognise that this relocation may pose some inconvenience to some patients, we believe that the benefits far outweigh any temporary disruptions. The consolidation will result in an expanded and improved workspace, fostering a better working environment for both patients and staff. This initiative is an integral part of a larger transformation and development programme aimed at elevating healthcare standards in the region. We are working with patients to ensure we have listened to concerns and addressed any specific issues around access to care.

Urgent and Elective Care

3.2 We have seen an ongoing improvement in our delivery of the 4–hour organisational safety standard which has moved the trust from being in the 4th quartile of all acute trusts, to the 2nd quartile for which the trust received a financial reward for the most improved organisation and we remain on track against our planned trajectory. This was achieved by maximising streaming opportunities to the Urgent Treatment Centre,

together with a focus on rapid assessment for walk in patients which has contributed to an increase in non-admitted performance from 61% in December to 72% in May. Admitted performance has also improved by sustaining a reduction in bed occupancy as compared with Q4 2023-24.

Despite no material reduction in the number of patients who no longer meet the criteria to reside (NCTR), we managed to de-escalate and reduce the number of beds in use as planned, which is a critical enabler in progressing some of the ward reconfiguration plans that are currently underway.

In relation to planned care, we are continuing to deliver an increase in the elective activity provision for patients compared to the baseline period (2019/20). We estimate delivery of above 103% in both April and May 2024, which will enable access to Elective Recovery Funding (ERF) to support action on reducing the waiting list. Care Groups have developed plans to further increase elective activity up to 109%, by maximising productivity and opportunities to increase internal capacity, together with expansion of appointments and treatments through our insourcing independent sector providers.

We have achieved a reduction in our longest waits, with just 11 patients remaining on the waiting list at the end of May with a wait greater than 78 weeks and a plan to eliminate waits over 78 weeks by the end of June 2024. Cancer performance also improved in May 2024 with the Trust performing above the national 28-day Faster Diagnosis Standard and in the latest nationally reported performance data the Trust was the highest performer for the 31 d standard. Our focus on cancer is on achieving these standards consistently and on improving the time to first treatment (62-day standard).

Right Place, Right Person

3.3 Right Care, Right Person is an approach designed to ensure that people of all ages, who have health and/or social care needs, are responded to by the right person, with the right skills, training, and experience to best meet their needs. The approach focuses on the interface between policing and mental health services. We have been working with Dorset Healthcare to review the care offered to patients who have a mental health condition given the changes in police support outlined in the document. A new model of care is being developed and the legal aspects around providing that care is being investigated.

Human Tissue Authority (HTA) Inspection

3.4 The HTA carried out an inspection of our mortuaries in Poole, Bournemouth and Christchurch on 9 and 10 May this year. The report following the inspection unfortunately found some significant shortfalls. We take the findings of this report very seriously and have already completed several of the actions required. We are working hard to complete the remaining actions. We will respond to the HTA through the creation of a Corrective and Preventative Action (CAPA) plan and will also share this with our Trust Board.

4. FINANCE

4.1 The Trust has a very challenging financial plan for the year, which whilst balanced, requires a 5% efficiency saving, a 30% reduction in agency expenditure and an increase in elective activity to deliver 109% of 2019-20 outturn levels in aggregate

across the year. This must all be achieved within 20 funded escalation beds.

At the end of May the Trust has reported a deficit of £3.5 million being £0.1 million adverse to plan. This reflects a continued reliance on escalation capacity above the 20 funded escalation beds, and agency staffing to support the enhanced needs of our patients (albeit the latter is reducing month on month). Good progress is being made in the identification and delivery of efficiency savings, which is positive, however there remains a significant gap between the full years' savings forecast and the budget requirement.

5. TRANSFORMING CARE TOGETHER

Rheumatology

5.1 Rheumatology is now being provided by a single pan-Dorset 'Dorset Rheumatology Service', with UHD being the sole provider. UHD has taken on the clinics currently provided by Dorset County Hospital, and the locations in the west will continue to run as normal.

UHD will operate a single referral point and will manage a single waiting list with all patients being entered on to the relevant UHD systems. There are no changes to the way the service currently operates in Poole, Christchurch, and Bournemouth.

Stroke

5.2 In June colleagues came together to celebrate the handover of the new enhanced stroke unit. The unit brings all the team together for the first time, in a facility that has more beds, improved facilities and office space. Having the service on one site is already making improvements in patient care, particularly in reducing the average length of stay for patients.

6. CYBER INCIDENT

6.1 In early June, the Trust experienced a cyber security incident. Whilst due to the immediate action taken, this did not cause any outages to our digital systems or impact upon patient care; it could have been devastating.

The Trust has worked very closely with the National Cyber Security Team and in addition to the immediate actions that have already been taken, a suite of further improvement actions have been identified that will now be progressed.

7. PATIENT FIRST

7.1 We have recently celebrated the completion of the second wave of Patient First training and are in the process of videoing trainees sharing their experience of the course. A further three cohorts of trainees have begun their training. The course itself has been reduced in length following feedback from trainees and senior managers. Care Group staff are being offered the opportunity to visit other trusts where Patient First has been in place for some time and a Patient First Leadership Conference is being planned for 6 September.

8. WORKFORCE

Chief Digital Officer

8.1 The recruitment process for the Chief Digital Officer is now live. The advert can be found on NHS Jobs here:

https://www.jobs.nhs.uk/candidate/jobadvert/C9153-24-0664?searchFormType=main&keyword=Chief%20Digital%20officer&language=en

Non-Executive Opportunities

8.2 The Trust is also recruiting two non-executive director roles. Further details can be found on the following link:

Non-executive opportunities in the NHS » University Hospitals Dorset NHS Foundation Trust, Non-executive Director x2 (england.nhs.uk)

Fiona Hoskins – Deputy Chief Nursing Officer

8.3 This month sees Fiona Hoskins, Deputy Chief Nursing Officer leave the Trust to become Chief Nursing Officer at Milton Keynes University Hospitals NHS Foundation Trust. We would like to congratulate Fiona on her new and to thank her for covering the gap between Sarah Herbert joining and Paula Shobbrook leaving.

Workforce Plan

8.4 As at month 2 we are ahead of our workforce plan by 138 whole time equivalents and have made good progress in reducing our reliance on the temporary workforce with 170 less bank and agency workers used since 1 April 2024. We are on schedule to reduce our rate cards for nursing and midwifery to below the required cap by the end of June 2024 and are seeing month on month improvement in the use of off framework agency for this staff group. The Chief Medical Officer is leading the work on medical bank and agency through our contract with Locum Nest.

Too Hot to Handle

8.5 The national Too Hot to Handle report on racism captures the experiences of over 1300 staff when trying to raise racism within the NHS. It brings together the findings from Employment Tribunals as learning for the NHS in the failings as to how organisations respond to racism and draws on wider research about the experience of staff raising concerns. The report makes recommendation on what the NHS can do to be more intentional and to take racism seriously.

- The key findings of the report are as follows:
- That racial assumptions and stereotypes are widespread
- There is a lack of development opportunities for colleagues from a global majority background
- Relationships with colleagues are often littered with micro-aggressions – including scrutiny by managers
- There are barriers to raising concerns and a minimisation of issues raised

- There is limited support from those who are there to offer it including Freedom to Speak Up Guardians, HR and Trade Unions

- The findings from staff experience are consistent with the learnings from employment tribunals.

The Trust Management Group discussed the report at our meeting this month and committed to:

1. Talk regularly about racism to increase levels of competence and understanding.

2. Act upon all concerns raised (informal and formal).

3. Participate in ongoing development and to be active members of the staff diversity networks and to participate in the See Me First and Reverse Mentor programmes.

4. Set out expected standards for patients, the public and colleagues in a behavioural charter (currently in development).

5. Be proactive and preventative – look for racism - don't wait for individual staff to raise it.

Annual UHD Staff Awards

8.6 The UHD Awards was held on 20 June at the Pavillion in Bournemouth. From over 800 nominations a shortlist for the 14 categories was agreed by a multidisciplinary panel. The awards continue to go from strength to strength. I am so pleased to see how staff engage with the process of nominating their colleagues in recognition of the work they do and the extra mile they give.

9. JULY CAMPAIGNS AND EVENTS

- Alcohol Awareness Week

- South Asian Heritage Week

- UHD Cultural Celebration 24 July 2024

  As well as celebrating all the wonderful cultures that make up #TeamUHD, with the help of our staff networks, we will also be highlighting the diversity and individuality of our colleagues and their impact across UHD with an exciting line up of story sharing, dancing, music and entertainment.

  We look forward to an opportunity to celebrate, connect and collaborate with our colleagues.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

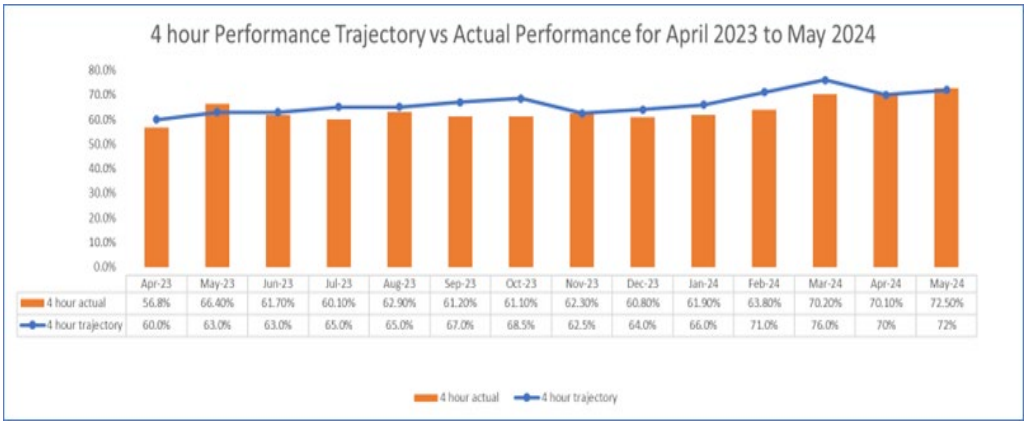
Meeting Date: 03 July 2024

Agenda item: 8.1

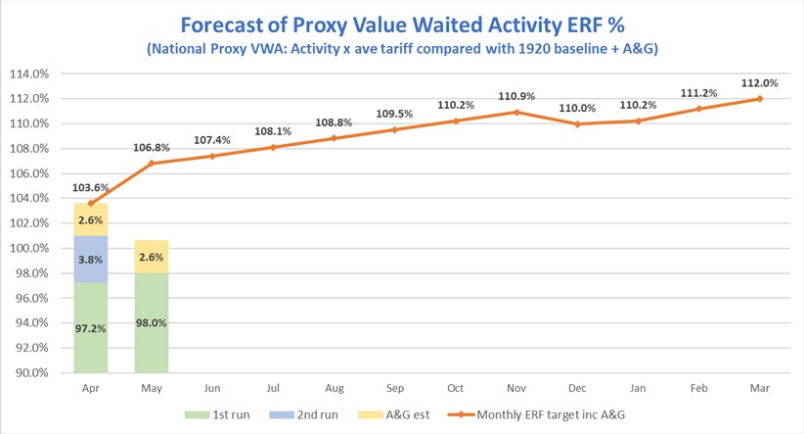
Subject:	Integrated Performance Report (Safety, quality, experience, workforce and operational performance)
Prepared by:	Executive Directors, Leanna Rathbone, Judith May, David Mills, Fiona Hoskins, Dr. Matthew Hodson, Irene Mardon, Jo Sims, Andrew Goodwin
Presented by:	UHD Chief Officers

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 for May 2024 - Appendix A
Purpose of paper:	Assurance
Executive Summary:	At the end of May 2024 the Trust has reported a deficit of £3.476 million against a planned deficit of £3.350 million, resulting in an adverse variance of £0.126 million. In month as part of the planning re-submission, the additional ERF target income to deliver 109% has been re-phased to commence in July 2024, rather than in April 2024. Emergency Department (ED) attendances and conveyances increased in May versus April 2024, as well as remaining significantly higher than May 2023. Despite this, meantime and time to decision remained relatively static and performance continues to improve increasing to 72.5% of patients admitted or discharged within 4 hours. No Criteria to Reside (NCtR) has also seen improvement during May with the average reducing to 189 (from 200 average in April). The Trust has an agreed capacity plan for 2024/25 that was shared with the Trust Management Group in May 2024 and is now being implemented with a focus on remaining within the core funded bed capacity. A reduction in length of waits for elective care continues to be delivered. 11 patients remained with a wait > 78 weeks at the end of May. >65 week waits

	increased in line with the re-forecasted operational plan trajectory, however there is an underlying reduction in the total Referral To Treatment waiting list and waits over a year. A deterioration in Cancer Faster Diagnostic Standard performance in April 2024 has been recovered in May 2024 and 62 day cancer performance exceeded the April planned trajectory. On 5 June 2024, the Trust was notified by NHS England of the outcome of a segmentation review for Quarter 4 – 2023/24 under the NHS Oversight Framework. The outcome agreed was that UHD would remain in segment 3 for Quarter 4, 2023/24. This was based on the following Oversight Framework metrics: • Elective (78 week waits) • Quality (Maternity Safety Support Programme) • Finance (Efficiency, Stability, Agency Spend) The next segmentation review will take place after the end of Quarter 1 – 2024/25. The future NHS Oversight framework is currently under national review.
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 linked to the Trust Strategic priorities and the Trust refreshed SDR process. • Providing SPC training to operational leads who compile the narrative against the data included within the report. ***We recognise as a Trust Board that behind every single metric discussed in this paper there is a patient.***
Urgent & Emergency Care (1 Assure)	**Strategic goal: To meet the patient national constitutional standards for Planned and Emergency care supporting reducing inequalities in outcome and access and improving productivity and value.** **Assure (1): Performance against the 4-hour standard for May 2024 is 72.5% against an internal trajectory of 72% and a year-end target to achieve 78% by March 2025.** • The Trust met its internal trajectory in May 2024 at 72.5%, against a target of 72%. (Type 1 and Type 3 attendances). • As a department, non-admitted Type 1 performance improved in May to 72%. • The total number of handovers that were over 60 minutes increased in May 2024 to 277, but the trend shows normal variation. This is 6.3% of the total ambulance handovers and a sustained improvement from the winter period November 2023 - January 2024.

	The IPR provides detailed performance against the national Urgent & Emergency Care standards.  The Trust's trajectory for 24/25 has been submitted with the national requirement to see a performance increase to 78% from 76%. Improvement Actions: • Review of work plan following improvement across quarter 4 in 2023/24 to ensure the department has clear steps to meet the national push and stretch target in 2024/25 of 78%. • Further improvement in UTC service provision cross-site is ongoing with slot utilisation and direct streaming from ED. In May 2024, we saw an increase in the number of patients streamed to 2104 from 821 in April. • The revised fortnightly UEC Programme Board is using the patient first methodology and reports to Trust Management Group. Engagement and plans are being monitored. A suite of metrics is in place. **Key areas of focus remain:** 1. **Clinical Workforce capacity:** Improving capacity in our Ambulatory Care Area (ACA) 2. **Senior clinical assessment** – Continued focus on supporting and increasing senior decision-making capacity (Triage & RAT) 3. **Reduce time in ED, with senior leaders escalating** so the flow blocks are removed – professional standards / culture. 4. **Signposting to alternatives**: Slot utilisation and direct streaming from ED to UTC & SDEC. 5. **Work with system partners** to improve attendance/admission avoidance and timely discharge and capture of all the programmes of work.
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) Ongoing challenges with occupancy and flow are resulting in escalation beds/spaces open and a number of beds occupied by patients with No Criteria to Reside.** The largest factor driving occupancy remains patients with No Criteria to Reside (NCtR) who occupy acute hospital beds at UHD. No Criteria to Reside (NCtR) has seen improvement with the May 2024 average of 189 (compared to 200 in

	April). The Trust bed capacity plan was signed off at Trust Management Group in May with a number of planned changes to improve utilisation of bed capacity. **Improvement Actions:** Focus continues on 5 key actions aimed at improving pathways for patients ready to leave hospital. This is being progressed at a Place level within the Dorset system, with UHD working closely with BCP Local Authority. This work gained momentum through April 2024 and continues into May. There are key workstreams at UHD to support improved processes. • Effectiveness of Transfer of Care Hub at each site with partners to facilitate improved discharge planning and transfers. • Use of the EDD (Estimated Date of Discharge) as a proactive planning tool. • Continuing work with Poole trauma wards in embedding a process that removes a significant number of steps in progressing a patient to a community rehabilitation bed; this is now being rolled out to older persons wards. • Focus on patients waiting over 21 days with a criteria to reside to make sure that we have optimised the patient pathway for these group of patients. Further internal actions are in place to continue to optimise discharges operationally daily, measured through the UEC Programme Board.
Referral to Treatment (RTT) (3 Advise, 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.** **Advise (1): Forecasted elective activity delivered in May 2024 is 104.4% of the 2019/20 baseline.** National data on elective activity levels in 2024/25 is not yet available. A Trust forecast of proxy value waited activity has been made based on actual activity values multiplied by an average tariff. Advice and Guidance using average value of 2.6% has then been applied, as outlined in the graph below. An initial 'first run' of the data after month end signals in May 2024 an increase in activity compared to April (98% versus 97.2% in April). A 'second run' following the outcoming process of treatments/clinics is expected to increase this position by a further 3.8% (based on April uplift after 2nd run). The resultant forecasted position is 104.4% in May 2024. Internal activity plans are in place to increase this further as we move through the year.



Assure (1) The Trust has delivered a reduction in the Referral to Treatment waiting list in May 2024.

Advise (2) A reduction in RTT waits greater than 78 weeks has been delivered, but not yet eliminated and while there was a marginal increase in >65 week waits in May 2024, this remains in line with the agreed trajectory.

- RTT waiting list has reduced in May to 68,343 and has been reflected in the resubmission of the operational plan trajectories.
- 11 patients with a wait greater than 78 weeks remained at the end of May 2024.
- 65 week wait reduction remains in line with the operational planning trajectory.

Planning requirement	April 24	May 24	
Referral to treatment 18-week performance	63.0%	62.4% ▼	National Target 92%
Eliminate >78 week waits	22	11 ▼	Plan Trajectory 0 (Excl. IA)
Eliminate >65 week waits	335	393 ▲	Plan trajectory 393 May 2024 (Excl. IA)
Reduce >52+ weeks	2,813	2,960 ▲	Plan Trajectory 3,119 by May 2024 (Excl. IA)
Stabilise Waiting List size	70,012	68,343 ▼	Plan Trajectory 68,343, May 2024 (Excl. IA)

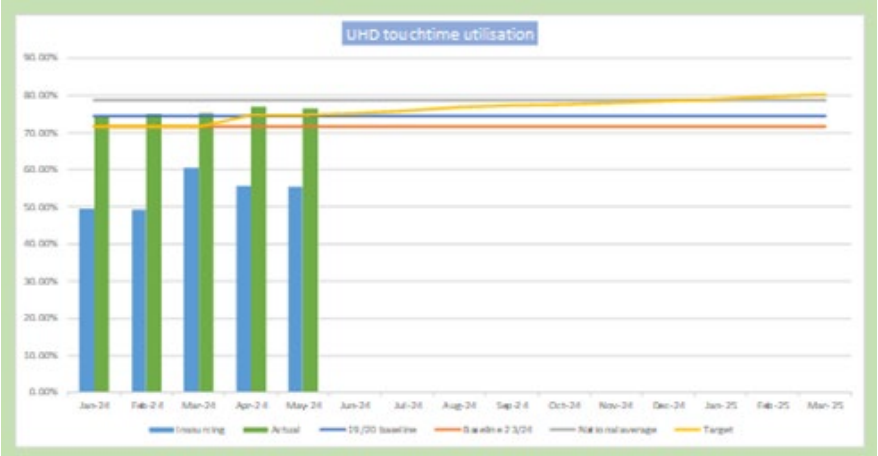
The Planned Care Improvement Group is using the patient first methodology to deliver improvement and reports to Trust Management Group. To conclude the interventions designed through the Intelligent Workflows (process mining) project in Outpatients.

Key areas of focus

- Prioritising patients at risk of breaching >65 weeks before September 2024 to eliminate these waits, with actions in place to ensure all patients in this group have attended a first outpatient appointment by 30 June 2024.
- Increasing elective activity.
- Delivering on productivity improvement plans for outpatients, theatres, endoscopy, length of stay and radiology.

Theatre productivity:

- Capped utilisation rates have increased in May for both main theatres (75%) and day case theatres (74%). The overall utilisation rate is above the agreed trajectory as shown below.
- The Trust's trajectory for 2024/25 is to deliver 80% by March 2025 and is in line with the national guidance to achieve an increase of at least 4% from the current baseline.



Improvement actions:

- **Increase booking of lists:** Early results of booking lists to 105% across a range of specialities has reduced late starts by 20% in the first week of implementation, and decreased turnaround times between cases.
- **Focused action in Orthopaedics:** Orthopaedics has a utilisation rate below 70%. All other specialities are performing above this benchmark.
  Improvement actions are in place within orthopaedics and showing evidence of improvement, to:
  - **Reduce late starts** by improving the timeliness of sending for patients and reducing turnaround times between cases.
  - Increase the **number of patients per list** and **reduce early finishes** by booking to 105% of list capacity.
- **Commence 'Golden patient' process:** Commenced in June, identifying a 'Golden patient' to start lists is evidenced to reduce delays to operating lists and reduced last minutes changes to list planning, this in turn reduces patient safety events.
- Start **'New' Theatre planning** weekly, inclusive of focus on >65 week long waiters.
- Complete **Faster First Theatre** Anesthetic and perioperative handbook assessments.

Outpatient productivity

- A 30% reduction in missed appointments rates (Did not attends) has been delivered since April 2023. The current rate remains at 5.3% in May against a target of 5% and a baseline position of 7.6% in April 2023.
- 97.6% of all clinics have text reminders switched on or have been excluded for clinical reasons. This, alongside a DNA predictor trial is expected to support a further reduction DNAs and patient experience.

	Advise (3): Performance for time to theatre for fractured neck of femur (# NoF) patients has reduced in May 2024. • May 2024 performance for time to theatre for fractured neck of femur (#NoF) patients decreased, whereby 68% of patients achieved surgery within 36 hours of being fit for surgery and 51% of patients were operated on within 36 hours from admission. • Special cause variation has however not been triggered. • Overall trauma admissions increased in May 2024 with 403 admissions, including 97 with a fractured neck of femur (#NoF) (compared to 90 in April 2024). The Hand Hub commenced in March 2024 continues to be successful, operating 2 sessions per week with up to 14 patients through the service, releasing 10 main theatre sessions.
Cancer Standards (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) Performance against the Cancer Faster Diagnosis Standard (FDS) in April 2024 was finalised at 66.3%, which was an 8.9% decrease from March 24. Full recovery in May 24 is expected. An improvement was seen in the 62 day performance and a reduction in the >62 day back log was also delivered.** • 28-Day Faster Diagnosis Standard - Performance in April 2024 decreased to 66.3% but has since recovered in May to 76.2% (provisional). April performance was impacted by a high number of slot issues (lack of capacity) within breast, colorectal, gynaecology, head & neck and skin at the beginning of the month. • 31-Day standard - Performance in April 2024 decreased to 94.6%, not achieving the 96.0% threshold but since recovered in May to 96.1% (provisional). The main breach was due to skin surgical capacity. • 62-Day Standard - Performance in April 2024 decreased by 0.5% to 68.4% exceeding the trajectory of 67.1%. • Over 62 Days - The total number on the PTL over 62 days remained below the 220 target with 207 patients over 62 days at the end of April. Improvement actions are detailed within the IPR and include: • Additional clinics in Gynaecology in Q1 2024/25 continue in order to improve performance. • Additional intelligence being provided to the service relating to referral variations to inform decisions on capacity requirements allowing additional

KPI	Target	Jan 24 FINAL	Feb 24 FINAL	Mar 24 FINAL	Apr 24 FINAL	May 24 - Prov
28 Day Faster Diagnosis Standard	75%	72.5%	77.8%	75.2%	66.3%	76.2%
31 Day Standard	96%	93.6%	96.1%	96.1%	94.6%	96.1%
62 Day Standard	85%	62.7%	65.0%	68.9%	68.4%	64.8%

<table>
<tr><td></td><td>insourcing capacity to be planned in month to support increased demand and reduce the backlog.
• Additional activity in Q1 in Dermatology to support an increase in referrals alongside the expansion of the Skin Analytics pilot.</td></tr>
<tr><td>DM01 (Diagnostics report) (1 Advise)</td><td>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 DM01 standard has achieved 87.1% of all patients being seen within 6 weeks of referral; 12.9% of diagnostic patients seen >6weeks in April 2024.

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

<table><tr><th>May 2024</th><th>Total Waiting List</th><th>< 6weeks</th><th>> 6 weeks</th><th>Performance</th></tr><tr><td>UHD</td><td>13,100</td><td>11,407</td><td>1,693</td><td>12.9%</td></tr></table>UHD remains one of the top performing trusts for diagnostics in the southwest region. Nevertheless, there are challenges related to workforce capacity in Echocardiology, Neurophysiology and Radiology (imaging). Overall, the number of patients waiting over 6 weeks increased from 11.8% to 12.9% of patients waiting a diagnostic test.

Improvement actions are being delivered as detailed within the IPR, including the delivery of the Community Diagnostic Centre programme.</td></tr>
<tr><td>Health Inequalities (1 Advise)</td><td>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)
Waiting list by Index of Multiple Deprivation (IMD) The median weeks waiting at the point of treatment for people in IMD 1-2 shows no variation compared to people from IMD 3-10. Analysing the same data by age band identifies no variation between children (<18 yrs) and adults.
Waiting list by ethnicity: An analysis of the median weeks waiting by ethnicity grouping identifies a 1-week variation between patients within community minority groups and White British populations in Quarter 1 to date. This mirrors the variance in Q4 2023/24. However, the level of variation increases to 7 weeks for <18-year-olds from community minority groups.
A deep dive into ENT services to understand the variations in ‘did not attend’ rates by IMD group and ethnicity has commenced to understand the reasons for missed appointments which are a contributing factor to increased waits. Improvement actions are being designed to address unwarranted variation.
Emergency dept. attendances by Index of Multiple Deprivation (IMD)
Attendances are lowest in deprivation deciles 1-3.</td></tr>
<tr><td>Maternity (1 Advise)</td><td>Advise (1) There are 3 areas currently flagging as red RAG rated:

• 3rd /4th degree tears although within normal variance range.</td></tr>
</table>

	• Apgar <7 at 5 minutes-increased over last two months. • Prompt Training -below 90% compliance. Improvement actions are detailed within the IPR.
Infection Prevention and Control: (2 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) *Clostridioides difficile* cases**: There was one period of increased incident *of Clostridioides difficile* identified in May 2024 on OPAU (RBH), no cases linked by ribotype and enhanced measures stepped down. • **Advise (2) MRSA bacteraemia: T**here have been three cases of *Methicillin-resistant Staphylococcus aureus,* reported in month. Two of these cases were Hospital Onset Hospital Acquired and One Community Onset and Hospital Acquired. Our post infection reviews are being completed by each ward with IPC, with learning taken back to ward and supporting services, no obvious source of bacterium identified to date. • **Advise (2) Hospital Associated cases trend** **HCAI Trends by month** | Organism | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 | Apr-24 | May-24 | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | C Diff | 11 | 4 | 8 | 8 | 4 | 8 | 6 | 9 | 13 | 3 | 10 | | E Coli | 14 | 9 | 11 | 11 | 11 | 17 | 17 | 8 | 8 | 7 | 14 | | MRSA | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 1 | 1 | 2 | | MSSA | 4 | 4 | 5 | 5 | 4 | 3 | 3 | 6 | 6 | 4 | 1 | • It is noted that cases of *Escherichia coli* blood stream infections have risen during the month of May. IPC team have commenced their trend and case analysis to formulate improvement actions required. • The IPC celebrated World Hand Hygiene and Gloves Off day and supported the organisation with a number of awareness session and ward visits.
Clinical Practice Team ***(4 Advise)***	**Clinical Practice Team:** **Advise (1) Moving and Handling - Essential Core Skills** The challenges 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 progressed; with filming undertaken in January 2024. There have been unforeseen challenges which the team are working through to get this completed promptly, this continues. **Falls prevention & management**: **Advise (2)** The number of serious falls incidents in month has increased with 4 moderate and four severe incidents reported in month. These incidents are following the appropriate scoping and investigation process through the patient

	safety investigation framework. Current themes however identified include toileting and chair related falls and lying and standing BP not recorded. **Tissue Viability:** **Advise (3)** The ability of the service to meet the increased demand remains on the risk register entry 1821 and rated as 9 (moderate), the action plan has been updated. There remain a significant number of complex patients being referred to the service. The TVN team continue with temporary staffing to support this demand and have recruited an additional substantive Band 6 TVN to start in August 2024. **Advise (4) Pressure Ulcers:** There were six new category three pressures ulcers reported in month which are following the appropriate investigation process and learnings identified. The lead Tissue Viability Nurse therefore continues to work with care groups to review how ward learning is shared though the pressure ulcer screening tool following an incident and further development of ward improvement plans.
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 Experience and Engagement Team Overview:** **PALS and Complaints numbers for May 2024** **Advise (1) The number of open complaints over 55 days** continue to be prioritised within the complaints team and care groups and has continued to decrease with further measures to reduce the number of outstanding complaints commenced. **Advise (2) Friends and Family Test (FFT)** The volume of FFT being received has maintained prior to the Patient Experience Team and BI managing the SMS FFT Service. UHD has seen a sustained high satisfaction score. The Trust's overall positive score remains above the upper control limit. **Advise (3) Mixed Sex Accommodation Breaches** There were 11 occurrences of MSA in May 2024 in critical care – continued monitoring of areas is in place with care group matrons.
Nurse Staffing: (2 Advise, 2 Assure)	**Care Hours per Patient Day (CHPPD):** **Advise (1)** May 2024 CHPPD for registered nurses remained stable at 4.7 for Registered Nurses/Midwives, and 8.2 overall (including non-registered staff). **Red Flag Reporting:** **Assure (1)** Eleven red flags were raised in month for UHD. Of note, no red flags were raised within maternity services. All red flags were mitigated/resolved with no critical staffing incidents. **Workforce Controls:** **Advise (2)** Allocate Safe Care continues to be embedded for safe staffing oversight. Training continues around the importance of 'live' roster updates when staff are moved. This ensures accurate capturing of CHPPD at the twice daily audit points.

	Assure (3) Ongoing review shows no impact on care delivery or safety as a result of the current workforce controls.
Workforce Performance:	**Strategic goal: To significantly improve staff experience, engagement and retention**
CPO Headlines:	
HR Operations **(1 Alert, 1 Assure)**	**Alert – Industrial Action** - The British Medical Association ('BMA') have reported that Doctors in Training will take strike action for 5 days from 7am on 27 June 2024 to 7am on 2 July 2024. Plans are in place to mitigate the impact of industrial action. **Assure – Trade Union Facilities Time** – In line with the Trade Union (Facility Time Publication Requirements) Regulations 2017, the Trust is required to annually upload data on the Government's portal, detailing the paid time-off granted to trade union representatives to carry out trade union duties during working hours. This has been uploaded and will also be published on the Trust's website.
Occupational Health **(1 Advise)**	**Advise – Employee Assistance Programme -**The Employee Assistance Programme service for staff moved from Care First to VIVUP in May 2024. The new service has been launched across the Trust and further regular staff communications are planned.
Workforce Systems (1 Alert, 2 Advise)	**Alert – Job Planning –** To date 232 (35%) job plans have been completed on Healthrota, 420 (65%) job plans still need to be completed. We are working with Care Groups to meet the deadline of 30 June 2024. **Advise – Medical and Dental Rostering Project -** There are currently 337 (48%) Doctors in Training and Clinical Fellows on Healthrota e-rostoring system, 365 are remaining. There are currently 255 (39%) Consultants and SAS Doctors on Healthrota, 393 are remaining. **Advise – Mandatory Requirements –** The scoping of Disclosure and Barring Service (DBS) and Professional Registration data quality has started, and baseline reports have been run for review.
Resourcing (1 Alert)	**Alert – Newly Qualified Nurse** - Recruitment took place in May 2024 with 86 out of 110 candidates successful at interview. To date 34 offers have been made, 24 candidates are awaiting offer pending vacancy approval. 25 candidates remain with no vacant position identified to allocate currently. We are working will Care Groups to allocate the remaining candidates.

Temporary Staffing (3 Advise)	**Advise – Medical Locums** - The mandated use of Locums Nest for processing additional duties has supported the Trust with increased transparency of Locum use. Additional controls are being put in place from 1 July 2024 with the removal of 'Ad Hoc' timesheets from Locums Nest which will support the Trust with improved rate and demand controls, accurate cost code reporting, attracting new talent to the Trust through increased visibility and more accurate reporting on vacancy reasons. **Advise - Agency Price Cap** - Preparations are underway for the 3rd and final round of agency rate reductions to bring Nursing, Midwifery and Support Workers agency supply within pricing cap compliance, this final rate reduction will be applied from 1 July 2024 and is Dorset wide. **Advise – Off-framework Agency -** The Trust has continued its focus to eliminate off-framework agency supply by 30 June 2024 and is working closely with any areas that still have off framework usage and liaising with suppliers to source alternative supply methods.
Organisational Development ***(3 Advise, 1 Assure)***	**Alert – Appraisal compliance –** Appraisal compliance remains low with 58% of colleagues recorded as having an appraisal in the last 12 months. Care Groups and Corporate Directorates have been asked to improve performance, which will be monitored through the strategy deployment review meetings. **Advise - Appraiser Essentials training** - Sessions for line managers were launched in early June. This has attracted a high level of interest. **Advise - Quarterly Pulse Survey** – We received 1,726 responses to the April pulse survey with an engagement score of 6.22 (improved since January). Directorate results have been circulated to leaders. **Advise - Freedom to Speak up -** 85 staff have raised concern with the FTSU team during Months 1 and 2 of 2024/5. This is an increase of over 100% from the same period last year. The main theme is relating to processes and procedures including contractual issues, parking, education, non-clinical guidelines (34 staff; 40%). Attitudes and behaviors remain a strong theme with 34% of cases (29 staff) followed by worker safety and wellbeing (18 staff; 21%).
Trust Finance Position ***(1 Alert, 2 Advise, 2 Assure)***	**Strategic goal: To return to recurrent financial surplus from 2026/27** **Alert (1): Efficiency Improvement Programme** As at 31 May 2024; efficiency savings of £5.585 million have been achieved against a target £5.560 million. The risk adjusted forecast saving for the full year is £31.9 million against a target of £42 million leaving a potential shortfall of £10.1 million. Detailed countermeasures continue to be developed by Care Group and Directorate teams to mitigate this risk. **Advise (1): Revenue Position** At the end of May 2024 the Trust has reported a deficit of £3.476 million against a planned deficit of £3.350 million, resulting in an adverse variance of £0.126 million. In month as part of the planning re-submission, the additional Elective Recovery Fund income budget has been rephased to recognise a trajectory of improvement throughout the year. A detailed forecast is currently being prepared and will be reported to the Finance and Performance Committee in July 2024.

	Advise (2): Public Sector Payment Policy In relation to the Public Sector Payment Performance the Trust is currently delivering performance of 92.1% against the national standard of 95%. Training and support continues to be made available to support the timely approval of valid invoices. **Assure (1): Capital Programme** The Trust has reported capital expenditure of £15.7 million against a plan of £15.7 million. As part of the re-submission of the plan we were required to rephase the capital plan to match actual spend at the end of Month 2. **Assure (2): Cash** As at 31 May 2024 the Trust is holding a consolidated cash balance of £80.2 million which is fully committed against the future Capital Programme.
Key Recommendations:	Members are asked to note the content of the report
Implications associated with this item:	Council of Governors ☐ Equality, Equity, Diversity & Inclusion ☒ Financial ☒ Health Inequalities ☒ 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	18/06/2024	Meeting has not yet taken place at the time of submission of this report.
Finance & Performance Committee (Operational / Finance Performance)	24/06/2024	Meeting has not yet taken place at the time of submission of this report.
Quality Committee (Quality)	25/06/2024	Meeting has not yet taken place at the time of submission of this report.

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

University Hospitals Dorset
NHS Foundation Trust



Integrated Performance Report

Reporting month: May 2024
Meeting Month: July 2024

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Achievements

In 2024/25 the achievements to date have been

- Friends and Family Test (FFT) : We are seeing a sustained increase in the number of Family and Friends Tests (FFT) responses being received. The Trust overall positive score has been above the upper control for eight consecutive months and remains above the average score.
- In May a higher proportion of patients on a referral to treatment pathway were seen within 18 weeks compared to March 2023.
- No patients are waiting over 2 years for elective treatment and fewer patients are at risk of waiting over 78 weeks.
- The Trust delivered against its improvement trajectory for A&E 4 hour performance and Ambulance handovers delayed over 60 minutes continue to decrease.
- UHD continues to deliver strong performance for diagnostic (DM01) performance.
- All monthly breast screening and bowel screening targets have been successfully met or exceeded.

Performance at a Glance Indicators (1)

			standard	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
SAFE																	
Quality	Presure Ulcers (Hospital Acquired Cat 3 & 4)			8	9	5	11	8	7	16	17	15	10	11	12	7
	Inpatient Falls (Moderate +)			2	5	1	3	4	6	3	4	2	13	7	4	8
	Medication Incidents (Moderate +)			0	1	1	1	2	1	2	2	8	4	3	2	7
	Patient Safety Incidents (All)			1352	1355	1458	1446	1468	1381	1367	1278	1260	1187	1230	1181	1340
	Hospital Acquired Infections	MRSA		0	0	0	0	0	0	0	1	1	0	1	1	2
		MSSA		6	8	4	4	5	5	4	1	3	6	6	4	1
		C Diff		8	19	11	4	8	8	4	8	6	9	13	3	10
		E. coli		8	17	14	8	11	11	11	8	17	8	8	7	14
EFFECTIVE																	
Mortality	HSMR In Month (UHD)	Latest Jan 24	(source HED)	112.6	108.2	110	113.8	103.4	114.5	105	117.2	100.2				
	Patient Deaths in Hospital			228	215	196	227	200	252	232	281	245	233	215	230	214
	Deaths within 36hrs of Admission			41	34	33	43	25	35	40	45	23	38	32	30	24
	Deaths within 5 day readmission spell			22	17	22	23	18	17	16	20	14	19	21	18	19
CARING																	
	Complaints Received			92	91	37	41	47	65	89	81	62	60	66	78	91
	Complaint Response Rate (55 Days)			69.8%	52.9%	23.6%	31.9%	14.3%	20.8%	42.3%	58.2%	56.2%	38.8%	38.8%	40.5%	58.6%
	Friends & Family Test			91.9%	91.0%	93.8%	94.2%	94.4%	93.3%	94.8%	94.4%	94.1%	94.2%	94.0%	94.7%	94.6%
WELL LEAD																	
Safety	Risks 12 and above on Register			40	37	33	38	39	40	47	47	48	43	40	36	33
	Risks 15 and above on Register			21	19	16	19	19	19	24	22	20	18	19	18	18
	Red Flags Raised*			43	25	19	13	20	15	13	15	28	13	14	13	11
People	Turnover			13.7%	13.4%	12.9%	12.3%	12.1%	11.7%	11.2%	11.0%	11.1%	11.1%	11.1%	10.9%	10.7%
	Vacancy Rate	Reported 1 month in arrears		7.0%	8.1%	9.1%	8.2%	7.7%	6.9%	6.3%	6.3%	7.1%	9.5%	7.8%	9.4%	
	Sickness Rate			3.7%	3.9%	4.1%	4.1%	4.3%	4.8%	4.6%	4.4%	4.5%	4.4%	4.4%	4.4%	4.4%
	Statutory and Mandatory Training			88.45%	89.41%	89.70%	89.75%	89.25%	88.88%	88.92%	88.93%	88.91%	89.43%	89.0%	89.5%	90.1%
	Appraisal Compliance - Values Based			4.66%	11.97%	23.80%	34.82%	53.33%	60.82%	63.79%	63.77%	64.20%	63.97%	63.7%	2.2%	6.8%
	Appraisal Compliance - Medical & Dental			60.61%	62.03%	60.91%	58.25%	55.9%	57.66%	57.29%	56.14%	59.24%	58.81%	58.5%	60.5%	59.9%
	Temporary Hours Filled by Bank			57.1%	53.1%	53.6%	54.2%	51.0%	51.8%	53.1%	52.4%	53.5%	55.6%	57.6%	57.8%	57.7%
	Temporary Hours Filled by Agency			21.6%	24.4%	26.3%	25.2%	26.8%	26.2%	27.8%	27.0%	24.6%	22.9%	23.2%	22.8%	22.0%
	Agency Pay as Proportion of Total Pay			4.1%	4.6%	4.7%	4.5%	5.0%	5.1%	4.5%	4.9%	5.3%	5.2%	4.4%	3.7%	3.5%

Performance at a Glance Indicators (2)

Performance at a Glance - Key Performance Indicator Matrix

			standard	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	
RESPONSIVE																	
RTT	18 week performance %		92%	54.3%	55.1%	55.4%	57.0%	57.6%	59.7%	60.8%	59.8%	60.3%	61.3%	62.0%	63.0%	62.4%	
RTT	Waiting list size		68,120 (May 24)	74,500	74,483	75,884	73,727	73,726	70,914	69,158	68,967	67,983	66,909	68,398	70,012	68,343	RAG rated based on trajectory
RTT	No. patients waiting 52+ weeks		3,119 (May 24)	4,813	4,574	4,613	4,501	4,426	4,199	4,196	3,879	3,722	2,967	2,767	2,813	2,960	RAG rated based on trajectory
RTT	No. patients waiting 65+ weeks			1,242	1,053	1,122	1,293	1,234	1,331	1,271	1,313	1,220	840	328	335	393	
RTT	No. patients waiting 78+ weeks		0	97	32	34	43	43	47	59	57	86	45	29	22	11	RAG rated based on trajectory
Theatre	Theatre utilisation (capped) - main		85%	73%	73%	73%	74%	75%	75%	74%	71%	73%	74%	73%	74%	74%	
Theatre	Theatre utilisation (capped) - DC		85%	74%	73%	72%	72%	74%	74%	75%	75%	76%	73%	72%	74%	75%	
Theatre	NOFs (Within 36hrs of admission - NHFD)		85%	33%	37%	37%	31%	47%	43%	56%	60%	73%	62%	64%	63%	51%	
Outpatients	**Outpatient metrics**																
Outpatients	Overdue Follow up Appts			31,057	30,594	29,622	27,619	27,946	27,493	26,506	26,733	26,506	25,844	26,075	26,161	26,046	
Outpatients	% DNA Rate		5%	6.5%	6.1%	6.2%	6.3%	6.2%	6.3%	5.9%	6.2%	5.9%	5.6%	5.3%	5.3%	5.3%	
Outpatients	Patient cancellation rate			11.3%	11.6%	11.0%	11.3%	11.6%	11.8%	11.2%	12.3%	11.3%	11.1%	10.6%	11.0%	11.4%	
Outpatients	% non face to face (telemedicine) attendances		25%	18.6%	17.5%	17.4%	17.5%	17.1%	17.0%	17.3%	17.4%	17.5%	17.1%	17.2%	17.0%	17.3%	
DM 01	**Diagnostic Performance (DM01)**																
DM 01	% of >6 week performance		1%	6.0%	7.7%	9.4%	13.2%	12.1%	10.4%	9.3%	10.8%	11.8%	8.7%	10.7%	11.8%	12.9%	
Cancer	28 day faster diagnosis standard		75%	70.2%	71.9%	60.1%	54.7%	64.7%	67.0%	64.3%	66.6%	72.5%	77.8%	75.2%	66.3%	76.2%	*May cancer position provisional*
Cancer	62 day standard		85%	62.7%	60.2%	63.0%	57.1%	60.2%	68.9%	65.8%	64.4%	62.7%	65.0%	68.9%	68.4%	*64.8%*	
Emergency Dept	4 hour care standard			66.4%	61.7%	60.1%	62.9%	61.2%	61.0%	62.3%	60.8%	61.9%	63.8%	70.2%	70.1%	72.5%	
Emergency Dept	Arrival time to initial assessment		15	19.0	22.0	24.0	16.0	16.0	21.0	19.0	19.0	20.0	20.0	20.0	19.0	19.0	
Emergency Dept	Clinician seen <60 mins %			27.6%	35.6%	20.3%	27.2%	26.1%	27.7%	32.2%	31.9%	31.3%	33.0%	32.0%	29.0%	30.0%	
Emergency Dept	Patients >12hrs from DTA to admission		0	82	13	59	2	-	-	70	294	483	202	207	145	214	
Emergency Dept	Patients >12hrs in dept			637	504	871	723	857	882	851	1271	1681	927	979	745	801	
SWAST SCAST	Ambulance handovers			4102	4015	4268	4447	4238	4433	4295	4456	4394	3974	4365	4130	4414	
SWAST SCAST	Ambulance handover 30-60mins breaches			625	684	750	824	874	1046	1139	1248	1238	876	1016	868	1040	
SWAST SCAST	Ambulance handover >60mins breaches			345	383	615	588	677	805	551	711	733	270	327	246	277	
Patient Flow	Bed Occupancy (capcity incl escalation)		85%	92.3%	94.4%	94.6%	93.5%	95.3%	95.8%	96.7%	95.3%	96.4%	92.4%	93.0%	94.0%	93.7%	
Patient Flow	Stranded patients:																
Patient Flow		Length of stay 7 days		502	480	474	476	500	502	526	534	566	551	528	527	512	
Patient Flow		Length of stay 14 days		322	294	295	308	310	318	331	339	370	363	336	339	324	
Patient Flow		Length of stay 21 days	108	223	199	202	220	211	220	220	231	266	255	235	241	230	
Patient Flow	Non-elective admissions			6288	6347	6223	6233	6141	6551	6519	6214	6538	6135	6718	6494	7030	
Patient Flow	> 1 day non-elective admissions			3826	3783	3863	3821	3779	4065	3934	3909	3981	3673	4175	3973	4193	
Patient Flow	Same Day Emergency Care (SDEC)			2458	2560	2358	2410	2310	2393	2458	2157	2391	2295	2395	2365	2629	
Patient Flow	Conversion rate (admitted from ED)		30%	29.90%	31.60%	28.70%	28.60%	30.70%	29.80%	32.30%	30.50%	28.47%	29.30%	30.70%	31.10%	30.30%	

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

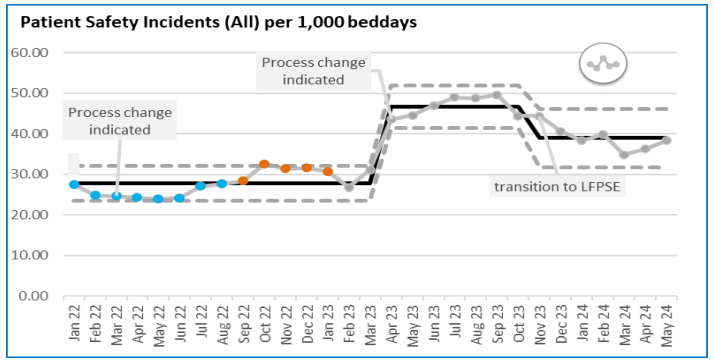
Quality Outcomes & Safety Patient Experience

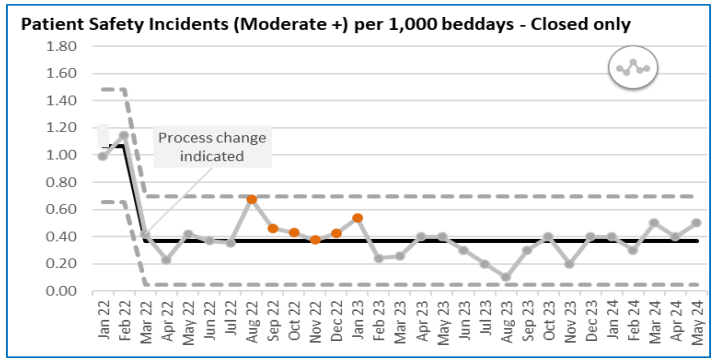

Sarah Herbert
Chief Nursing Officer
Dr Peter Wilson
Chief Medical Officer

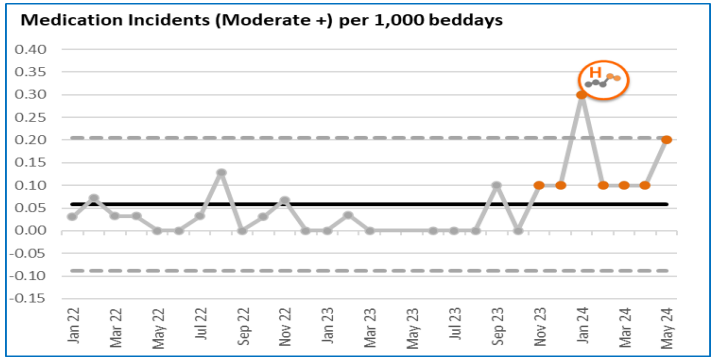
Operational Leads:
Matthew Hodson – Deputy Chief Nursing Officer (IPC, Clinical Practice and Patient Experience)
Fiona Hoskins – Deputy Chief Nursing Officer (Workforce and Safeguarding)
Sean Weaver – Medical Director for Quality & Safety
Jo Sims – Associate Director Quality, Governance and Risk
Lorraine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

Committees:
Quality Committee

Quality (1) – Safe







Background/target description

To improve patient safety.
Number of patient safety incidents per 1,000 bed days
Number of patient safety incidents (moderate or above) per 1,000 bed days – closed only
Number of medication incidents (moderate or above) per 1,000 bed days

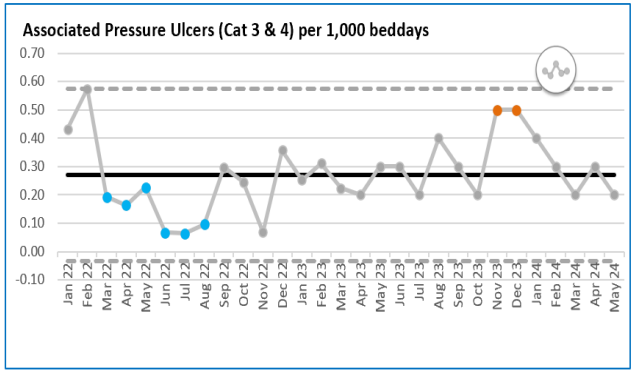
Performance

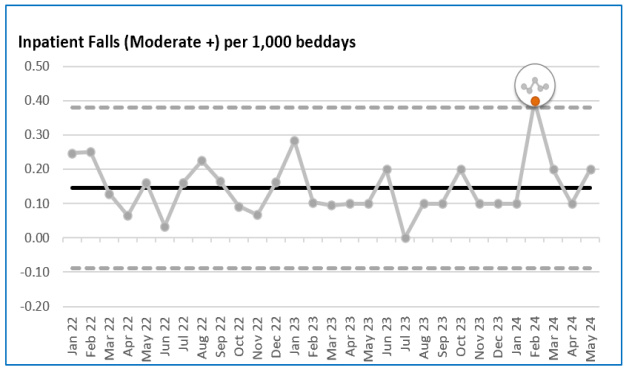
- The Trust transitioned to LFPSE in November 23 meaning the adoption of a completely different taxonomy for reporting a patient safety event was introduced. The definition change significantly reduced the number of incidents reportable to LFPSE as a Patient Safety Incident.
- No significant trends or changes in IPR reported metrics in month (Nov 23 – May 24 position).
- Redesign of IPR and Quality Dashboard metrics to report on PSIRF themes and trends is in progress.
- From 1 April 24 the Trust has adopted the PSIRF framework which means the language of "Serious Incident" will no longer be used. Patient Safety Incident Investigations (PSIIs) will be undertaken in accordance with the Trust PSIR Plan
- PSIRF investigation response tools are available on the Quality and Risk pages of the intranet

Key Areas of Focus

Full report on learning from completed investigations to be included in CMO report to Quality Committee and Board. Learning is also shared via Safety Alerts, SBAR reports, LERN synopsis and the CGG Top 10.

Quality (2) – Safe





Background/target description

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

Performance

Clinical practice:

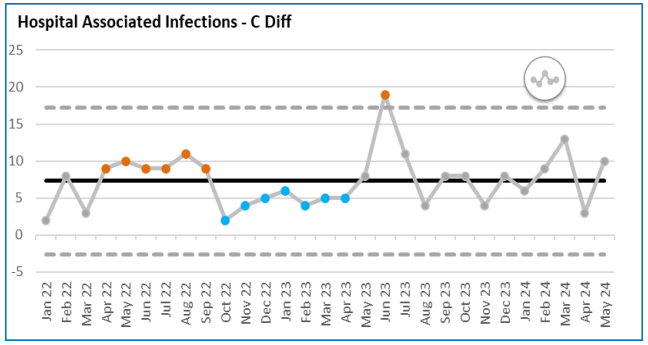
- There have been a slight decline with six identified new category three pressure ulcers reported in month, which are following the appropriate investigation. Common cause variation continues.
- There has been an increase in the number of serious* falls incident in month with four moderate and four severe falls reported. These fall will follow the appropriate follow-up as per the patient safety framework investigation. Falls are within common cause variation.

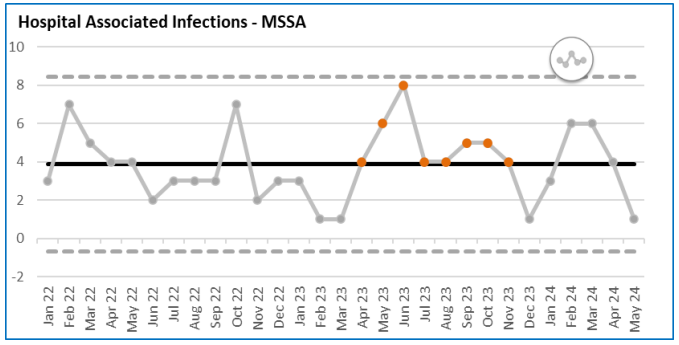
Infection Prevention and Control

- There has been three cases of *Methicillin-resistant Staphylococcus aureus,* reported in month. Our post infection review is being completed by ward and IPC, learning taken back to ward and supporting services, no obvious source of bacterium identified to date.
- *Escherichia coli* blood stream infections have risen during the month of May. IPC continue rend and case analysis to formulate improvement actions required
- There was one period of increased incident *of Clostridioides difficile* identified in May 2024 on OPAU (RBH), no cases linked by ribotype and enhanced measures stepped down.
- Cases of COVID-19 and Influenza A remained at low base level during May 2024

Key Areas of Focus

- Work continues with ward teams on Falls and Tissue viability improvement plans
- Infection Prevention and Control Team to work with ICB to understand deep dive review and utilise trend analysis in building quality improvement work linked to gram negative bacteraemia



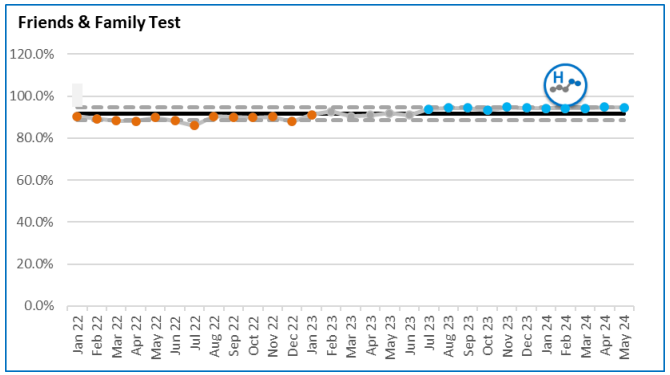


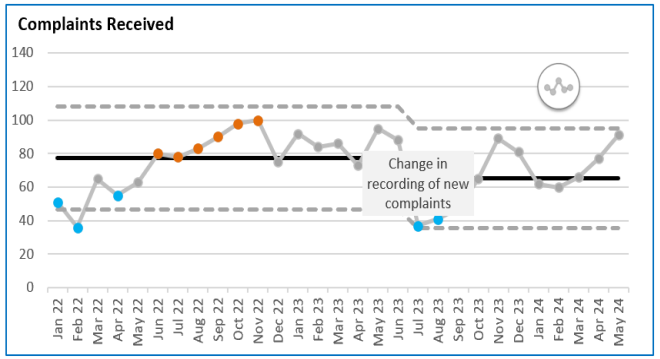
HCAI Trends by month

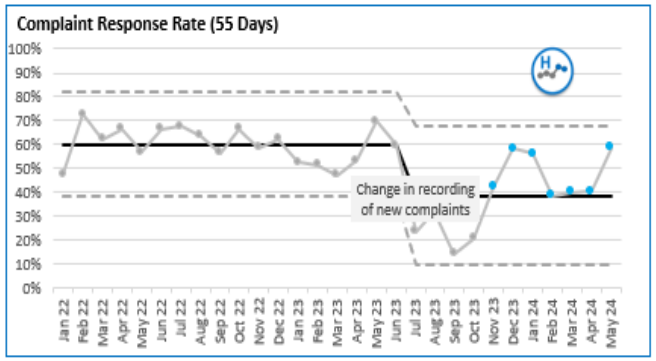
Organism	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
C Diff	11	4	8	8	4	8	6	9	13	3	10
E Coli	14	9	11	11	11	17	17	8	8	7	14
MRSA	0	0	0	0	0	1	1	0	1	1	2
MSSA	4	4	5	5	4	3	3	6	6	4	1

*Categorised as Moderate or Severe

Quality (3) – Caring







Performance and Areas of Focus

PALS and Complaints Data for May 2024:

Overview:

- 544 PALS concerns raised
- 38 new formal complaints
- 53 Early Resolution complaints (ERC) processed.
- The number of complaints that were responded to and closed in May was 70.

Complaints and PALS themes include communication and not meeting fundamentals of care. The top 5 issues are being discussed through the PEG with Trust wide actions to address through the Nursing Midwifery and Professions Forum and Ward Leaders meetings.

The number of open complaints over 55 days continue to be prioritised within the complaints team and care groups and has continued to decrease, as identified in the SPC chart as a special cause high improving variation. The average complaint turnaround time was 45 days in May 2024.

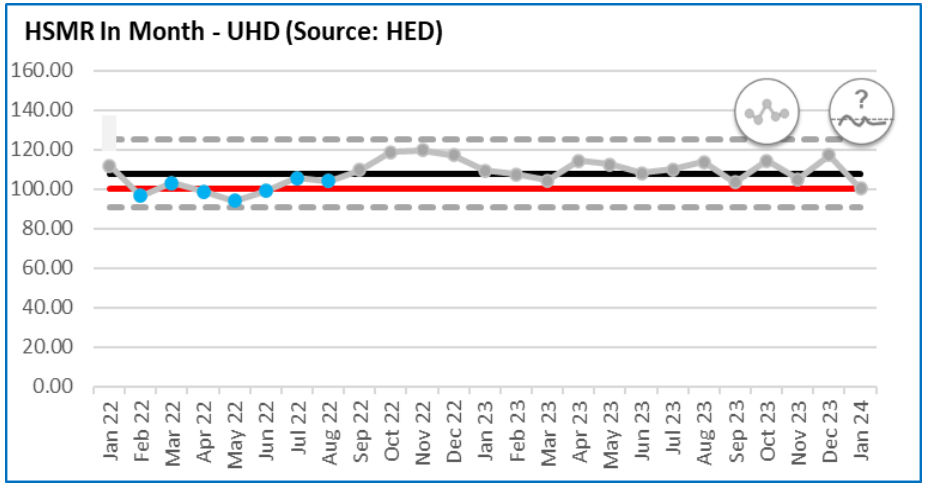
Friends and Family Test (FFT)

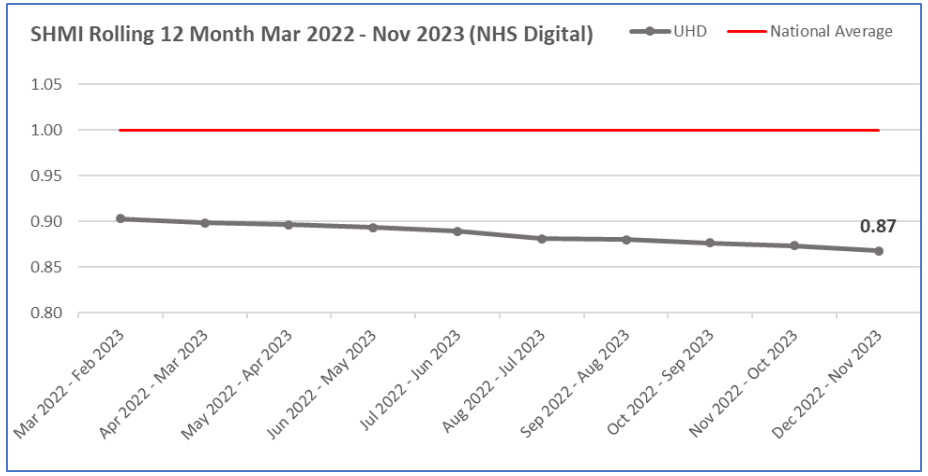
FFT results: FFT responses being received remain steady. More clinical areas are now receiving FFT results. The Trust overall positive score has been above the upper control for eight consecutive months and remains above the average score. Seen in the SPC chart as special cause improved variation. To note, the interface between ED Aygle and BI has not yet been realised, meaning that ED responses to FFT are currently low.

Mixed Sex Accommodation Breaches

There were 11 occurrences of MSA in May 2024 in critical care – continued monitoring of areas continues with care group matrons.

Quality (4) – Effective & Mortality





Background, Performance and Areas of Focus

The headline figure for mortality reporting is UHD trust-wide Hospital Standardised Mortality Ratio (HSMR). This is the key metric for the Patient First Quality Outcomes and Safety strategic theme.

The other main mortality metric is the Summary Hospital-level Mortality Indicator (SHMI)*. This does not alter by change in data supplier (now HED) and is set by NHS Digital over the previous year.

Both are significantly influenced by the fact that the Trust is unusual in having two hospices. These raise our HSMR as people are dying in our hospices rather than at home or in the community. They reduce our SHMI as people are not dying in the 30 days after leaving our trust instead, they remain in our Trust to die.

Our rolling HSMR over the last year is 109.21 (Feb 23 – Jan 24). Our SHMI is 0.867 (Dec 22 – Nov 23, Sourced NHS Digital)

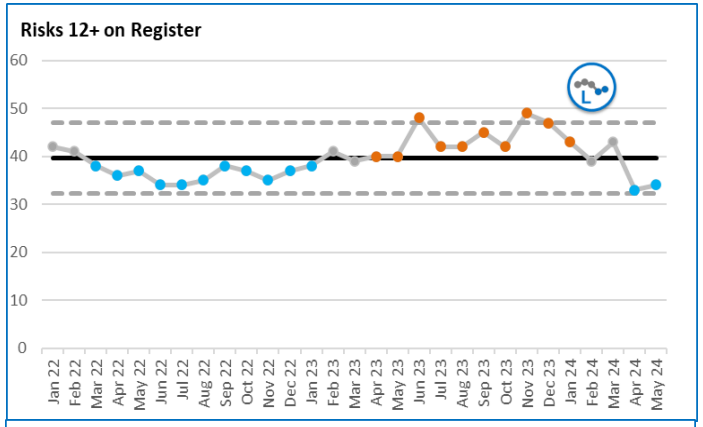
*The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust (within 30 days) and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

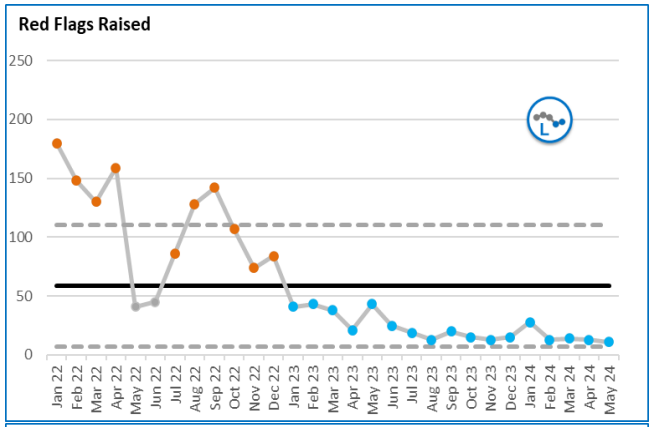
Areas of Focus

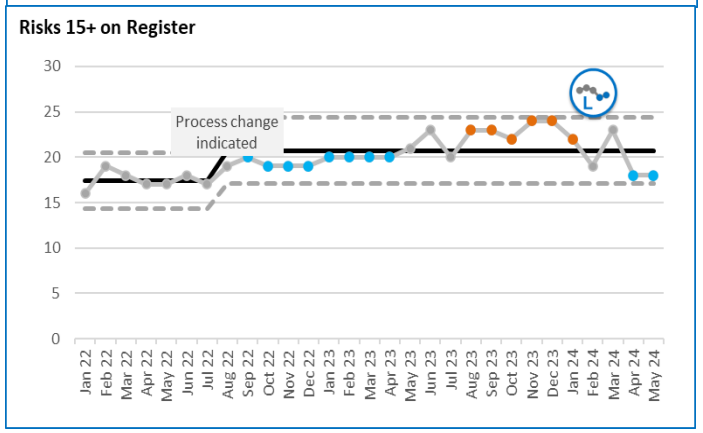
We are learning how to use the Healthcare Evaluation Index (HED) data most effectively and will be setting up alerts in the next month and doing a deep dive into our pneumonia data which is our leading cause of death.

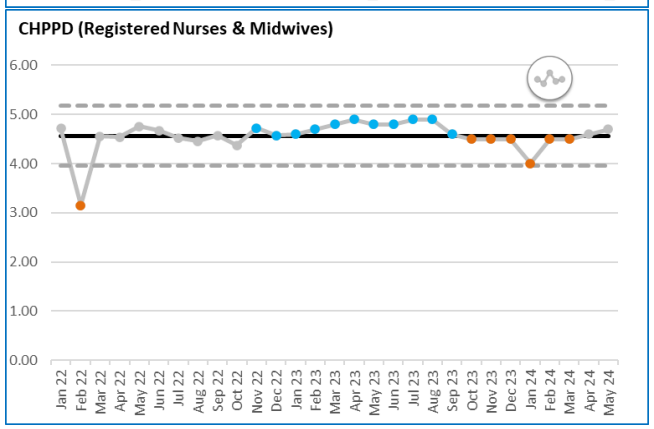
The lack of admin for the learning from death review process has been escalated at SDR as this limits our ability to review and learn from deaths.

Quality (5) – Well Led









Performance

- May 2024 CHPPD for registered nurses and midwives combined is 4.7. Guidance for organisational level CHPPD for registered nurses and midwives advises this should be >3.
- The Red Flag data for May was 11 raised in month (zero for maternity.) No critical staffing incidents were reported during this period indicating that the flags were mitigated, and safe staffing was maintained.
- Overall percentage rota fill rate against planned staffing (day & night) was 99.4% for May 2024.

Key Areas of Focus

- Separate risk report provide to Trust Management Group Quality Committee and Trust Board
- Exec reviews of 12+ risks in progress/ongoing
- Action plan to review and amend Trust Risk management strategy, risk appetite and risk tolerance statements in progress.
- The use of Safecare continues to be embedded across the Trust. Work embedding staff movements on safecare continues.

Safe Staffing (Rota Fill Rates and CHPPD) - Total (Day & Night Combined) May 2024/25

Hospital Site name	Patient Count	Registered Nurses/Midwives			
		Total monthly planned staff hours	Total monthly actual staff hours	Fill Rate %	CHPPD
Poole Hospital	16163	86643.3	81322.5	93.9%	5.0
Bournemouth & Christchurch	17548	82493.5	77450.8	93.9%	4.4
UHD Total	33711	169136.8	158773.4	93.9%	4.7

Maternity (1)

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

Surveillance Scorecard

Perinatal Quality Surveillance scorecard	Metric	Alert (national standard/ average where available)	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Perinatal	Red flags: 1:1 care in labour not provided	0	0	0	0	0	0	0
	3rd/4th degree tear overall rate	>3.5%	1.7%	2.2%	2.3%	1.7%	3.70%	4.2%
	Obstetric haemorrhage >1.5L	>3%	5.4%	3.9%	4.8%	3.6%	4.50%	2.80%
	Term admissions to NNU	National <6%, Regional <5%	4.90%	6.10%	4.70%	6.00%	6.50%	6.50%
	Apgar < 7 at 5 minutes	<1.2 %	1.4%	1.9%	0.9%	0.9%	0.70%	0.6%
	Stillbirth number	Actual	0	0	0	0	0	1
	Stillbirth number/rate (per 1,000) per quarter	<2.6 /1000	3			0		
Workforce	Rostered consultant cover on Delivery Suite - hours pw	<72	72	72	72	72	72	72
	Dedicated anaesthetic cover on Delivery suite - per week	<58	58	58	58	58	58	58
	Midwife/band 3 to birth ratio (establishment)	01:23	01:21	01:21	01:21	01:21	01:21	01:21
	Midwife/band 3 to birth ratio (in post)	01:23	01:22	01:22	01:21	01:21	01:21	01:21
Feedback	Number of compliments (Smiles via Badgernet)		no data	40	36	38	no data	96
	Number of concerns (PALS) negative		1	0	5	0	5	2
	Complaints	3	2	1	1	4	4	4
	FFT Repsonse from November 23		276	297	307	no data	140	
Training	UHD Mandatory training - women's health midwives	90%	85%	87%	88%	90%	89%	89%
	PROMPT/Emergency skills all staff groups	90%	82%	86%	88%	95%	96%	97%
	K2/CTG training all staff groups	90%	86%	86%	86%	96%	99%	96%%
	CTG competency assessment all staff groups	90%	86%	86%	86%	96%	99%	98%
	Core competency framework compliance - Midwife update	90%	91.00%	moved to ccf2	moved to ccf2	96%	no data	98%
	Coroner Reg 28 made directly to the Trust		N	N	N	N	N	N
	HSIB/CQC etc. with a concern or request for action		Y(CQC)	Y(CQC)	Y(CQC)	Y(CQC)	Y(CQC)	Y(CQC)

Data and Target

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:

- Obstetric Haemorrhage >1.5 litres- action plan in place
- Term admissions to NICU

There is 1 area currently flagging as green RAG rated this month Obstetric Haemorrhage >1.5 L which we will continue with quality improvements.

Key Areas of Focus

3rd/4th degree tears: we have asked our Consultant Midwife to lead on this piece of work to ensure a sustained reduction in serious tears. She In June the quality improvement programme includes a lithotomy challenge for UHD staff to raise awareness and promote the importance of protecting the perineum.

Term admissions to NICU : term admissions to NICU has increased this month term .A detailed action plan is being reviewed at the monthly ATAIN meetingsof Focus
Areas of Focus

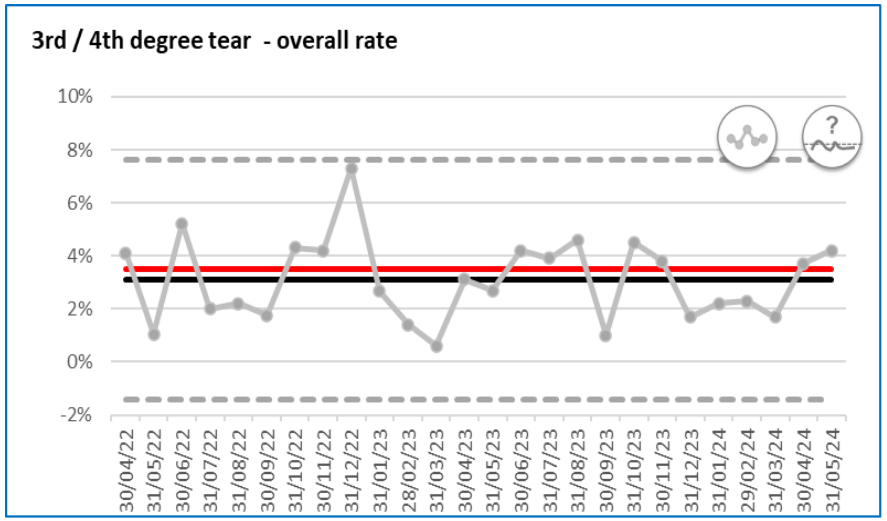
Training – CTG and Prompt training midwives update day continue to be above >90% and the team continue to sustain this standard.

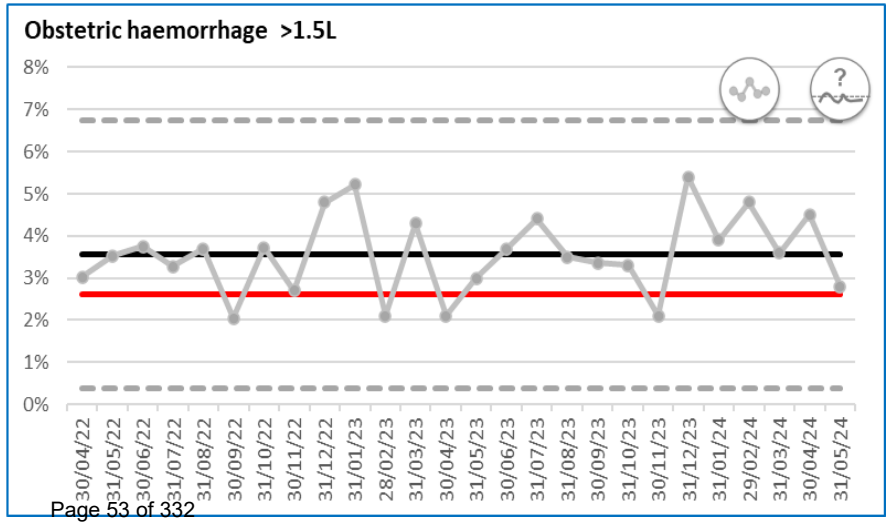
Maternity (SPC)

Executive Owner: Sarah Herbert (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	May 24	4.2%	3.5%			3.1%	-1.4%	7.6%
Obstetric haemorrhage >1.5L	May 24	2.8%	2.6%			3.6%	0.4%	6.8%
Term admissions to NNU %	May 24	6.5%	6.0%			5.7%	2.9%	8.4%





Maternity (2)

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

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

National position & overview

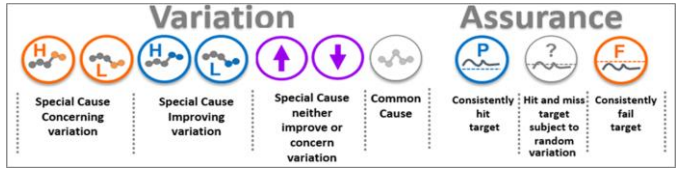
- The Perinatal Quality Surveillance Dashboard describes a standard data set for Trust Board overview
- The dashboard implementation using the Perinatal Quality Surveillance Tool forms part of our Maternity Safety Self Assessment and Ockendon 1 requirements
- There are a number of items which require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

Findings of review of all perinatal deaths using the national monitoring tool	Matters for Board information and awareness	Progress in achievement of Year 5 Maternity incentive scheme
MBRRACE reportable cases: There have been 1 reportable cases for MBRRACE in May. IUD –no learning identified. **PMRT** There were 1 new PMRT cases in May – learning: importance in recording first language at booking. Joint PMRT monthly meeting held by UHD and Dorset County Hospital **MNSI** There were new cases in May to MNSI Final report received L117885 learning: neonatal recommendations to ensure processes are in place to support staff during resuscitation and during a difficult intubation.	**Patient Safety Incident Response Framework** (PSIRF) PSIRF is being implemented in maternity and our top 3 areas identified for thematic reviews are 1. Stillbirth 2. Term admissions to NICU - 6 months deep dive presented to ICB and safety champions in November ongoing action plan. 3. PPH greater than 1.5 liters initial quality improvement commenced. **There has been NHSR learning submitted in May through safety champions/quality committee.**	**MIS year 6 - new standards published 2nd April 2024.** Work continues on all safety standards with monthly assurance meetings to monitor compliance. There will be a mid-way review in July with the auditors to ensure progress towards standards continues. **For the standards partially met, further progress has been made in May** **CQC maternity action plan** All actions now complete continue to monitor standards and ensure sustainability **CQC patient survey** Action plans developed with the MNVP and in progress. **Insight and 3- year delivery plan** On target to achieve insight actions and year 2 plan **MSSP exit criteria** Good progress being made.

Performance at a glance
Quality - Key Performance Indicator Matrix

Quality IPR

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Associated Pressure Ulcers (Cat 3 & 4) per 1,000 beddays	May 24	0.20	-			0.27	-0.03	0.58
Inpatient Falls (Moderate +) per 1,000 beddays	May 24	0.20	-			0.15	-0.09	0.38
Medication Incidents (Moderate +) per 1,000 beddays	May 24	0.20	-			0.06	-0.09	0.20
Medication Incidents (All) per 1,000 beddays	May 24	5.30	-			5.08	3.19	6.97
Patient Safety Incidents (All) per 1,000 beddays	May 24	38.30	-			38.93	31.70	46.15
Patient Safety Incidents (Moderate +) per 1,000 beddays - Closed only	May 24	0.50	-			0.37	0.04	0.70
Serious Incidents	May 24	1	-			3	-3	8
Never Events	May 24	0	-			0	-1	1
Hospital Associated Infections - MRSA	May 24	2	-			0	-1	1
Hospital Associated Infections - MSSA	May 24	1	-			4	-1	8
Hospital Associated Infections - C Diff	May 24	10	-			7	-3	17
Hospital Associated Infections - E Coli	May 24	14	-			8	-2	19
HSMR In Month - UHD (Source: HED)	Jan 24	100.20	100.00			107.96	90.53	125.38
Mixed Sex Accommodation Breaches	May 24	11	-			7	-15	30
Complaints Received	May 24	91	-			65	35	95
Complaint Response Rate (55 Days)	May 24	59%	-			39%	10%	68%
Friends & Family Test	May 24	94.6%	-			91.5%	88.4%	94.5%
Patient Deaths in Hospital	May 24	214	-			236	170	302
Deaths Within 36hrs of Admission	May 24	24	-			35	15	56
Deaths Within Readmission Spell (5 day readmission)	May 24	19	-			22	8	36
Risks 12+ on Register	May 24	34	-			40	32	47
Risks 15+ on Register	May 24	18	-			21	17	24
Red Flags Raised	May 24	11	-			59	7	111
CHPPD (Registered Nurses & Midwives)	May 24	4.70	-			4.57	3.95	5.18
			-					



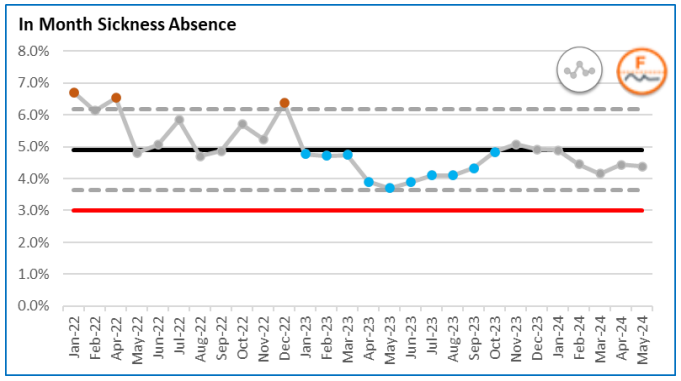
Our People

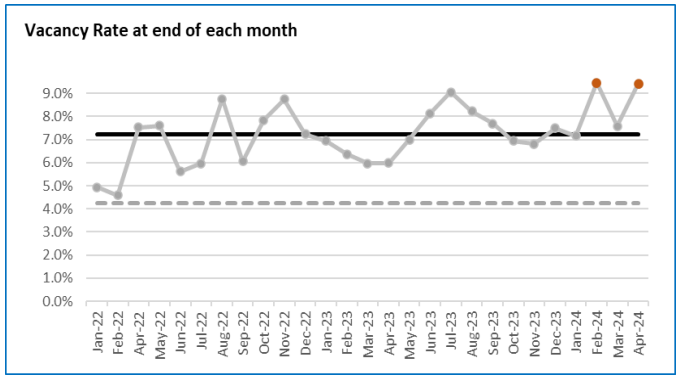
Tina Ricketts
Chief People Officer

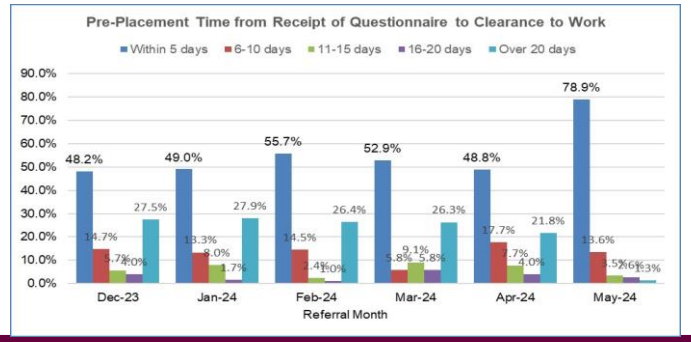
Operational Leads:
Irene Mardon - Deputy Chief People Officer

Committees:
People and Culture Committee

Well Led - Workforce (1)







Performance

Sickness Absence and Wellbeing

- In month sickness absence for May 2024 was at 4.4% which is the same as the previous month. The latest rolling 12 month rate (as at end of May 2024) is 4.5% which is a slight increase on the previous month, but demonstrates normal variation.
- Anxiety/stress/depression was the top reason for absence in May (risk 1493).

Vacancy Rate

- Vacancy rate is reported a month in arrears to allow for reconciliation with the ledger. The latest vacancy position is 9.4% (as at end of April) which is an increase from March at 7.6%, as a result of the budget setting for the new financial year.
- The total number of job offers made in May was 218, an increase on the previous month, with 189 for non- medical roles, compared to 181 in April, and 29 made for medical posts, compared to 30 in the previous month.

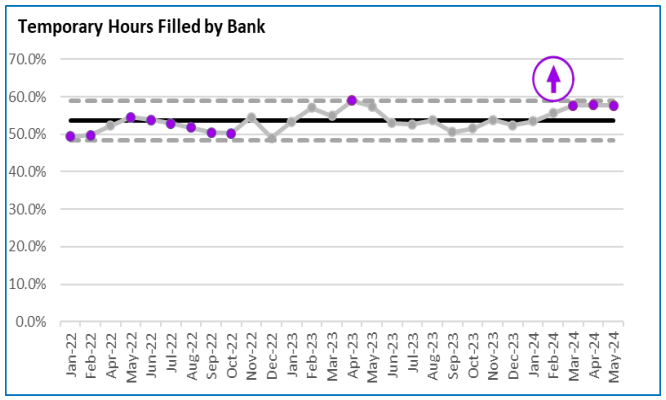
Healthcare Support Worker Recruitment

- Healthcare support worker vacancies have remained at similar level to the previous month, with the vacancy gap being 204 WTE. A total of 10 offers were made in May 2024.

Occupational Health

- 78.9% of pre-employment referrals were cleared to work in 5 days, a significant improvement from 48.8% in April 2024.

Well Led - Workforce (2)

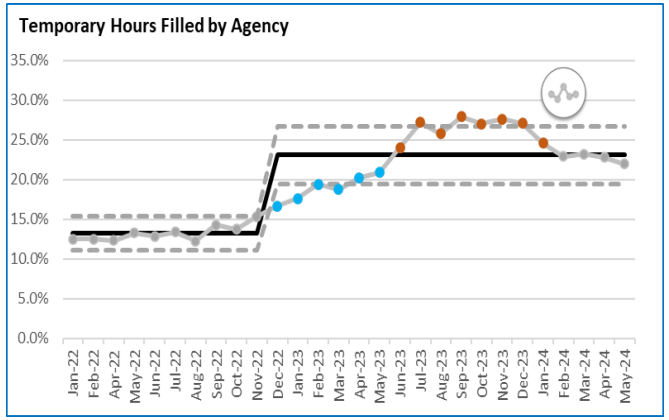


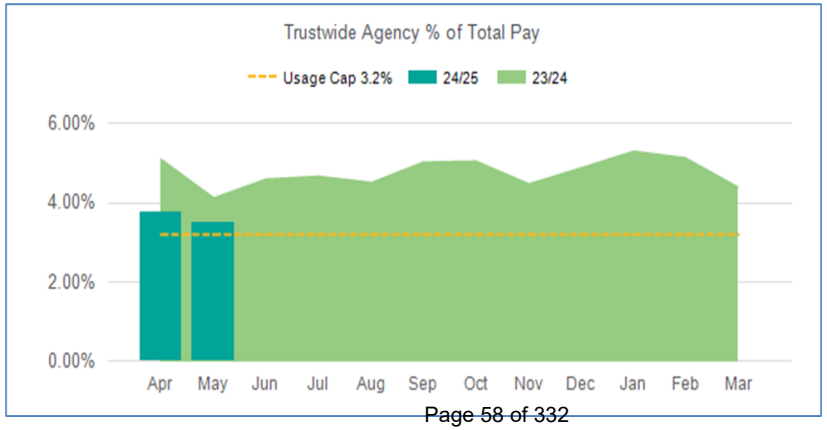
Performance

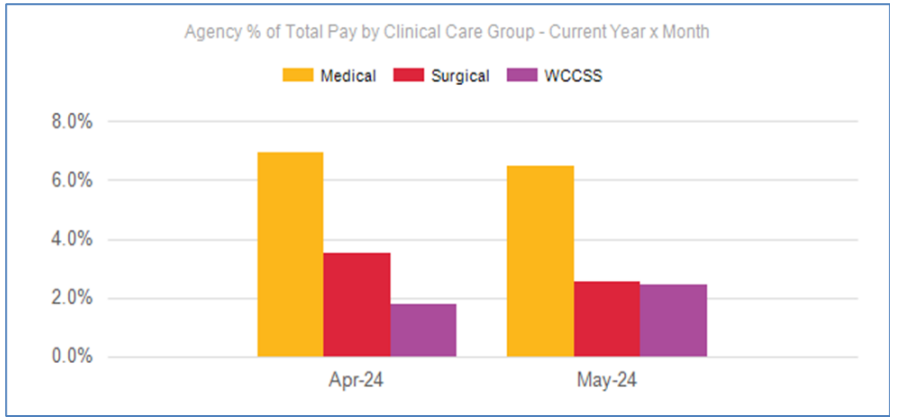
- We have seen an overall decrease in agency spend from 3.74% in Month 1 to 3.51% in Month 2.
- Agency spend has decreased in the Medical Care Group from 6.9% (April 2024) to 6.5% (May 2024), the Surgical Care Group has seen a decrease from 3.5% to 2.5%. Women's, Children, Cancer and Support Services Care Group has increased from 1.8% to 2.4%.
- Total off-framework usage is at 1.6% in M2 compared to 1.8% in M1 – work with suppliers has continued and we expect further reductions in the next 2 months.
- There was a 3% increase in requests for shifts to be filled by Bank and Agency workers in M2 which equates to 6,175 additional hours requested compared to M1
- The number of hours filled by bank and agency increased by 2% in M2, equating to 3,176 additional hours filled, with this increase in demand being met by bank fill, and agency fill remaining flat
- 3rd and final stage of agency rate reductions to bring supply into cap compliance by 1st July in progress

Key Areas of Focus

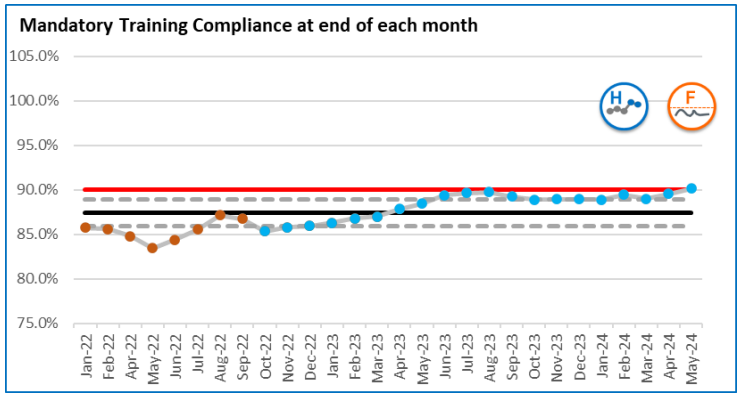
An agency reduction plan is in place which is monitored through the Trust Management Group

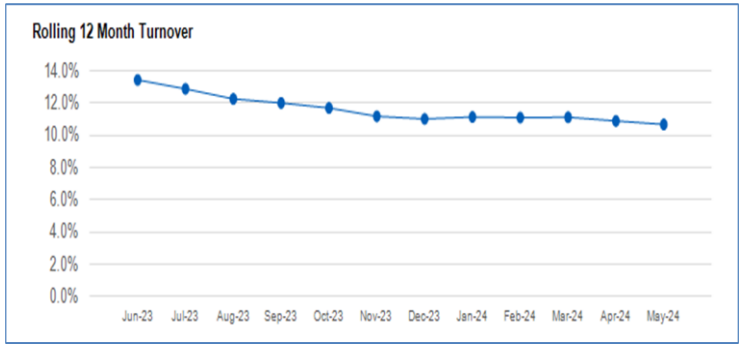


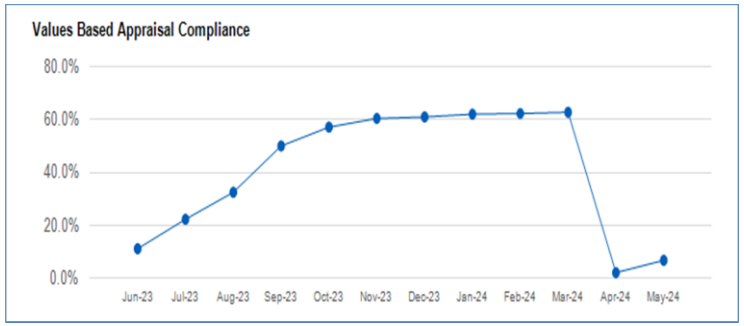


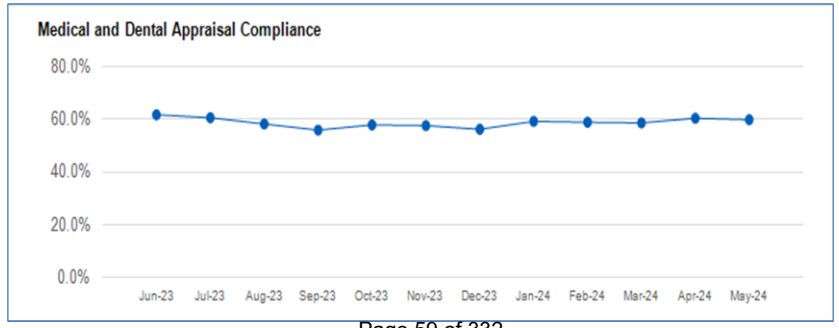


Well Led - Workforce (3)









Performance

Mandatory Training

- Mandatory Training compliance has increased to 90.1% as at end of May 2024, just over the target of 90%.

Turnover

- The rolling 12 month staff turnover rate (excluding fixed term temp) is at 10.7% as at end of May 2024, a reduction on last month at 10.9%. The trend remains downward year to date.

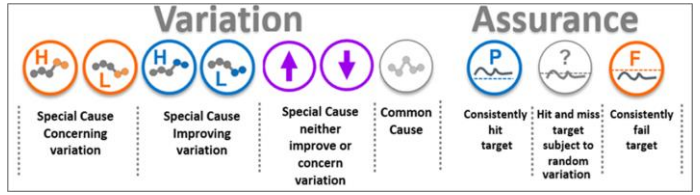
Appraisal

- Updated appraisal procedure was ratified in May 2024
- Appraisal compliance for values based as at end of April 2024 is at 6.8%, this restarted on 1st April for the new appraisal season. Medical and Dental compliance is at 59.9%
- The Trust Management Group have approved a change in logic for non-medical appraisal compliance. We will start reporting a rolling 12 month compliance in line with medical staff with effect from July.
- Currently, rolling 12- month compliance is 59.9% for non-medical, and 59.9% for medical staff, as of 31st May 2024. The exclusions relating to doctors in training for medical appraisals compliance have also been reviewed and will take effect from July also.

Performance at a glance
Well Led - Key Performance Indicator

UHD Workforce

KPI	Latest month	Actual	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Vacancy Rate at end of each month	Apr 24	9.4%	-	H		7.2%	4.3%	10.2%
In Month Sickness Absence	May 24	4.4%	3.0%		F	4.9%	3.6%	6.2%
Mandatory Training Compliance at end of each month	May 24	90.1%	90.0%	H	F	87.4%	85.9%	88.9%
Temporary Hours Filled by Bank	May 24	57.7%	-			53.6%	48.3%	58.9%
Temporary Hours Filled by Agency	May 24	22.0%	-			23.1%	19.5%	26.7%
Agency Pay as Proportion of Total Pay	May 24	3.5%			?	4.6%	3.0%	6.2%



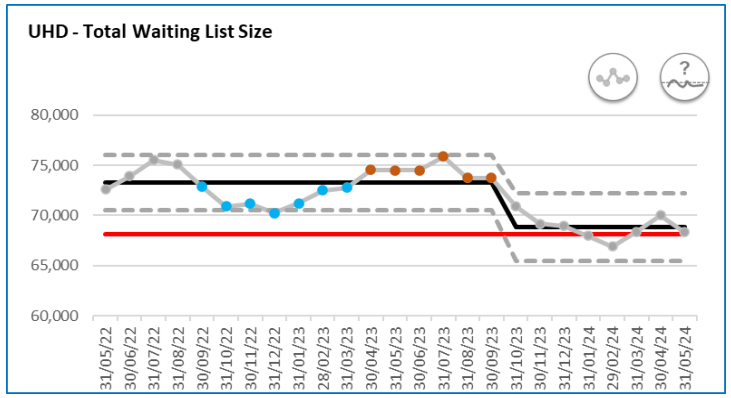
Population Health and System Working

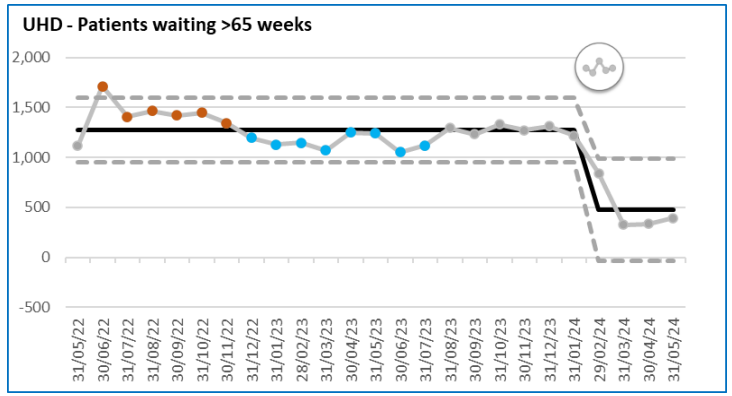
Mark Mould
Chief Operating Officer

Operational Leads:
Judith May – Director of Operational Performance and Oversight
Mark Major – 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)





Referral To Treatment	Standard	UHD	% of pathways with a DTA
18 week performance %	92%	62.4%	
Waiting list size (and trajectory)	68,120	68,343	20%
Waiting List size % variance compared to trajectory		0.3%	
No. patients waiting 26+ weeks		16,671	34%
No. patients waiting 40+ weeks		7,356	40%
No. patients waiting 52+ weeks (and % of waiting list)	4.3%	2,960	42%
No. patients waiting 65+ weeks (and % of waiting list)	0.6%	393	55%
No. patients waiting 78+ weeks (and % of waiting list)	0.0%	11	64%
% of Admitted pathways with a P code		98.10%	

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.
Number of patients on an elective RTT waiting list whose wait exceeds 65 weeks. National target 0 by Sept 2024.

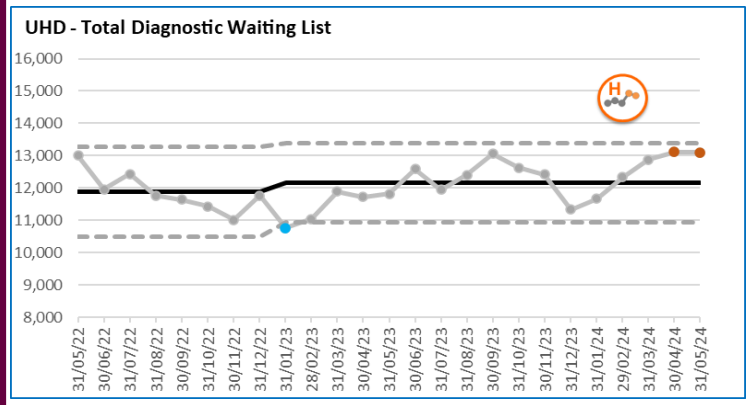
Performance

- The Referral to Treatment (RTT) waiting list size shows a level of natural variation. There was a reduction in the waiting list in May 2024 (-223) and the variance to the operational planning trajectory has reduced to 0.3% (trajectory 68,120). The target however lies within the upper and lower process control limits.
- RTT performance decreased from 63% in April to 62.4% in May.
- 11 patients with a wait greater than 78 weeks remained at the end of May 2024. This was above a plan of zero but represents an improvement from 22 in April 2024. In month equipment issues (resolved) and patient choice impacted on the Trust's ability to eliminate 78 week waits in May. No patients are expected to be waiting longer than 78 weeks in the forecast at the end of June.
- >65-week waits increased but remained below the recalculated mean, and at 393 is in line with the operational plan trajectory
- Gynaecology, ENT, Colorectal and Orthopaedics (Shoulders) remain the most challenged specialities.
- Waits greater than 52 weeks have met the operational plan trajectory.

Key Areas of Focus

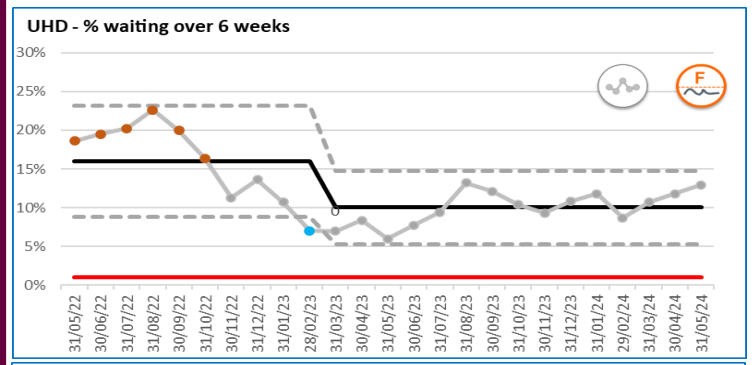
- Delivery of capacity plans to eliminate 78 week waits at the end of June and eliminate 65 week waits by September 2024 (except where patients choose to wait longer).
- Increasing productivity within core capacity. This includes reducing missed appointments (DNAs) and improving theatre and outpatient session utilisation rates.
- Conclude the interventions designed through the Intelligent Workflows (process mining) project in Outpatients.
- Scheduling activity at a level which represents a minimum of 109% against a 2019/20 baseline activity level.
- Prioritising elective recovery funding to build capacity is some specialities to meet demand, through insourcing and waiting list initiatives delivered below tariff.

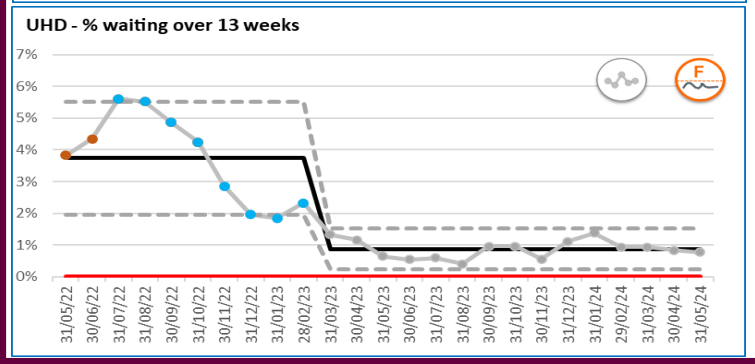
Responsive – (Elective) Diagnostic Waits



Diagnostic Performance (DM01)

% of >6 week performance *(6+ Weeks / Total)*	1%	1693/13100	12.9%





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

May 2024 performance reduced to 12.9% compared with 11.8% at the end of April 2024. Performance remains within the upper and lower process control limits; however further improvement is required to meet the 1% target. An increase in the overall diagnostic waiting list (showing special cause variation) is reflective of increased urgent suspected cancer referrals and elective activity.
There are currently 101 patients waiting more than 13 weeks for a diagnostic test (majority cardiac MRI)
Endoscopy performance reduced to 16.5% at the end of May (11.8% at the end of April).
There is ongoing use of 18weeks insourcing and waiting list initiatives (WLIs) to support delivery of the Community Diagnostic centre activity plan.
Echocardiography performance has improved to 12.3% in May, from 14.2% in April, predominately due to less inpatient escalation within the cardiology bed base.

- Heart failure remains the challenge in achieving DM01. Additional Heart Failure clinic capacity from a visiting GP is now in place. However, there are ongoing vacancy gaps and sickness reducing capacity and a significant increase in referral numbers.

Neurophysiology performance improved to 33.7% in May from 41.7.% in April.

- A 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 department to manage performance.

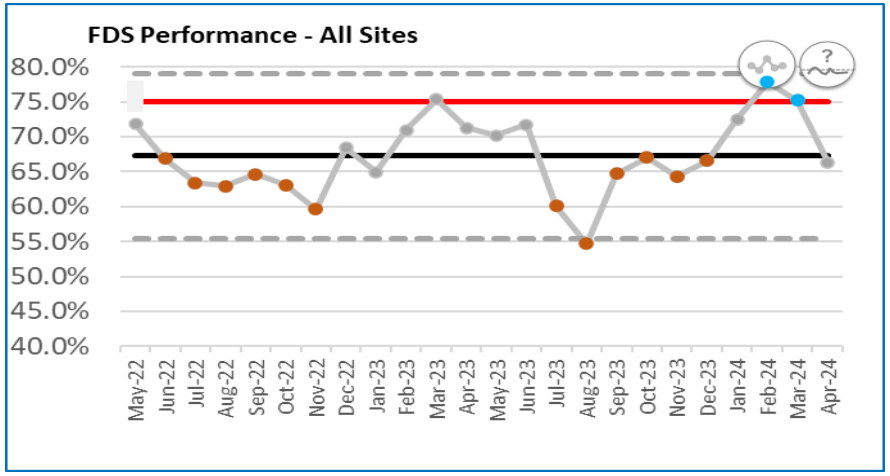
Radiology performance has reduced to 9.1% in May , from 6.8% in April, the target is not being achieved predominately due to the ongoing reduction in cardiologist CT / MRI sessions.

Key Areas of Focus

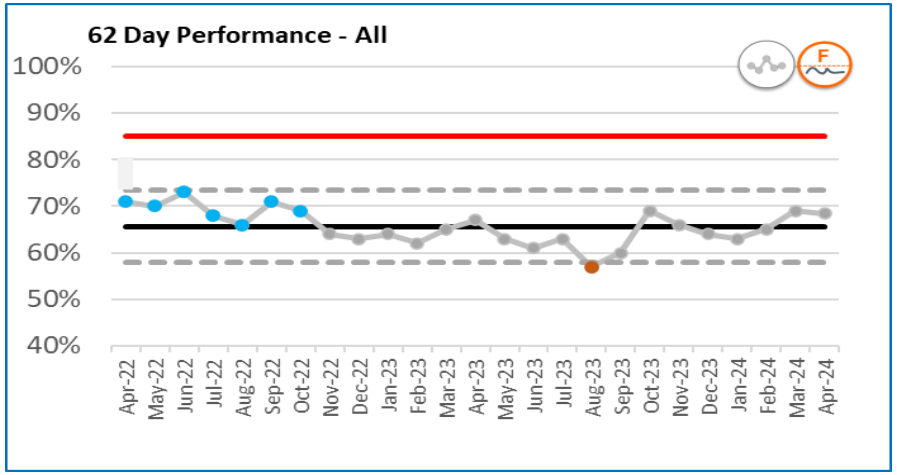
- **Endoscopy:** Dr Doctor launched late April for ongoing management of bookings to ensure high utilisation (resultant reduction in DNA rate of 4.83% April to 2.56% May).
- **Echocardiography:** Sustain **i**ncrease in stress-echo capacity from April 2024.
- **Radiology**: Mobile CT and mobile MRI contracts have now ended; capacity replaced through use of additional weekend and evening sessions. Paediatric MRI (GA) list now at almost 10 week wait, have MR capacity but lack anaesthetist capacity.
- **Cardiology** have provided some additional sessions with a locum helping to recover the cardiac position (currently 500 patients breaching 6 weeks). Exploring potential insourcing opportunity for cardiac CT/MR backlog reduction, and to reduce long waiters.

Responsive (Elective)
Cancer FDS & 62 Day Standard

28 Day Faster Diagnosis Standard (Target 75%)
Finalised UHD April Performance (66.3%)



62-Day Standard (Target 85%)
Finalised UHD April Performance (68.4%)



Data Description and Target

- Percentage of patients informed of diagnosis within 28 days from referral. Faster Diagnosis Standard = 75% (77% by March 2025)
- Percentage of patients who receive their 1st treatment for cancer within 62 days. 62 Day Standard = 85% (70% by March 25).
- The number of 62-day patients waiting 63 days or more on their pathway – remain below 220.
- The proportion of patients who have a cancer diagnosis, and who have had a decision made on their first or subsequent treatment, who then start that treatment within 31 days. 31D standard = 96%

Finalised April Performance

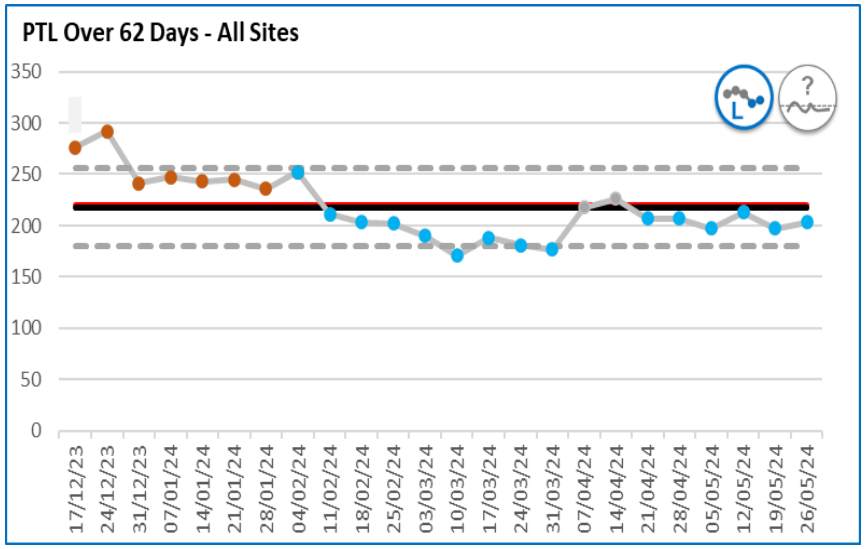
- **28 Day Faster Diagnosis Standard** - Performance in April decreased to 66.3%, not achieving the 75.0% threshold. Performance was impacted by a high number of slot issues within breast, colorectal, gynaecology, head & neck and skin at the beginning of the month. Performance decreased by 8.9% compared to March but remains within the process control limits, which demonstrates the standard can be met within the current processes. 7 out of 14 tumour sites achieved the standard.
- **62 Day Standard** - Performance in April decreased by 0.5% to 68.4% compared to March, however exceeded the operational plan trajectory of 67.1%. Performance continues to demonstrate normal variation within the process control limits, with the upper process control limit falling below the standard. A change in process therefore is needed to meet the standard. The main breach reasons in April were caused by capacity at the front end of the pathway and delays to surgical and oncological treatments.
- **31 Day Standard** - Performance in April decreased to 94.6%, not achieving the 96.0% threshold. The main breach was due to skin surgical capacity at Christchurch.
- **Patient Treatment List (PTL) Over 62 Days** - The total number on the PTL over 62 days remained below the 220 target with 207 patients over 62 days.

Provisional May Performance (un-finalised)

- **28 Day Faster Diagnosis Standard -** Performance in May is currently 76.2% which is a 9.9% increase compared to April and 1.9% above the May trajectory of 75.0%. The main reason for the improvement in performance is due to an increase in capacity at the front end of the pathway for breast, colorectal, gynaecology, head & neck and skin.
- **62 Day Standard** - Performance in May is currently 64.8%, which is below the 67.2% trajectory, however this is expected to increase as further treatments are reported.
- **31 Day Standard** - Performance in May is currently achieving the 96.0% threshold at 96.1%.
- **Patient Treatment List (PTL) Over 62 Days** - The month end position continues to be below the 220 threshold with 203 patients over 62 days.

Responsive (Elective)
Cancer Over 62 Day Breaches

Over 62 Day PTL (Target April: 220)
Finalised UHD April Performance: 207



High Level Performance Indicators

Cancer Standards	Standard	Final	Provisional
		Apr-24	May-24
28 Day Faster Diagnosis Standard	75%	66.3%	76.2%
31 Day Standard	96%	94.6%	96.1%
62 Day standard	85%	68.4%	64.8%

Key Areas of Focus

In 2024/25 the focus for Cancer Performance has returned to the 3 main National Standards (28 Day, 31 Day and 62 Day). UHD remain committed to maintaining the over 62 day PTL under 220. The national standard for 62D performance is 85%. However, in 24/25, the operational planning target is to meet 70% by March 25.

Key areas of focus for Quarter 1 are the 5 most challenged tumour sites:

Gynaecology:
- Additional weekday and Portland Post Menopausal Bleeding sessions planned in June.
- An additional GA hysteroscopy list per month and an extra GA hysteroscopy case on every theatre list.
- Pathway navigator appointed, awaiting start date - this role will focus on planning capacity to meet fluctuations in demand.

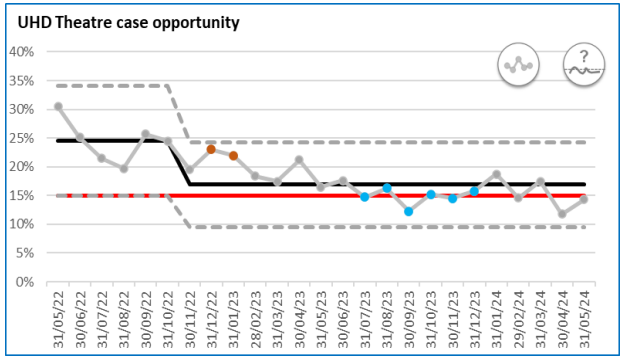
Skin:
- Impact of the commencement of Tele-Dermatology continues to be closely monitored in order to inform future capacity requirements in Quarter 2 2024/25.
- Additional waiting list initiative (WLI) activity scheduled to accommodate an increase in referrals received prior to the expected seasonal variation.

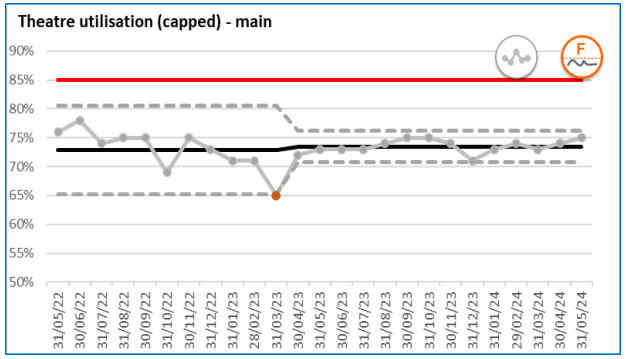
Colorectal:
- Service to utilise Wessex Pathway Analyser to inform an improved performance position against all standards including over 62 day.
- Ongoing insourcing to manage demand alongside elective long waiters.

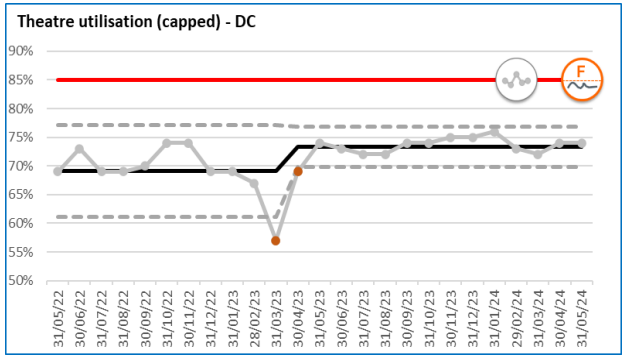
Breast:
- Service to commence MDT Transformation Programme with focus on aligning processes in one stop clinics across sites in Quarter 1.
- Continued partnership working with Radiology to ensure all one stop clinics are fully supported.
- Additional weekend clinics to be scheduled to reduce the number of patients waiting for an urgent suspected cancer referral appointment.

Head and Neck:
- Insourcing solutions sourced and WLI activity agreed to provide additional capacity in June 2024.
- Partnership working with Outpatients Department regarding configuration of clinic capacity to enhance Head & Neck pathways.

Responsive (Elective)
Theatre Utilisation







Data Description and Target

Trust is 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 trauma capacity which will be lower than capped utilisation (left) due to the unpredictable nature of emergency and trauma versus 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.
Day case rate (Target 85%)

Performance

- Capped utilisation within main theatres remains lower than the 85% target but sitting above current mean @ 75% for main, and day case utilisation is at 74%. There is a sustained reduction in variation, however further action is required to deliver a process capable of meeting the target.
- As of the 31st May the average late start time held to 23 mins.
- Ongoing focussed work around orthopaedic lists has triggered special cause variation (improvement) for both capped utilisation and early finishes, however further improvements are still required. Key drivers of performance in Orthopaedics (60.75%) remain - early finishes, late starts, booking processes and theatre E-camis data validation
- There has been an overall increase in touch time and decrease in downtime minutes measured. On the day cancelations also reduced in month
- Gynaecology and general surgery lists booked well
- The day case activity rate is 84% (target 85%) in the previous 3 months.

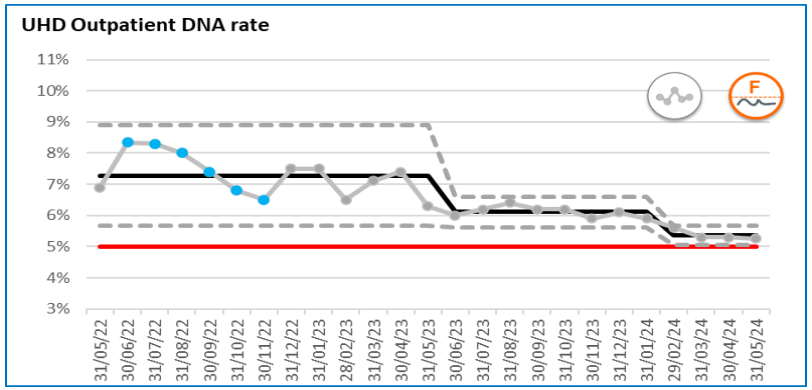
Key Areas of Focus

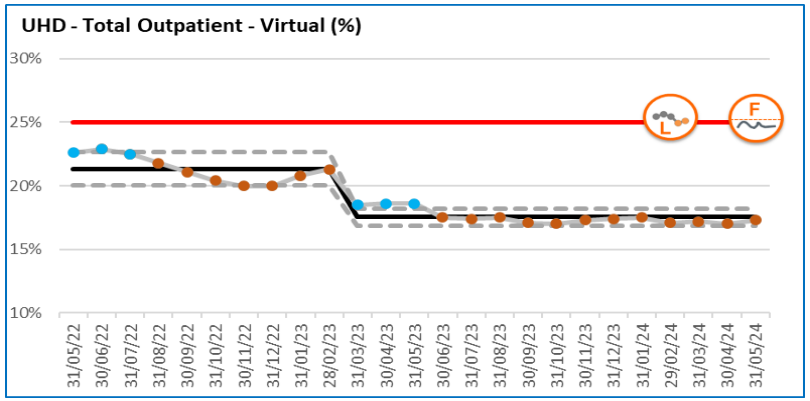
Further work is underway to unlock case opportunity and increase utilisation across all specialities.

- Pilot being run in June to book to 105% theatre capacity. The pilot is a proof of concept to identify any barriers to improving utilisation of theatres.
- Golden patient process commencing June 2024
- Relaunch 6,4,2 in June Increased focus on utilisation, list planning, and speciality specific improvement
- Increase cluster support to ensure fully utilised lists, with appropriate support and equipment
- Actions identified on CCS tools, for ownership of utilisation within specialities
- Improving data quality and delay reasons to inform improvement work.
- On the day cancellations focus required for specialities to improve.
- Ensure data validation of scheduled activity correctly captured through E Camis

Responsive (Elective) Outpatients

Referral Rates (MRR Return)		Standard	This Year	Trust Perf
GP Referral Rate year on year		-0.5%	20446	4.1%
Total Referrals Rate year on year		-0.5%	31413	5.4%
Outpatient metrics				
Overdue Follow Up Appointments (Cons-Led Only)				26046
New Attendances				21246
Follow-Up Attendances				32223
% DNA Rate	*(Total DNAs / New & Flup Atts)*	5%	2966 / 53469	5.3%
Hospital cancellation rate	*lospital Canx / Total Booked Appts)*		11237 / 76358	14.7%
Patient cancellation rate	*Patient Canx / Total Booked Appts)*		8686 / 76358	11.4%
Reduction in face to face attendances (acute only)				
% telemed/video attendances	*(Total Non F-F / Total Atts)*	25%	9256 / 53469	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 May is at 5.3% which is an improved position but within normal variation. The process control limits indicate the target can be met within existing processes. The planned switch on of text reminders across all clinics (unless a clinically led opt-out rationale is provided by specialty teams) is being staggered. Currently 97.6% of all clinics have text reminders switched on or have been excluded. Once the remaining clinics are switched on, this is expected to have a further positive impact on reducing DNAs.

17% of attendances were delivered via telemedicine/video in May which has remained static over the past year. Current process control intervals demonstrate the target will not be met unless process improvements are made. Work is underway to ensure all activity is being captured on our patient administration systems, including video consultations. Video consultations went live on the Dr Doctor platform from 1st April 2024, with no adverse fall in usage rates.

The number of patients overdue their target date for a follow up appointment reduced by 115 in May 2024. A proportion of the reduction in numbers are due to Phase 4 of the Focus on Follow Up validation work.

Key Areas of Focus

- Ongoing completion of clinic utilisation and template reviews at specialty level to ensure up to date templates are in place.
- Delivery of outpatient productivity improvements, which support a reduction in DNA rates, increased use of Patient Initiated Follow Ups (PIFU) and increased clinic utilisation.
- Conclude initial 10-week Process Mining and Intelligent Workflows Project in Outpatients. Improvement interventions are currently being delivered.
- Progress e-outcomes project. Currently delayed while critical testing issues are resolved.
- Implement single repository (Bookwise) for room booking/management and cancellations within the Trust. Progress project plan next month. Online clinic room 'builds' underway.
- Continue a review of cancellations less than 6 weeks. Single UHD cancellation process being. Standard Operating Procedure completed an being reviewed with a plan to relaunch early July.
- Identify Outpatients team member to lead on focussed PIFU workstream.

Responsive - (Elective) Screening Programmes

Breast Screening

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

BREAST SCREENING	STANDARD	ACHIEVED
Round Length within 36 months	90.00%	98%
Screening to first offered assessment appointment within 3 weeks	98.00%	100%
Screening to Normal Results within 14 days	95.00%	99%
Longest Wait Time (Months)	36	36
UPTAKE – QTR 2 (Jan – Mar 24)	70%	66.6%

Background/target description
To ensure the breast screening access standards are met.

Performance:
- All monthly targets have been successfully met.

Underlying issues:
- The National Breast Screening incident has proved to be a challenging body of work for the department due to our high population numbers. However there has been a good response from those women involved and the department anticipate no issues in completing the required studies within the expected deadline. There will be additional workload pressure from individual clinical reviews.
- Radiology staff pressures are increasing due to retirement, resignation, sickness and maternity leave as well as a vacancy. This is on the risk register. This is adding increasing pressure which will impact services significantly in the coming months .
- Low Radiography staffing levels and long-term sickness continue to impact the rate of screening. It is essential to increase and maintain a higher volume to keep on track and effectively manage the expected pressures following the covid recovery. A regular throughput of between 2500 – 3000 per month is essential to meet the round length target going forward. At the current low rate of screening, breaches will be experienced in the round length towards the end of summer 2024.
- Christchurch screening site is now fully operational and is working extremely well.

Actions:
- An open appointment system is in place to enable us to effectively manage the throughput of screening and minimise any future breaches whilst reducing wasted unused screening appointments. However, this places a great deal of strain on the admin process in the unit due to the high volume of calls to book appointments. The position is being monitored.

Bowel Screening

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

Background/target description
To ensure the bowel screening access standards are met.

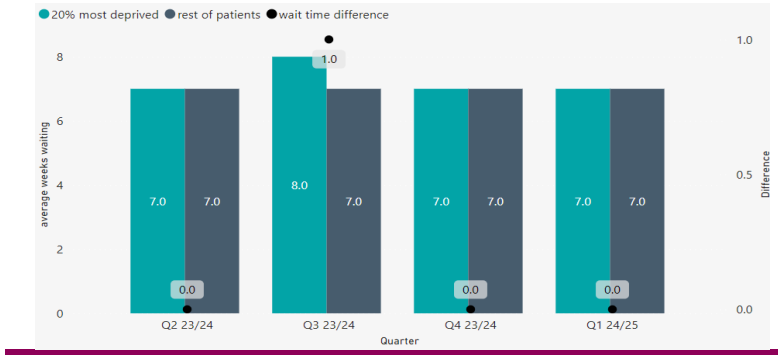
Performance:
- SSP Clinic Wait Standard: This standard continues to be maintained at 100%.
- Diagnostic Wait Standard: This standard was delivered at 100% in May 2024.

Underlying issues:
- One screener at DCH is due to leave soon. This reduction in capacity will be partly mitigated but there will be a reduction in overall capacity. Succession plan being worked through but will take time for aspirant screeners to gain accreditation.
- Replacement capacity for the system potentially joining in August.
- Next phase of age extension due April 2024 but NHS England has delayed, moving to Q2.

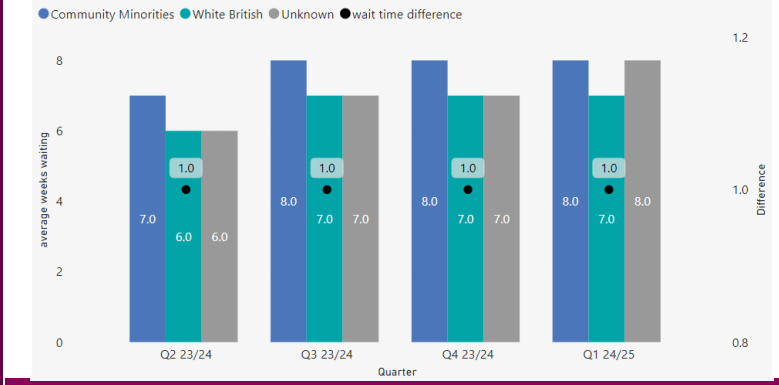
Actions:
- Deliver plans with Dorset County to use additional insourcing capacity in 24/25
- Review insourcing plan for UHD for 24/25 until replacement capacity has been established.
- Support accreditation process for 2 potential new screeners and identify other endoscopists where possible

Health Inequalities

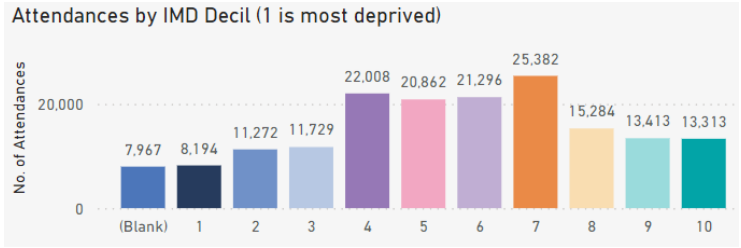
Median Weeks (elective) waiting by Deprivation Group



Median Weeks (elective) waiting by Ethnicity Group



Emergency Department attendances by Deprivation Group



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.
Emergency department admissions by Index of Multiple Deprivation (IMD) decile

Performance

Waiting list by Index of Multiple Deprivation (IMD) Analysing elective waits in Quarter 1 2024/25 to date, 8.5% of patients on the waiting list live in the 20% most deprived areas of Dorset (IMD 1-2). The median weeks waiting at the point of treatment for people in IMD 1-2 shows no variation compared to people from IMD 3-10. Analysing the same data by age band identifies no variation between children (<18 yrs) and adults.

Waiting list by ethnicity: 9.9% of patients on the waiting list are from community minority ethnicity groupings. An analysis of the median weeks waiting by ethnicity grouping identifies a 1-week variation between patients within community minority groups and White British populations in Quarter 1 to date. This mirrors the variance in Q4 2023/24. However, the level of variation increases to 7 weeks for <18 year olds from community minority groups.

A deep dive into ENT services to understand the variations in 'did not attend' rates by IMD group and ethnicity has commenced to understand the reasons for missed appointments which are a contributing factor to increased waits.

Emergency dept. attendances by Index of Multiple Deprivation (IMD) Attendances are lowest in deprivation deciles 1-3.

Key Areas of Focus

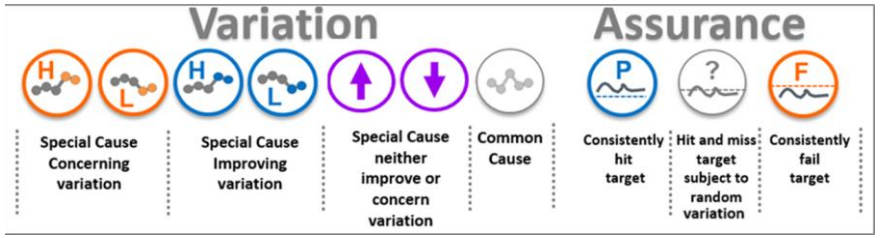
The Trust Health Inequalities group are working to:

- Deliver against the duties outlined within the NHS England's statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006) to collect, analyse and publish information on health inequalities.
- 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 through Patient First.
- 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.

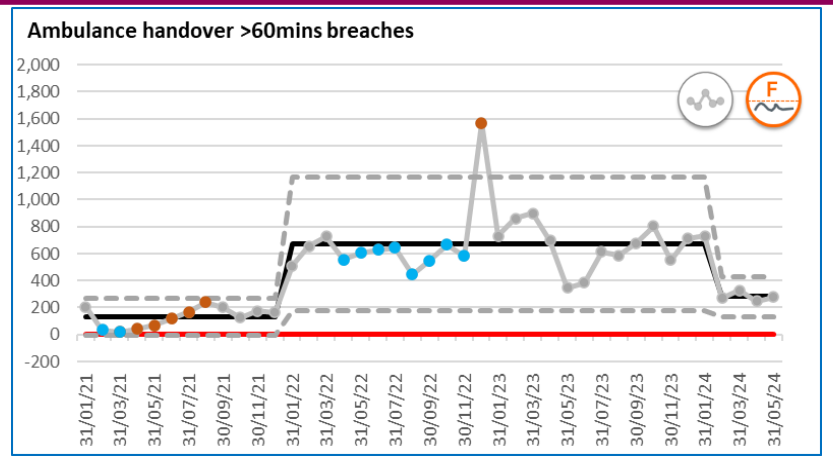
Performance at-a-glance
Responsive (Elective) - Key Performance Indicators Matrix

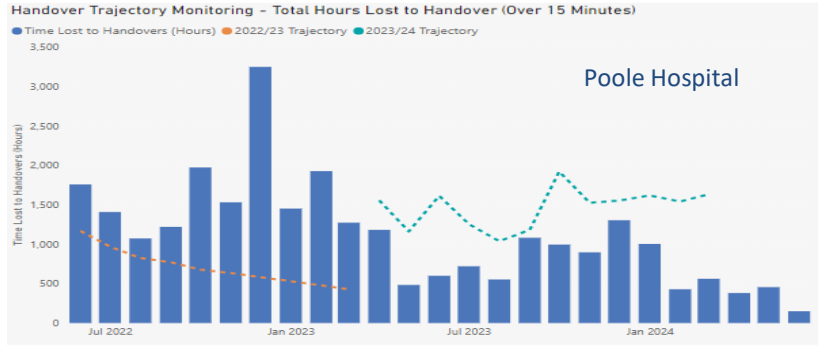
UHD Elective Care

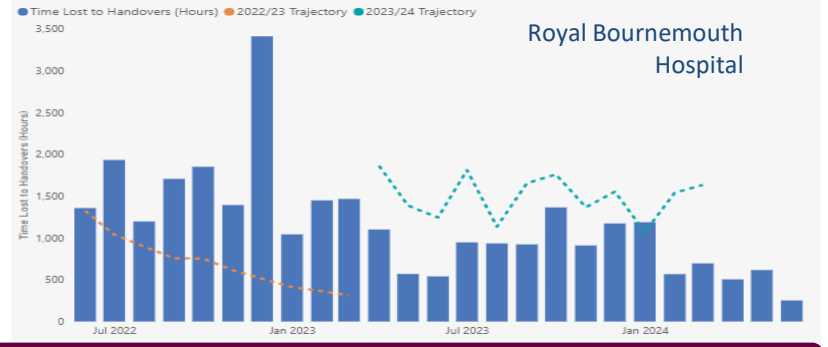
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
UHD - Total Waiting List Size	May 24	68343	68120			68836	65500	72171
UHD - Patients waiting >78 weeks	May 24	11	-			54	11	98
UHD - Patients waiting >65 weeks	May 24	393	-			474	-38	986
UHD - Patients waiting >52 weeks	May 24	2960	3230			3046	2282	3809
UHD - Patients waiting >52 weeks non admitted	May 24	1707	0			1548	1124	1972
UHD - RTT Performance against 18 week standard	May 24	62.4%	92.0%			61.3%	58.9%	63.6%
UHD - Total Diagnostic Waiting List	May 24	13100	-			12160	10927	13394
UHD - % waiting over 6 weeks	May 24	12.9%	1.0%			10.0%	5.3%	14.7%
UHD - % waiting over 13 weeks	May 24	0.8%				0.9%	0.2%	1.5%
UHD - Faster Diagnosis Standard (FDS) 28 days	Apr 24	66.3%	75.0%			69.3%	57.9%	80.7%
UHD 62 day standard	Apr 24	68.4%				64.3%	55.7%	72.8%
Trauma Admissions	May 24	403	-			368	316	421
% of NOF patients operated on within 36 hrs of admission	May 24	51.0%	85.0%			62.6%	45.3%	79.9%
% Outpatient appointments with procedures	May 24	18.5%				16.9%	15.1%	18.8%
UHD - Total Outpatient - Virtual (%)	May 24	17.3%	25.0%			17.5%	16.9%	18.2%
UHD Outpatient DNA rate	May 24	5.3%	5.0%			5.4%	5.1%	5.7%
Theatre utilisation (capped) - main	May 24	75.0%	85.0%			73.5%	70.8%	76.2%
Theatre utilisation (capped) - DC	May 24	74.0%	85.0%			73.4%	69.9%	76.8%
UHD Theatre case opportunity	May 24	14.3%	15.0%			16.9%	9.5%	24.3%



Responsive – (Emergency) Ambulance Handovers







Data Description and Target

- Number of ambulance handover delays greater than 60 minutes from arrival to a receiving Emergency Department. 15 minutes is the target for an Ambulance to handover to a receiving ED from arrival. There should be no ambulances waiting over 60 minutes.
- Number of ambulance hours lost due to handover delays. There is a site level recovery trajectory for lost ambulance hours per day.

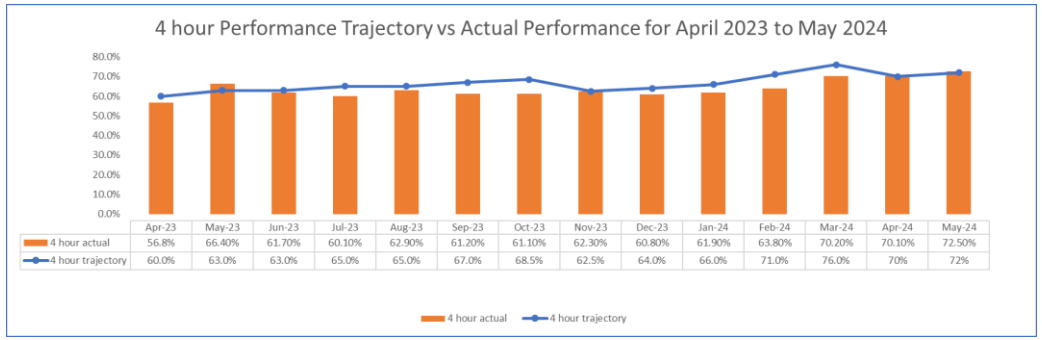
Performance

- The total number of Ambulance handovers increased in May to 4,414 vs 4,130 in April. There were 142 Ambulances per day against 137 in April. This was driven by Bournemouth increasing from 65 ambulances per day in April to 68 in May with Poole continuing to receive 73 per day.
- Both sites still received more Ambulances than in May 2023. This is consistent across both sites with approximately 18 additional conveyances a day cross-site.
- Ambulances waiting longer than 60 minutes increased marginally to 279 in May vs 245 in April, however show normal variation. May 2024 performance amounts to 6.3% of total handovers vs 5.96% in April and 7.49% in March 24.
- Average handover duration also increased marginally to 24.6 minutes at PH and to 31.7 minutes at RBCH. The regional average slightly increased to 48.9 minutes vs 45 minutes in previous months.
- Based on the 15-minute ambulance handover standard Poole reported a total of 447 hours lost in May and RBH reported 597 hours lost.
- In terms of the Dorset wide picture, April data shows there were 1,002 total hours lost to handover- this was predominantly driven by UHD with May data currently pending.

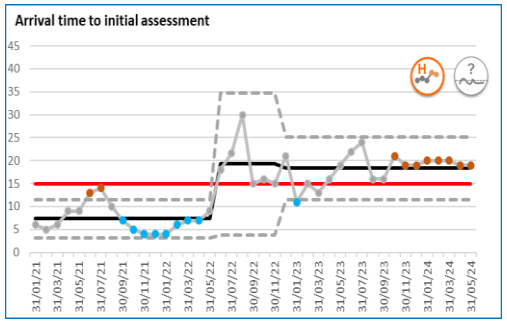
Key Areas of Focus

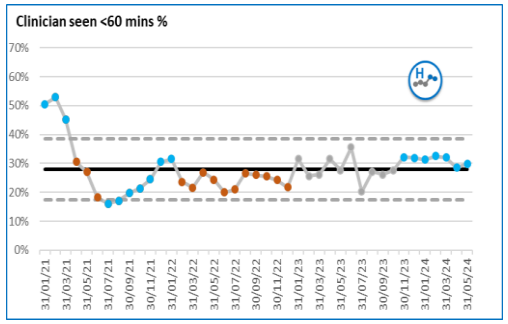
- The Trust risk score relating to Ambulance Handovers remains at 15 with the main reason for delayed handover relating to insufficient staff to complete handover as well as no physical capacity.
- The team have continued to combine cohorting and corridor care with SWAST, this has enabled the sites to maintain flow and improve handover performance- however safety and risk implications are under review with a risk to be added to the Trust risk register for assurance of appropriate mitigation purposes.

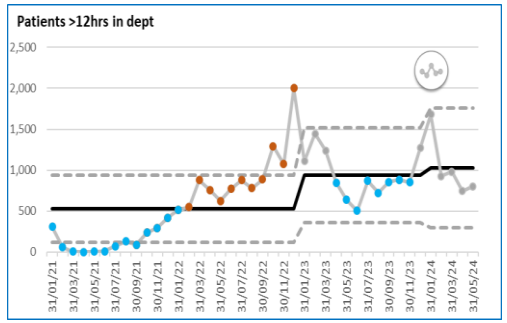
Responsive (Emergency) Care Standards

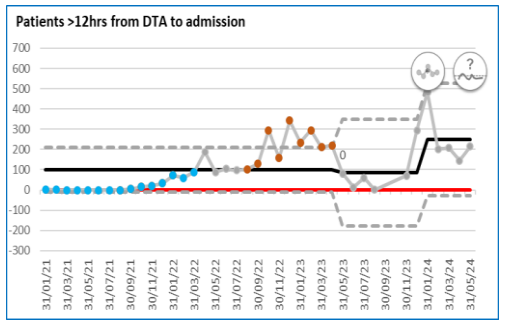


	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
4 hour actual	56.8%	66.40%	61.70%	60.10%	62.90%	61.20%	61.10%	62.30%	60.80%	61.90%	63.80%	70.20%	70.10%	72.50%
4 hour trajectory	60.0%	63.0%	63.0%	65.0%	65.0%	67.0%	68.5%	62.5%	64.0%	66.0%	71.0%	76.0%	70%	72%









Data Description and Target

UHD has now returned to reporting against the national 4-hour standard. The national requirement is to achieve 78% of all patients leaving ED within 4 hours for 2024/25.

Performance

The Trust delivered 72.5% against an internal trajectory of 72% in May 2024 with the next target for June of 73%.

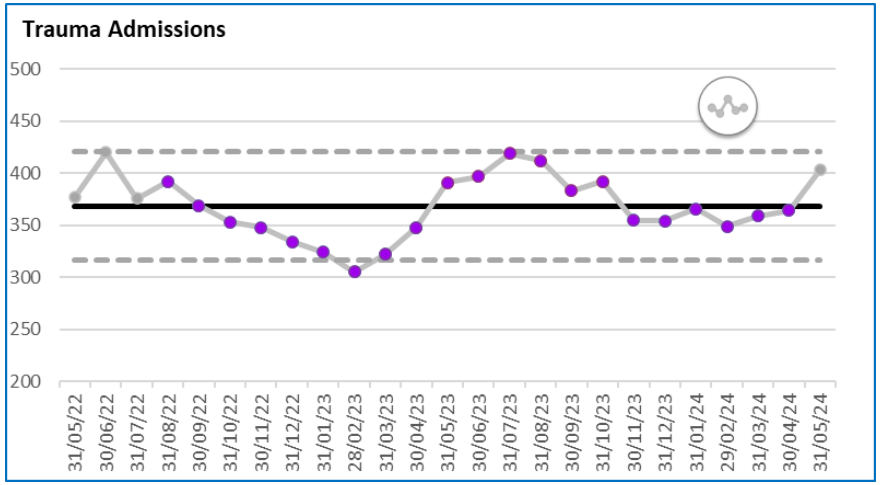
- Total attendances for May significantly increased with 15,318 attendances vs 14,081 attendances in April. There were approximately 494 attendances a day cross site in May vs 469 in April 24. They also remain significantly higher than May 2023 which amounted to 463 attendances a day.
- Arrival time to initial assessment remains relatively static as per previous months at 19.3 minutes in May vs 18.5 minutes in April and 20 minutes in March despite the surge in attendances.
- This is also reflected in meantime in the department with a further decrease, to 263 minutes vs 270 minutes in April. This is the sixth consecutive month and the lowest meantime since May 23.
- Arrival time to decision to admit also continues to see further improvements and dropped by a further 12 minutes in May to 234 minutes vs 246 minutes in April, 252 in March and 262 in February 24.
- Total number of patients waiting more than 12 hours increased slightly to 801 vs 745 in April 24. This was mirrored in patients waiting longer than 12 hours following a decision to admit which was 214 in May vs 145 in April. Both are within the range of normal variation.

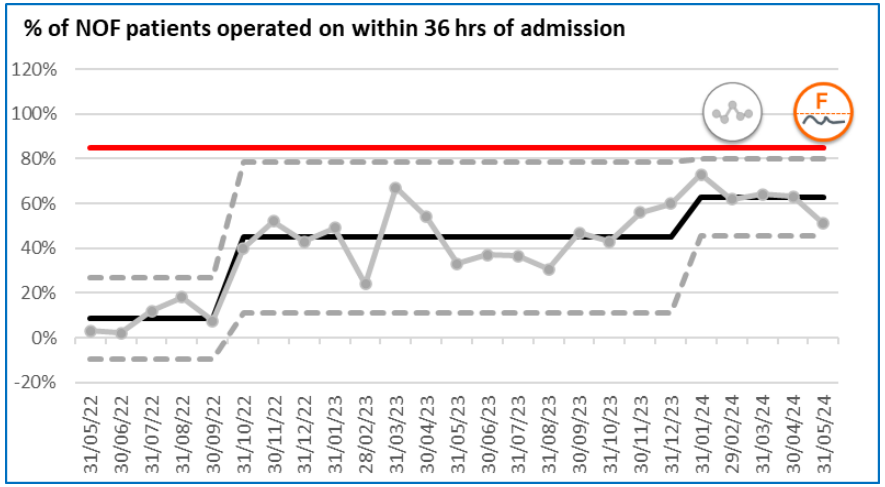
Key Areas of Focus

As a department Type 1 Non-Admitted performance improved in May to 72% improving from 70.4 % in April. Performance peaked at 80%. Type 1 Admitted performance has a sustained average of 31% in May vs 30.2% in April. Performance similarly peaked at 50%.

A review of UTC service provision cross site is on-going with slot utilisation and direct streaming from ED and walk ins being implemented whilst maintaining directly bookable and 111 capacity. In May we saw an increase in the number of patients streamed to 2104 from 821 in April.

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

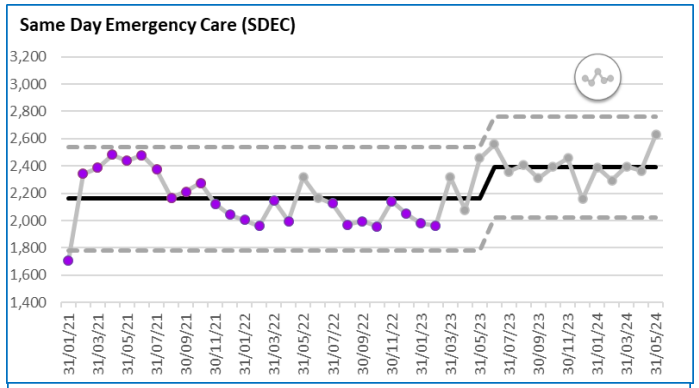
May performance for time to theatre for fractured neck of femur (# NoF) patients: 68% achieving surgery within 36 hours of being fit for surgery and 51% operated on within 36 hours from admission. This is a reduction in performance compared to April and below the national average.

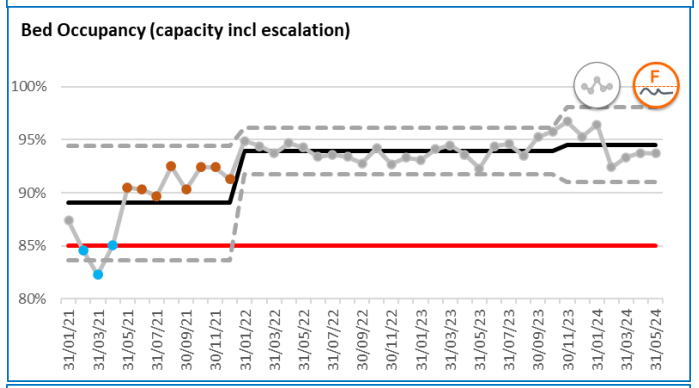
- Overall trauma admissions increased with 403 in May including 97 with a fractured neck of femur (NoF).
- 18 of the 97 NoF's were unfit for surgery on admission.
- 17 Shaft of femur (SoF) fractures admitted in May with all requiring surgery, 13 patients with a #NOF required a THR.
- 15 patients required 2 trips to theatre, equating to an additional 16 theatre cases .
- Overall admissions increasing as expected during summer months.

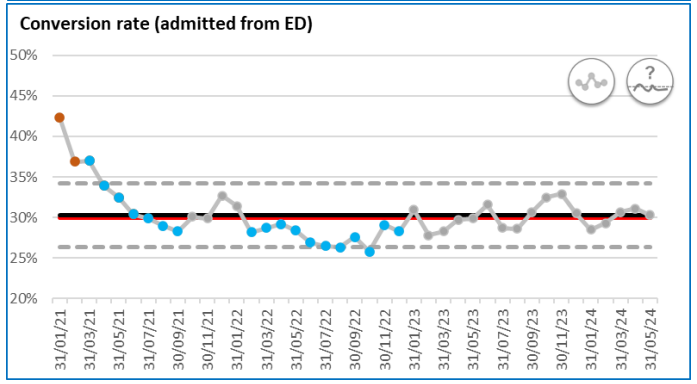
Key Areas of Focus

- e-Trauma , Digital ED link to Virtual Fracture Clinic (VFC) has ceased due to Agyle implementation, which has delayed e-trauma virtual fracture clinic implementation. Risk register updated, contextual link to be implemented, testing in progress.
- Hand Hub continues to be a success operating 2 sessions per week with 14 patients through the service, releasing 10 main theatre sessions
- Trauma outliers continue to remain low.
- Review of weekend trauma capacity underway.
- Reduced availability of orthogeriatric input due to reallocation of resources to OPS.

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. The ICB operational plan uses 92% occupancy as its ambition.

Performance

Bed occupancy remained high in May at an average of 1046 adult beds occupied, 6 more than in April, which is 96% of planned adult beds open (1079).

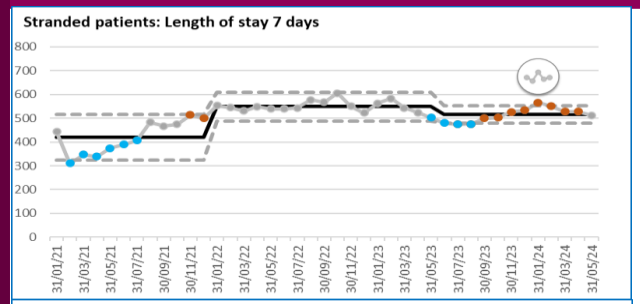
The average number of escalation beds open in May saw a further decrease compared to April to an average of 49. There were significant delays with patients waiting for beds at times in ED, with an average of 19 per day waiting for beds every morning.

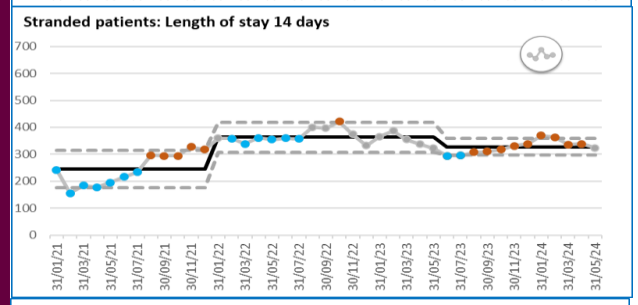
No Criteria to Reside (NCtR) continues to impact occupancy and escalation. NCtR again decreased further in May from an average of 200 to an average of 188.

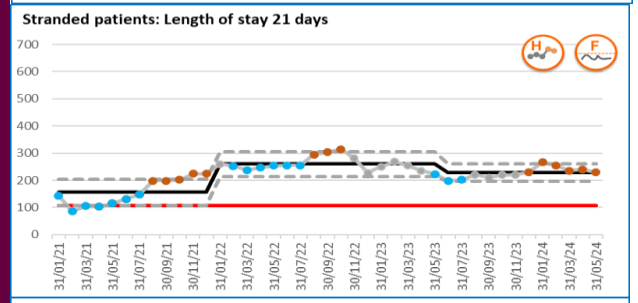
Key Areas of Focus

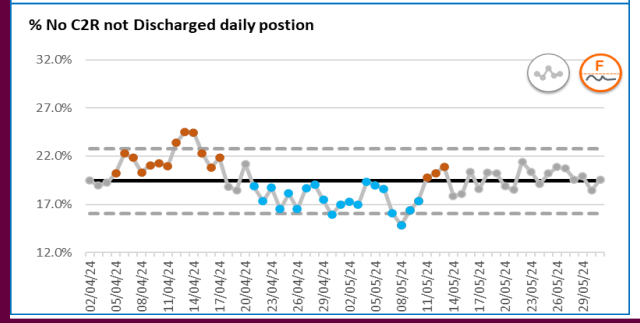
- UHD continues to 'hold the line' on not reopening SDEC care spaces that have been released from bedded capacity. Some escalation capacity has remained open on the Poole site in April, alongside escalation of CIU in order to maintain cardiology inpatients and access the lab; this has led to cancellations.
- In March, all partners in the ICB received a letter from the ICB Chief Operating Officer asking for immediate focus on 5 key actions aimed at improving pathways for patients ready to leave hospital. This has been progressed at a 'Place' level with UHD working closely with BCP. This continues with the Transfer of care Hub (ToC) established; however, benefits realisation has not been fully delivered.
- Virtual Ward is a significant success. On average there were 108 patients per week being admitted which is a 12 patient increase on the previous month, with 1500 Occupied Bed Days recorded in May.
- Same Day Emergency Care (SDEC) continues to make progress but is not achieving the 12 hours per day, 7 days a week standard in all areas. This is a core element of the UHD recovery plan. An SDEC strategy workshop is taking place on 9th June to agree forward work plans.

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. 2034/24 ICB ambitions to reduce the number of patients with No Criteria to Reside (NCtR) were substantially missed, currently no ICS baseline or trajectory has been established for 24/25.

Performance

21+ day length of stay position shows wards are far from the target of a maximum of 108 patients. In May the average number was 229, which is a decrease of 20 compared to April.

No Criteria to Reside (NCtR) has seen improvement during May with the average reducing to 189 (from 200 average in April).

Analysis of the discharge profile for the last 3 months shows that the improvement has not been achieved by higher numbers of discharges with support. This number remains challengingly low at an average of 14 a day with no improvement in May when compared to April, there has however been a marginal increase to 9 discharges at weekends from 6 in April. Further analysis of those discharged home with support (pathway 1) confirms that 40-50% of those discharged are supported by a service directly provided or commissioned by UHD, rather than community health or social care providers.

UHD continues to reduce unfunded beds in May in line with the agreed capacity plan. The number of escalation beds in use reduced from an average of 59 in April to 49 in May. The ICB has revised the ask of UHD as part of 24/25 operational planning and are being asked to establish 20 additional core beds. There have been further changes to the bed base in June in line with the capacity plan 24/25.

Key Areas of Focus

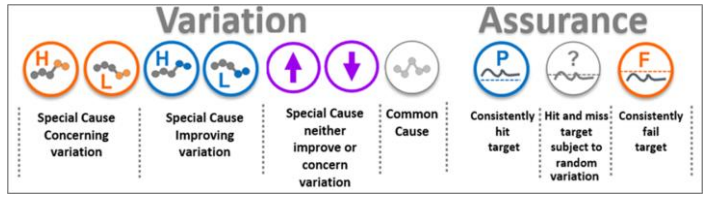
Every patient with a LoS of over 100 days is reviewed at a weekly meeting with system partners to ensure all actions are being progressed to achieve the discharge, community health care partners are joining this meeting moving forward.

As part of the UHD Capacity plan patients who have been in hospital longer than 21 days with a criteria to reside will be reviewed and tracked. The Transfer of Care Hub (ToC) has started using the EDR date for complex discharge planning from the end of April, this will bring forward discharge dates by reducing the time a patient has no criteria to reside in a hospital bed.

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	May 24	19	15			18	11	25
Clinician seen <60 mins %	May 24	30%	-			28%	17%	38%
Patients >12hrs from DTA to admission	May 24	214	0			250	-27	528
Patients >12hrs in dept	May 24	801	-			1027	298	1755
4 hour safety standard	May 24	72.5%	76.0%			64.0%	58.0%	70.0%
Ambulance handovers	May 24	4414	-			4253	3698	4807
Ambulance handover 30-60mins breaches	May 24	1040	-			1059	666	1452
Ambulance handover >60mins breaches	May 24	277	0			280	130	430
Bed Occupancy (capacity incl escalation)	May 24	94%	85%			95%	91%	98%
Stranded patients: Length of stay 7 days	May 24	512	-			515	478	551
Stranded patients: Length of stay 14 days	May 24	324	-			327	296	358
Stranded patients: Length of stay 21 days	May 24	230	108			228	195	260
UHD NCTR % - all delays	May 24	43.0%	-			46.5%	40.2%	52.9%
Non-elective admissions	May 24	7030	-			6041	5159	6924
> 1 day non-elective admissions	May 24	4193	-			3780	3186	4374
Same Day Emergency Care (SDEC)	May 24	2629	-			2393	2024	2763
Conversion rate (admitted from ED)	May 24	30.3%	30.0%			30.3%	26.3%	34.2%



Sustainable Servicers

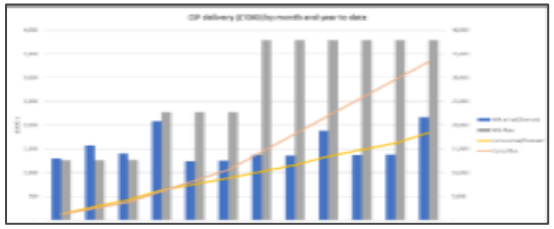
Pete Papworth
Chief Finance Officer

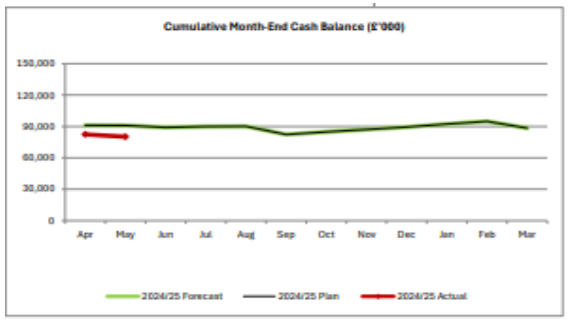
Operational Lead:
Andrew Goodwin, Deputy Chief Finance Officer

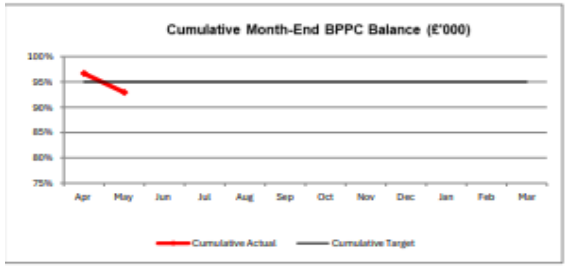
Committees:
Finance and Performance Committee

Finance

FINANCIAL INDICATORS	Year to date		
	Budget £'000	Actual £'000	Variance £'000
Control Total Surplus/ (Deficit)	(3,350)	(3,476)	(126)
Capital Programme	15,699	15,699	0
Closing Cash Balance	91,038	80,230	(10,808)
Public Sector Payment Policy	95.0%	92.1%	(2.9)%







Commentary

At the end of May 2024 the Trust has reported a deficit of £3.476 million against a planned deficit of £3.350 million, resulting in an adverse variance of £0.126 million. In month as part of the planning re-submission, the additional ERF target income to deliver 109% has been rephased to commence in July 2024, rather than in April 2024.

Income is £0.594 million favourable to plan year to date. Included within this position is a £0.973 million favourable variance against Dorset ICB income related to the dental contract, details of which are still being finalised. Other non-NHS income is £0.1 million adverse due to a shortfall on private patient income and RTA (Road traffic Act) income. Other operating income is adverse to plan by £0.2 million due to a shortfall in car park income, and donated income, both of which are anticipated to recover.

Operating expenditure is £1.324 million adverse to plan year to date. Pay is £0.365 million adverse, primarily due to premium nursing agency expenditure including additional unfunded bed capacity, enhanced nursing care needs and non-delivery of the pay efficiency improvement programme target. This has been off-set in part by staff vacancies. Drugs are £1.2 million adverse year to date, primarily due to Homecare drugs. Premises & Fixed Plant is £0.5 million favourable to plan year to date, mainly due to energy costs being lower than plan.

Agency spend in month is £1.598 million against a planned level of £1.119 million being the cap value equating to 3.2% of total pay expenditure. Whilst this is a reduction when set against the expenditure in March, it represents an adverse variance to budget of £0.479m.

Efficiency savings of £5.585 million have been achieved against a target £5.560 million. As of 31 May 2024, EIP (Efficiency Improvement Plans) are reporting a forecast risk adjusted saving of £31.9 million against a target of £42 million leaving a potential shortfall of £10.1 million.

The Trust has reported capital expenditure of £15.7 million against a plan of £15.7 million. As part of the re-submission of the plan we were required to rephase the capital plan to match actual spend at the end of Month 2.

As at 31 May 2024 the Trust is holding a consolidated cash balance of £80.2 million which is fully committed against the future Capital Programme.

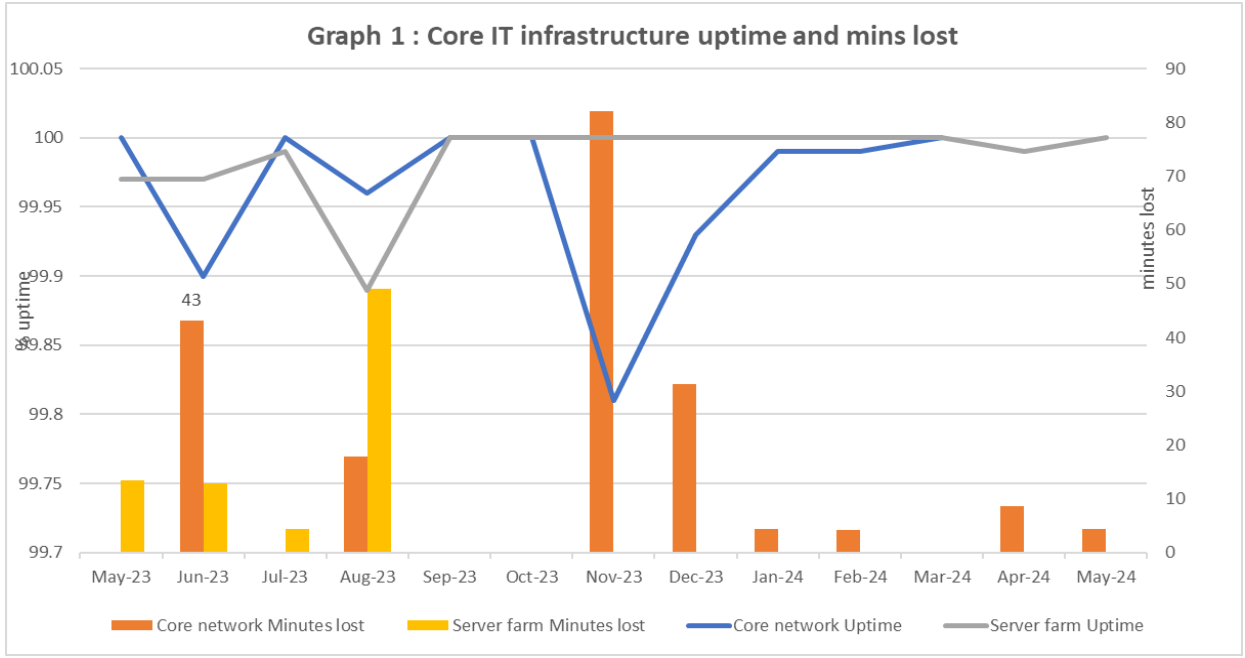
In relation to the Public Sector Payment Performance the Trust is currently delivering performance of 92.1% against the national standard of 95%.

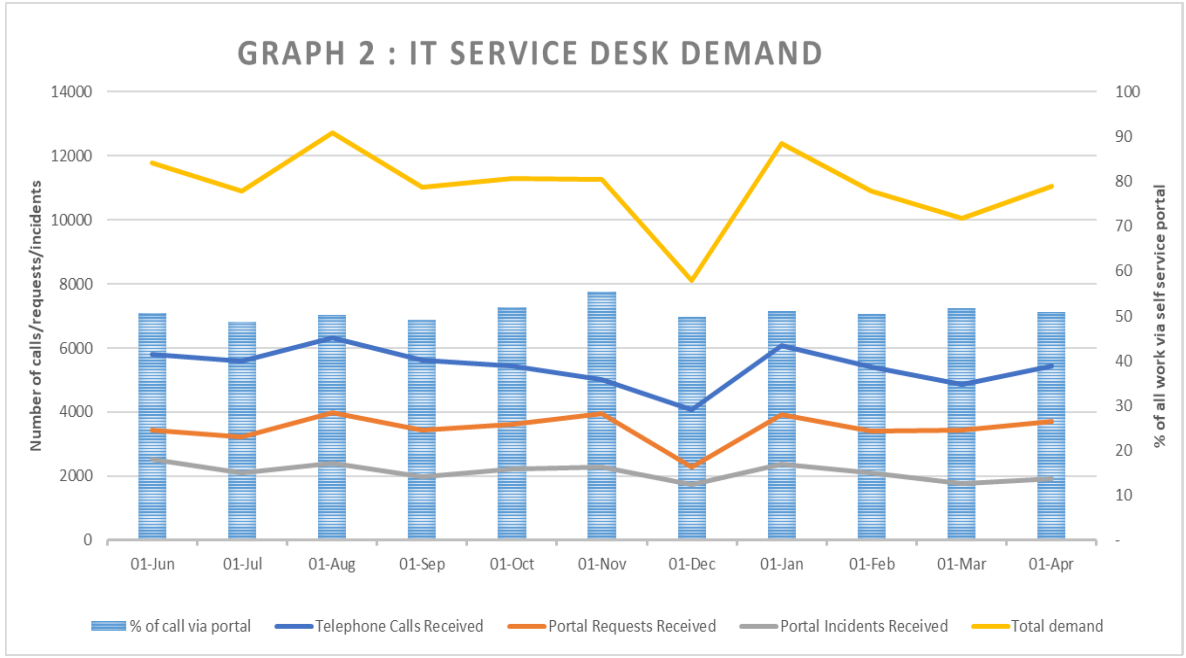
Digital

Pete Papworth
Chief Finance Officer

University Hospitals Dorset
NHS Foundation Trust

Information Technology



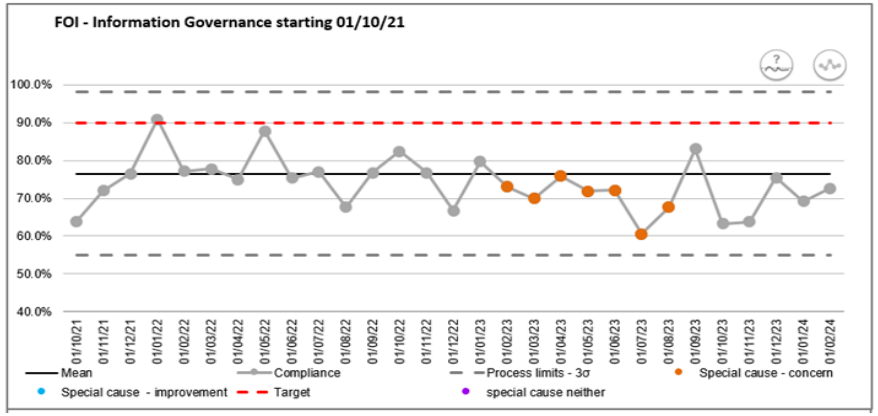


Commentary

Graph 1: Minimal issues on Core infrastructure for May 2024.

Graph 2: The Service Desk demand remains within the bounds of expected variation.

Information Governance



Commentary

Table 4 shows a Statistical Process Control chart for the UHD Freedom of Information Act Compliance.
Table 5 Device Growth position of desktops and servers at UHD
Chart 6 Cyber alerts trending for UHD
Table 7 Current position on Windows devices at UHD and their security status.

Table 5: Device position

Devices	Last Month	Now	More/Less	Change %
Desktop Estate Growth	9,037	8,884	-153	-1.69%

Devices	Last Month	Now	More/Less	Change %
Server Estate Growth	594	587	-7	-1.18%

Table 6: Cyber Alert Trending

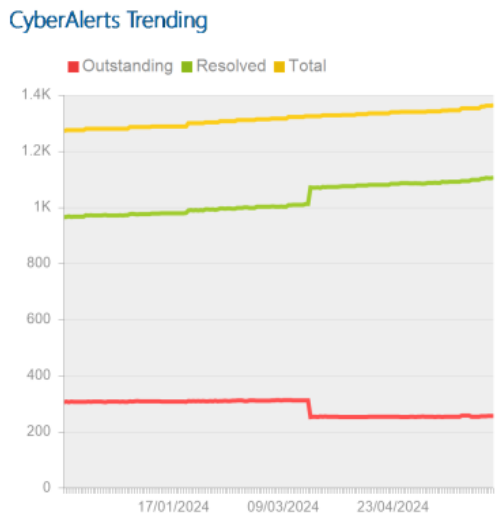


Table 7: Windows Device position

Health Records

Table 8: Priority 1 System Downtime

Times	SLA Adherence	Comment	Root Cause Resolved
1st May 930-955 am	Yes	Alerts not displaying in EPR	Yes
11th May 0830 - 13th May 0900	No	HICSS Server error - System out a number of times over the weekend	Yes
24th May 1015- 1030	Yes	Agyle unavailable	Awaiting update
28th May 1445 - 1715	Yes	ICE Slow and unresponsive	Yes

Commentary

Table 8 Shows key applications system outages for May 2024

Graph 9 Shows Demographic Data Quality – Numbers of Merged Records

Chart 10 shows the staff trained by system in April.

Graph 9 : Demographic Data Quality – Numbers of Merged Records

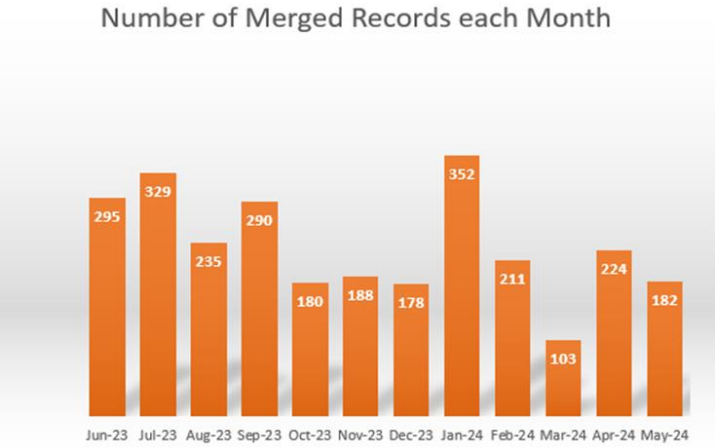
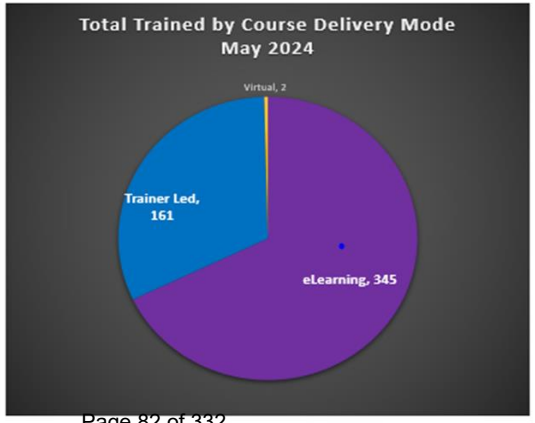


Chart 10 : Training Statistics



University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 03 July 2024

Agenda item: 8.2.1

Subject:	Key Issues and Assurance Report to Board of the Quality Committee meetings held on 28 May 2024 and on 25 June 2024
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:	At its meeting on 28 May 2024, the Committee received the following: • Update from NHS Dorset • Risk Register: risks rated 12-25 (new and current) • Integrated Performance Report • Developing the Clinical Strategy report • CQC Update • Annual Claims and Litigation Report • Maternity Safety Champions Report • Mental Health Report • Patient Safety Update • Draft Quality Account • Quality Committee Annual Report • Assurance/alerts from the Clinical Governance Group. At its meeting on 25 June 2024, the Committee received the following: • Board Assurance Framework – Risks 4, 5 and 6 • Risk Register: risks rated 12-25 (new and current) • Integrated Performance Report • Electronic Health Record Update • CQC Update • Quality Impact Assessment Process • Maternity Safety Champions Report • Safeguarding Report • Dementia Report • Annual Complaints Report • Assurance/alerts from the Clinical Governance Group and Mortality Surveillance Group.

Significant issues for escalation to Board for action:	Matters for Board awareness:
	In addition to reports that would be presented to the Board (including new risks rated 12-25, Maternity Safety Champions Report, Annual Complaints Report, draft Quality Account and Quality Committee Annual Report):
	• At its May 2024 meeting, the Committee agreed to raise the following matters to the Board
	  • Progress on job planning
	  • The update provided on mental health
	  • The update on progress against the CQC actions.
	• At its June 2024 meeting, the Committee agreed that there were no matters to escalate to the Board. However, for awareness, it was agreed to raise the following matters to the Board
	  • The new BAF 6 risk
	  • Safeguarding report
	  • Restraint policy
	  • Aspirations for complaints response times to move from 55 days to 35 days
	  • Human Tissue Authority report and the actions being taken
	  • Nursing and Midwifery Council feedback in relation to Maternity.

Progress of Board Assurance Key Risks Assigned to Committee:	BAF Risk 4 – score remained constant at 6 for April 2024 and May 2024, target of 6 BAF Risk 5 – score remained constant at 8 for April 2024 and May 2024, with a target of 6 BAF Risk 6 – score remained constant at 9 for April 2024 and May 2024.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 03 July 2024

Agenda item: 8.2.2

Subject:	Maternity Safety Champions Report
Prepared by:	Lorraine Tonge, Director of Midwifery Kerry Taylor, Head of Midwifery Suzie Warwick, Risk & Governance Manager Christine Smith, Senior Matron Inpatient Services Akeisha Robinson, Senior Matron Outpatient Services
Presented by:	Lorraine Tonge, Director of Midwifery

Strategic themes that this item supports/impacts:	Systems working and partnership ☒ Our people ☒ Patient experience ☒ Quality: outcomes and safety ☒ Sustainable services ☒ Patient First program ☒ One Team: patient ready for reconfiguration ☒
BAF/Corporate Risk Register: (if applicable)	None
Purpose of paper:	Assurance
Executive Summary:	Highlights from the maternity safety champions report will be used in conjunction with IPR slides attached to give the Board a summary of the key areas of focus for maternity. **Activity** – Advise: Antenatal clinic attendances continue to be high in May 2024 a review of antenatal pathways is underway, and consideration is being given to services that could be offered as an outpatient service. This will be ongoing work over the next 3 months. **Perinatal quality surveillance** – Assure: There were 1 MBBRACE reportable cases for May - baby death expected due to congenital abnormalities no immediate learning identified. There were no HSIB (MNSI) cases reported in May. Advise: PMRT learning identified – Improvement in documentation of first language at booking was needed. Evidence by audits that this has improved.

MNSI L117885 Final report received – There was 2 neonatal safety recommendations made to ensure processes are in place to support staff during resuscitation and to ensure processes are in place during a difficult intubation.

Coroner's inquest
There is one expected inquest in November of a baby born in January 2023 and died at 12 hours of age. MNSI recommendations have previously been reported: Key recommendations were:
Holistic care
Neonatal resuscitation training
Full observation of babies' head on admission to NICU.

Advise
Top 3 reported Lern incidents
Term admission to NICU
Insufficient number of clinicians
Post partum hemorrhage >1500
3rd and 4th degree tears

There are ongoing quality improvement projects for PPH and 3rd/4th degree tears.

Workforce: Safe staffing –
Advise
Medical staff on risk register at 12 with 2 vacant Consultant post. Interviews planned for July. Impact on team continues until staffing is resolved.

Assure.
Midwifery vacancies at 0% in May. Focus is now supporting these junior staff and retention of our staff in preparing for the move in 2025.

Advise:
Although the vacancy rate is 0% for midwives there remains an increased junior workforce that continues to need support.

Assure:

Red flags last month showed there were 51 incidences and this month Matron and Consultant keep this under continuous review to ensure risks are assessed to maintain safety.

1:1 care was provided 100 %.

The labour ward coordinator was supernumerary 100% of the time at the start of each shift.

Service user voice:
Advise.
MNVP

There have been no walkarounds conducted by MNVP due to a resignation in he MNVP team however one is planned for July as well as the relaunch of 15 Steps.

Assure:
The MNVP chair is now involved in governance process with complaints and PMRT to give the woman's perspective.

Complaints
There were 4 new complaints in May.
Themes Communication -Consent-birth choices- process for baby identification.
All are being actioned and learning disseminated.

FFT -not available at time of reporting due to staffing capacity in that team.

Staff feedback
Walkabout completed by NED, CNO, DOM and HOM. Observed busy wards and how this impacts staff on giving warm welcomes. Staff made aware and teams working on how this can be improved. Staff also thanked for their hard work.

Training- Assure
Compliance is currently >90 % in all areas of training to meet the maternity incentive scheme and the challenge is in maintaining the required standards.

Maternity improvement plans

CQC action plan –

Assure
Action Plan now closed as completed.

Maternity incentive scheme year 6 –

Assure

MIS year 6 requirements were published on 2nd April 2024. Work progressing well. Challenge to meet the requirements will need investment of 1 additional neonatal consultant and suitable training space for now and in the new build.

Assure
Insight and 3-year delivery plan
An action plan has been developed and is being reviewed monthly at the assurance meetings - all action in progress.

Assure
MSSP exit criteria.
All actions progressing.

Maternity safety dashboard:

Perinatal Quality Surveillance scorecard	Metric	Alert (national standard/ average where available)	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Perinatal	Red flags: 1:1 care in labour not provided	0	0	0	0	0	0	0
	3rd/4th degree tear overall rate	>3.5%	1.7%	2.2%	2.3%	1.7%	3.70%	4.2%
	Obstetric haemorrhage >1.5L	>3%	5.4%	3.9%	4.8%	3.6%	4.50%	2.80%
	Term admissions to NNU	National <6%, Regional <5%	4.90%	6.10%	4.70%	6.00%	6.50%	6.50%
	Apgar < 7 at 5 minutes	<1.2 %	1.4%	1.9%	0.9%	0.9%	0.70%	0.6%
	Stillbirth number	Actual	0	0	0	0	0	1
	Stillbirth number/rate (per 1,000) per quarter	<2.6 /1000	3			0		
Workforce	Rostered consultant cover on Delivery Suite - hours pw	<72	72	72	72	72	72	72
	Dedicated anaesthetic cover on Delivery suite - per week	<58	58	58	58	58	58	58
	Midwife/band 3 to birth ratio (establishment)	01:23	01:21	01:21	01:21	01:21	01:21	01:21
	Midwife/band 3 to birth ratio (in post)	01:23	01:22	01:22	01:21	01:21	01:21	01:21
Feedback	Number of compliments (Smiles via Badgernet)		no data	40	36	38	no data	96
	Number of concerns (PALS) negative		1	0	5	0	5	2
	Complaints	3	2	1	1	4	4	4
	FFT Repsonse from November 23		276	297	307	no data	140	
Training	UHD Mandatory training - women's health midwives	90%	85%	87%	88%	90%	89%	89%
	PROMPT/Emergency skills all staff groups	90%	82%	86%	88%	95%	96%	97%
	K2/CTG training all staff groups	90%	86%	86%	86%	96%	99%	96%%
	CTG competency assessment all staff groups	90%	86%	86%	86%	96%	99%	98%
	Core competency framework compliance - Midwife update	90%	91.00%	moved to ccf2	moved to ccf2	96%	no data	98%
	Coroner Reg 28 made directly to the Trust		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)

Areas of focus for quality improvement:
3rd and 4th degree tear
PPH
ATAIN.

Background:

The purpose of the Maternity Quality and Safety Report is for the Board Level Safety Champion to share emerging guidance for maternity services, provide updates from reviews of published national and local inspection reports, include feedback from women and their families, support quality improvement and escalate locally identified safety issues in Maternity.

Key Recommendations:

To note report

Implications associated with this item:

Council of Governors	☐
Equality, Equity, Diversity & Inclusion	☐
Financial	☐
Health Inequalities	☐
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
Maternity quadrumvirate Safety champions meeting Directorate meeting Care group Board	11/06/2024	Report will be discussed
Quality Committee	25/06/2024	Meeting has not yet taken place at the time of submission of this report.

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

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 03 July 2024

Agenda item: 8.2.3

Subject:	Annual Complaints Report 2023/ 24
Prepared by:	Christina Harding – Deputy Head of Patient Experience Matthew Hodson – Deputy Chief Nursing Officer
Presented by:	Sarah Herbert – 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)	Not Applicable
Purpose of paper:	Assurance
Executive Summary:	In summary, this Complaints Annual Report 2023/24 describes how complaints have been managed at University Hospitals Dorset. The report details the number and nature of complaints received during the year and demonstrates the Trust's commitment to learning and improvement. This Annual Complaints report therefore sets out the statutory requirements needed to meet these requirements detailed further in the report. For assurance the report concludes that UHD meets the statutory and regulatory responsibilities required alongside, •Providing a consistent, positive and proportionate experience for complainants. •Aligned the legacy systems with minimal disruption to services. •Promotes a culture of learning and ensures complaints are acted on to improve services. •Achieves or working towards achieving best practice standards (Patient Association 2013; NHSE 2015; Healthwatch 2016; Parliamentary & Health Service Ombudsman, 2020, Care Quality Commission 2022). •Support the new Parliamentary and Health Service Ombudsman (PHSO) Complaints Standards Framework

	currently being piloted nationally, of which UHD is part of the early adopter group for this work. There are also a number of recommendations to continue to ensure we learn from complaints, focus on early resolution and further reduce our complaint response times.
Background:	The Local Authority Social Services and National Health Service Complaints (England) Regulations (2009), requires that all NHS Trusts provide an annual report on the handling and consideration of complaints.
Key Recommendations:	Several recommendations and conclusions are drawn at the end of the annual report which we ask Quality Committee Members to note.
Implications associated with this item:	Council of Governors ☐ Equality, Equity, Diversity & Inclusion ☐ Financial ☐ Health Inequalities ☐ Operational Performance ☐ People (inc Staff, Patients) ☐ Public Consultation ☐ Quality ☒ Regulatory ☒ Strategy/Transformation ☐ System ☐
CQC Reference:	Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well Led ☒ Use of Resources ☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Quality Committee	25/06/2024	Meeting has not yet taken place at the time of submission of this report.

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

University Hospitals Dorset
NHS Foundation Trust

2023/2024

ANNUAL COMPLAINTS REPORT

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1.0 INTRODUCTION

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

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

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

2.0 THE PROCESS FOR MANAGING CONCERNS AND COMPLAINTS

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

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

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

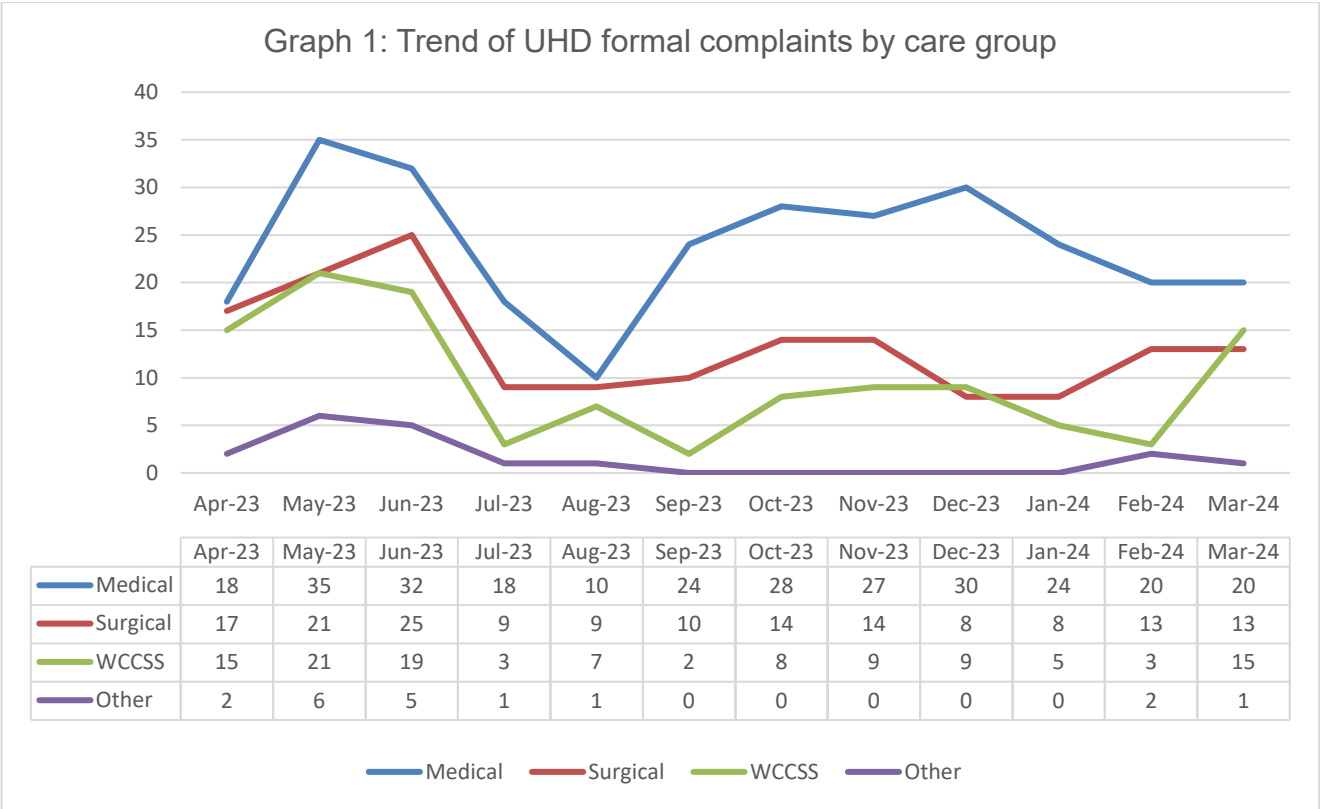
- Early Resolution complaints – complaints that are part of the complaint process but are resolved within 10 working days
- care group investigations and responses
- corporate investigations and complaints – these are the more complex and serious complaints.

This model was again revised in 2023 due to delays with the care group investigation and responses. All complaints are now managed centrally by the corporate complaints team.

3.0 COMPLAINTS RECEIVED

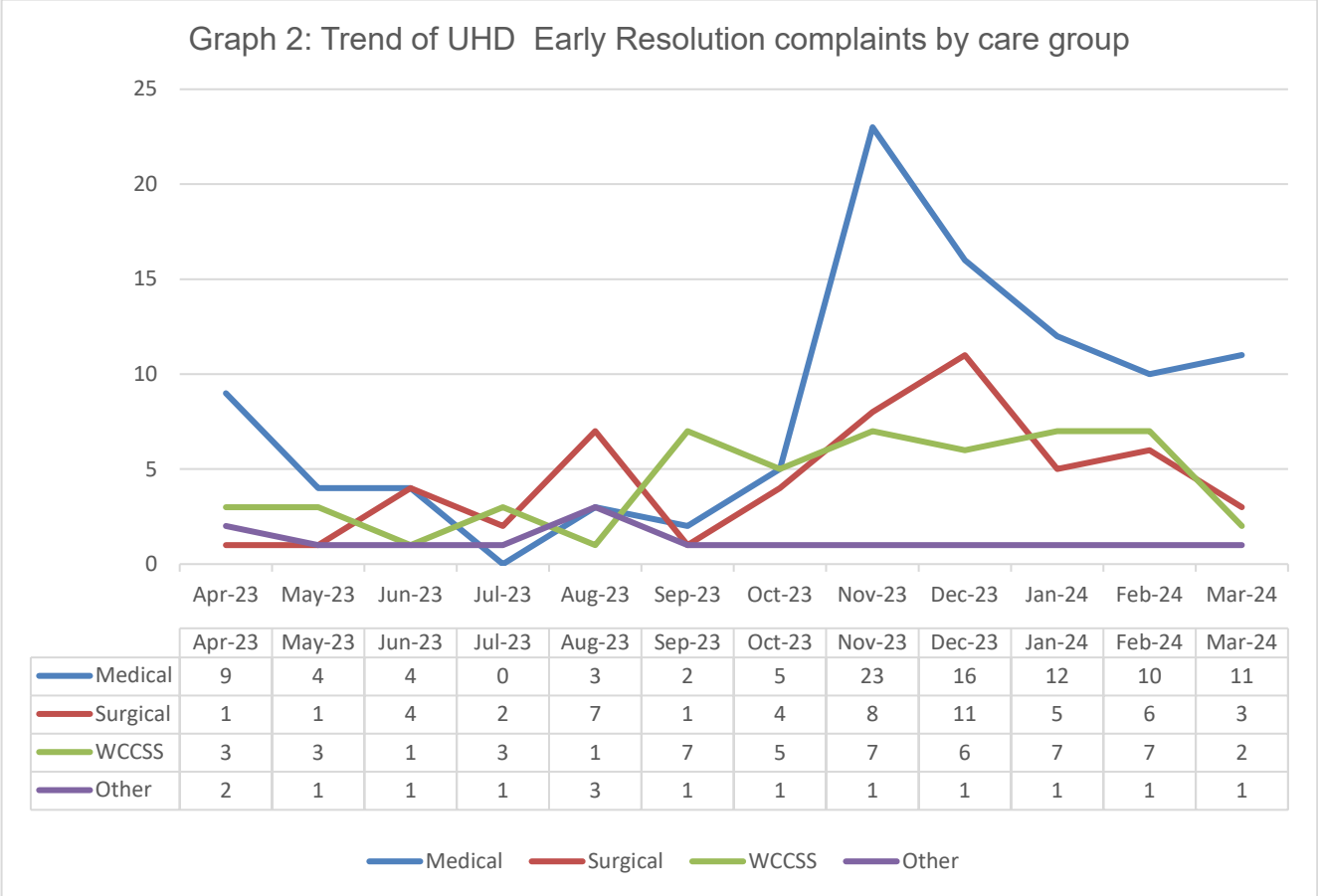
3.1 The Trust (incorporating single organisation data) received a total of 800 complaints in 2023/2024. This includes the Early Resolution complaints that had not been counted in complaints total received previously. However, as they form part of the complaint process their figures are now included.

The Trust managed 581 formal complaints. This is presented as a monthly trend, by care group, in Graph 1.



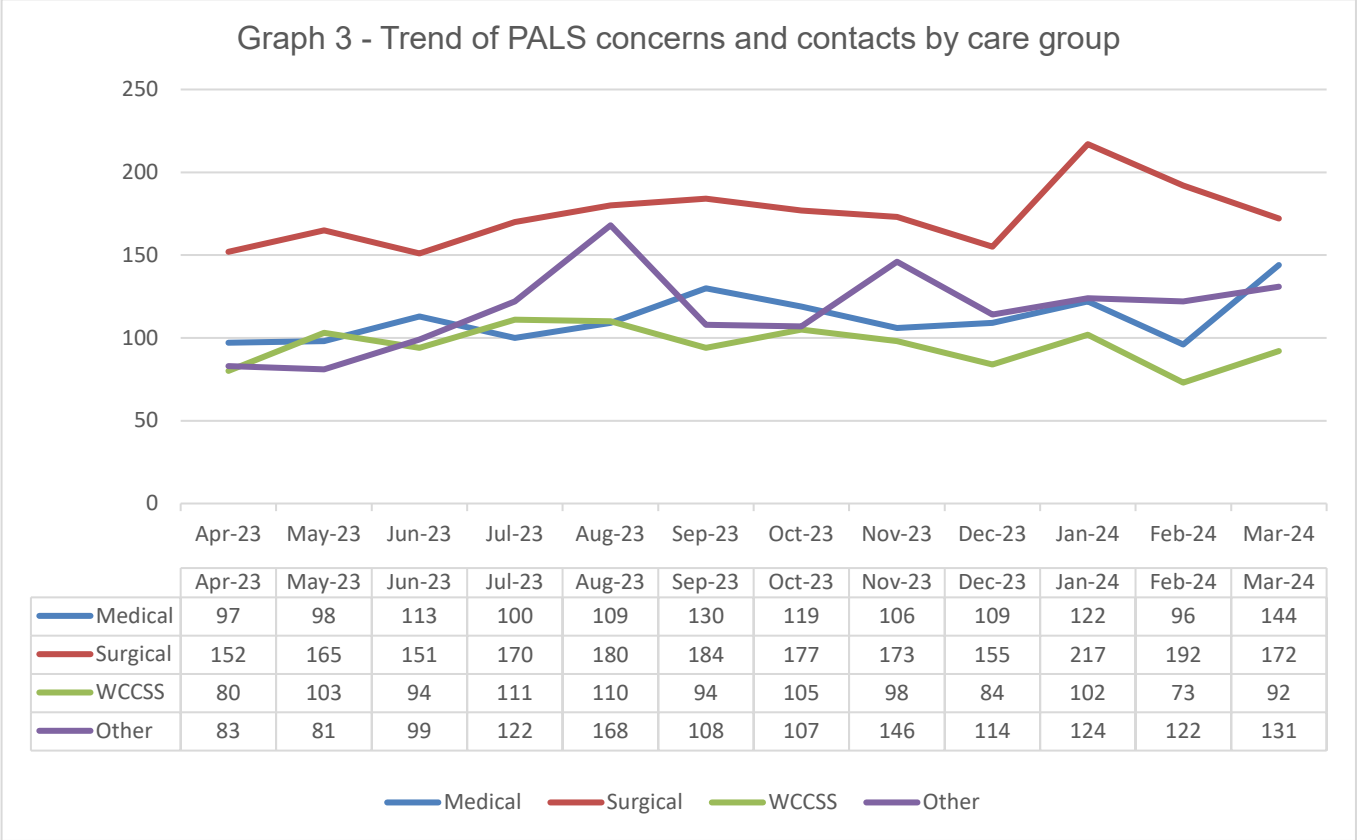
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Medical	18	35	32	18	10	24	28	27	30	24	20	20
Surgical	17	21	25	9	9	10	14	14	8	8	13	13
WCCSS	15	21	19	3	7	2	8	9	9	5	3	15
Other	2	6	5	1	1	0	0	0	0	0	2	1

3.2 In addition to the 581 formal complaints, the Trust also handled 219 early resolution complaints. This has been broken down to the care groups and is shown in Graph 2



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Medical	9	4	4	0	3	2	5	23	16	12	10	11
Surgical	1	1	4	2	7	1	4	8	11	5	6	3
WCCSS	3	3	1	3	1	7	5	7	6	7	7	2
Other	2	1	1	1	3	1	1	1	1	1	1	1

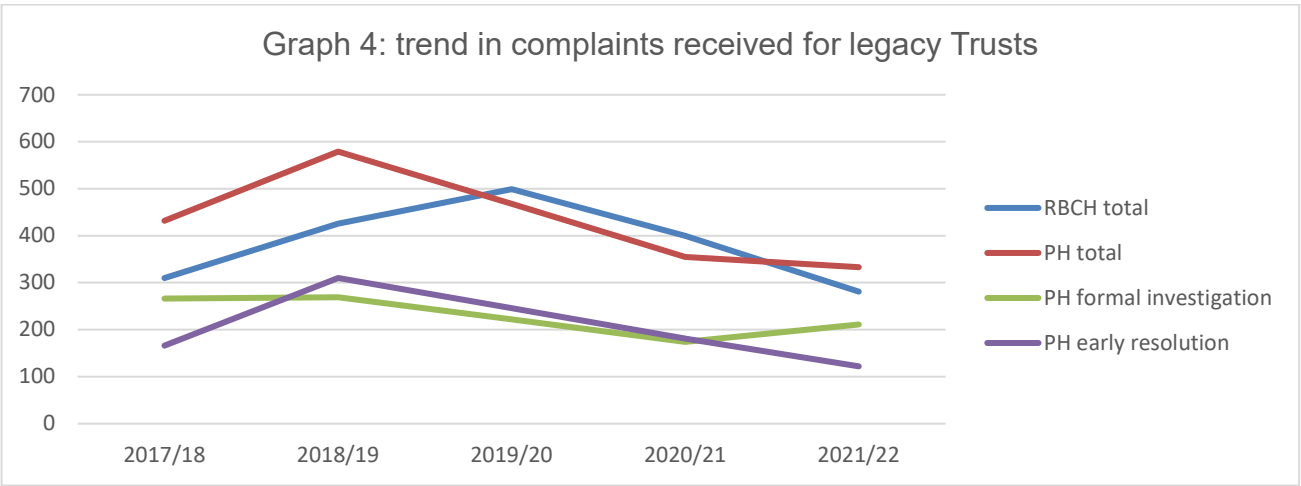
3.3 A total of 5981 PALS concerns, and contacts were processed and responded to in this year, via the UHD Patient Advice and Liaison Service (PALS). This is detailed in Graph 3.

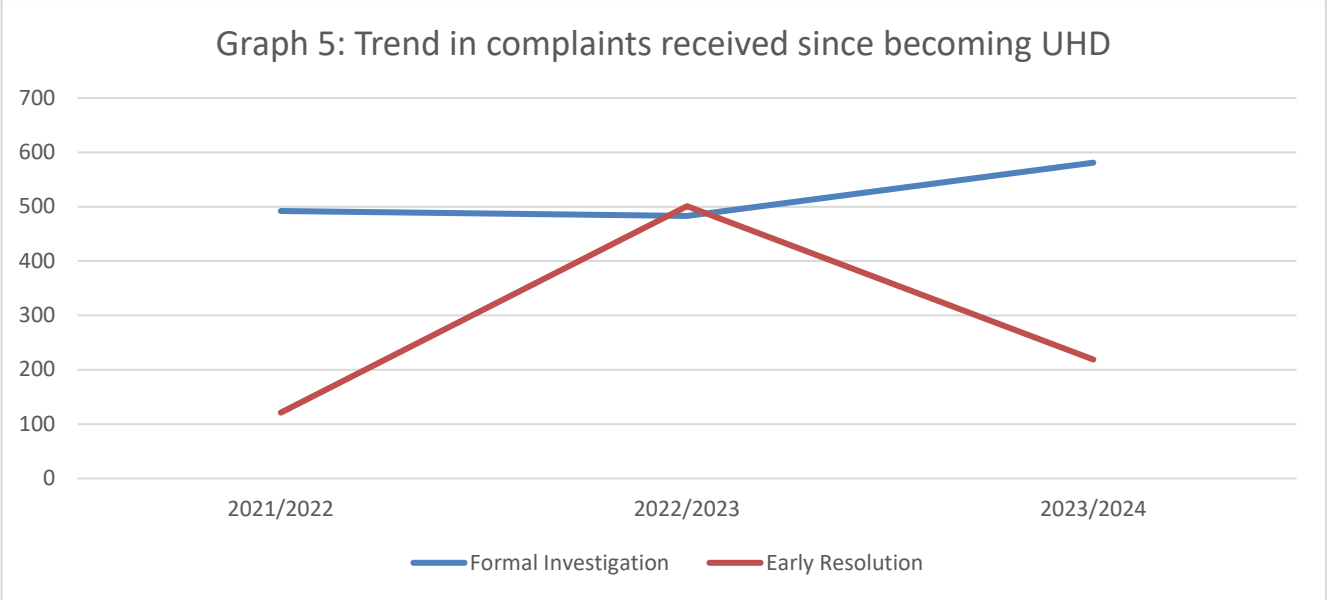


	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Medical	97	98	113	100	109	130	119	106	109	122	96	144
Surgical	152	165	151	170	180	184	177	173	155	217	192	172
WCCSS	80	103	94	111	110	94	105	98	84	102	73	92
Other	83	81	99	122	168	108	107	146	114	124	122	131

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

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



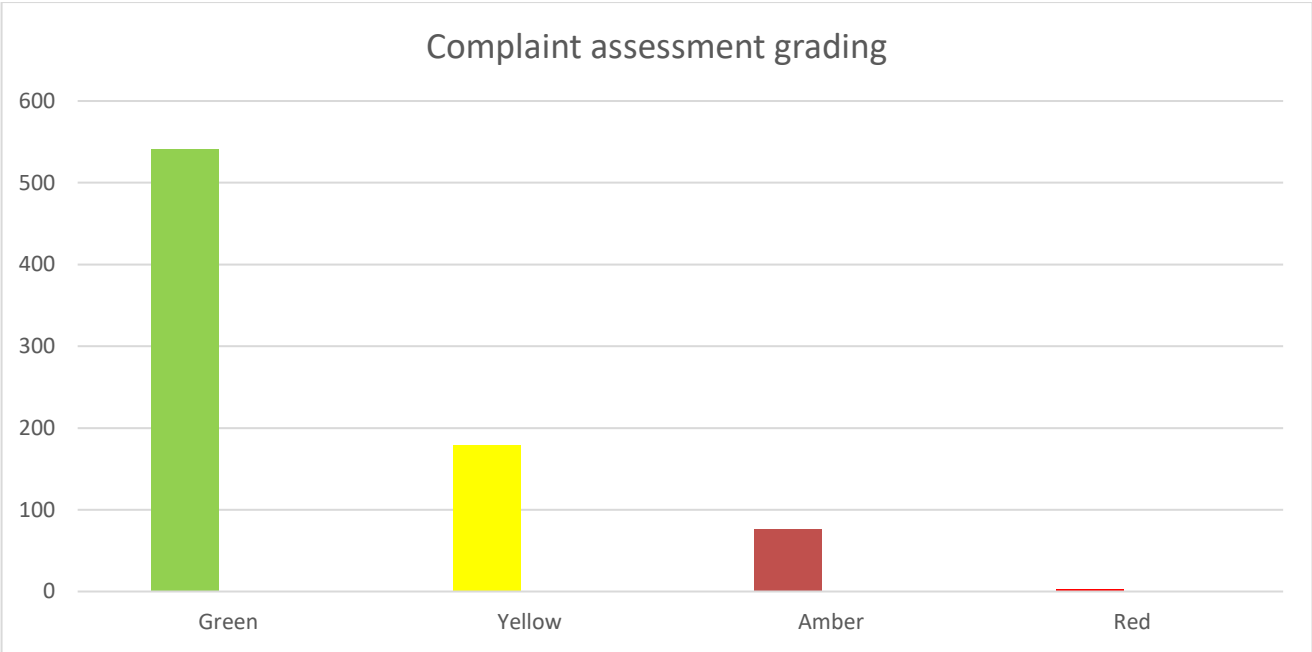


3.7 Table 2 shows the breakdown of persons making a complaint and their method of communication. The low 'In Person' mode of communication reflects the impact of the Covid-19 pandemic and temporary pause on receiving face-to-face PALS callers.

Table 2: Complainant profile and mode of communication, 2023/24

Person making the complaint		**Mode of communication**	
Patient	**51.9%**	Phone	8.1%
Spouse	**10.1%**	Email	83.1%
Parent	**10.2%**	In person	2.8%
Relative / Carer	**25.5%**	Letter	6.0%

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



Graph 6: Breakdown of complaints received, by grade

4.0 RESPONSIVENSS AND PERFORMANCE

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

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

4.3 The response timescale remained set to 55 working days. This was to enable a more thorough review of the complaint and align the investigation processes, to provide a more detailed response to people who unfortunately needed to raise a complaint. The intention is to start reducing this during 2024/25 to an response timescale of 35 working days

Table 4: complaint handling performance	Q1	Q2	Q3	Q4	Yr end
Number of complaints received	250	125	235	190	800
% complaints acknowledged within 3 working days (KPI 100%)	69.6%	96.8%	98.7%	98.9%	89.3%
% response within 55 day internal target (KPI 75%)	40.8%	26.4%	46.4%	44.7%	41.1%
Number re-opened complaint investigations (KPI <10%)	9	7	8	11	35
Complaints opened for investigation by the PHSO	5	2	3	3	13
PHSO investigations closed (& upheld/partially upheld)	4	0	1	2	7

4.4 The outcome of all closed complaints, by quarter, is shown at Table 5, the numbers will be lower than the information in the previous table as there are complaints received that remain under investigation. The data shows that UHD upholds fewer complaints when compared to the national average. Fewer upheld complaints may indicate fewer incidents where care fell below

the expected standard, caution needs to be applied to this conclusion as it could also indicate a lack of robustness within the Trust investigation process. However, it is assuring that the Parliamentary Health Service Ombudsman (PHSO) looks at the way the hospital complaint process investigations are conducted as part of the review. In 2023/24 13 complaints were opened for investigation by the PHSO and 7 upheld or partially upheld. The remaining cases were all closed without investigation progressing once the complaint casefile and records were supplied.

Quarter		Table 5: Outcome of complaints investigated and resolved					
	Closed	**Upheld**	***National average***	**Partially Upheld**	***National average***	**Not upheld**	***National average***
Q1	258	35 (13.5%)	*27.6%*	57 (22.2%)	*39.6%*	166 (64.3%)	*32.7%*
Q2	163	37 (22.7%)	*27.6%*	35 (21.5%)	*39.6%*	91 (55.8%)	*32.7%*
Q3	179	47 (26.2%)	*27.6%*	46 (25.7%)	*39.6%*	86 (48.1%)	*32.7%*
Q4	263	68 (25.8%)	*27.6%*	74 (28.1%)	*39.6%*	121 (46.1%)	*32.7%*

4.5 The number of reopened investigations and upheld/partially upheld PHSO investigations are measures of the quality of complaint handling. During 2023/24, the number of reopened investigations fell well below the internal target of <10%.

5.0 BDO AUDIT

5.1 An Audit was carried out in 2023 by partners in BDO and was published in September 2023. There were some actions that the Trust were recommended to take as detailed in the below table.

Recommendation	Action Agreed	Priority level	Progress
1 The Trust should set a trajectory to get complaints response times back in line with policy by a realistic date acknowledging operational and resource pressures 2 Where appropriate, complaint acknowledgements could indicate that there may be a delay in response to manage patient expectations	Additional actions taken are as follows; a. PALS and Complaints team are to merge to reduce duplication of process and effort to improve complainants experience. The team will be merging on 2 October 2023 with staff all working to the same job description. b. The team focus will be on resolution with all members of staff aiming to resolve concerns without needing to process a	Medium	A trajectory has been set and numbers of overdue complaints are declining. Internal process has been changed with more ownership being taken. Progress is being made, a) Several of the team are already hybrid working (mix of complaints and PALS work) there still remains a backlog of complaints work that is slowly being cleared to allow the rest of the team to move over to fully hybrid working b) all staff continue to have a focus on resolution of

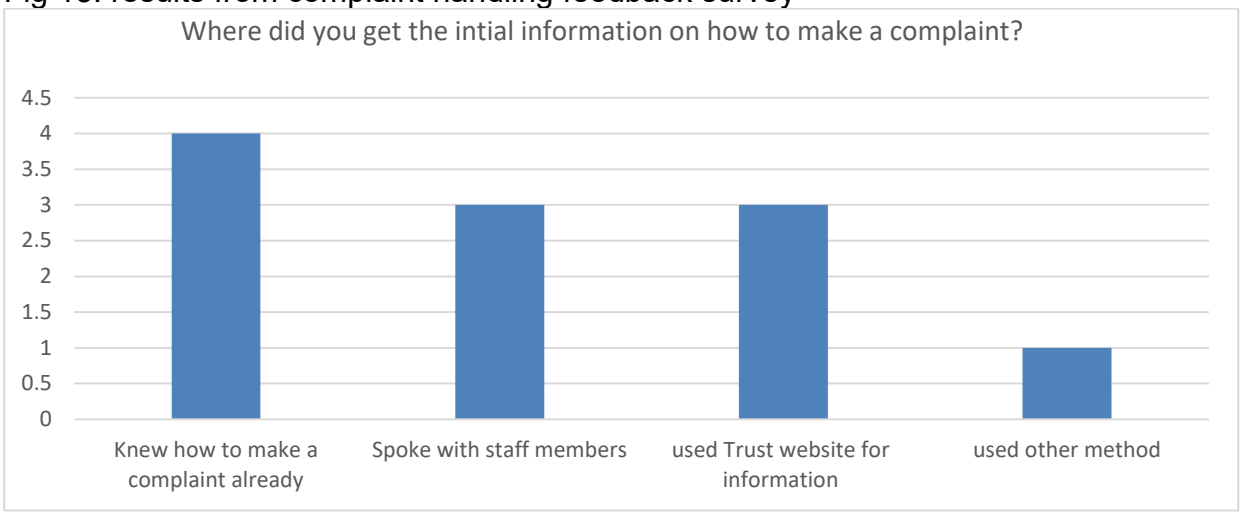
	formal investigation. This is in line with the PHSO guidance. c. Recruitment into complaints team is now completed with a start date end of September. d. Aligning the complaints process with care Group leads for oversight through continuation of weekly care group complaints meetings. e. Improved clarity and escalation of sign off process for complaint responses.		concerns and are limiting the formal investigation process if at all possible c) Aligning process is in process, once fully staffed and merged there will be a member of the corporate team assigned to each care group for continuity d) All staff are aware of the escalation for complaint responses
1. The Trust should design an online survey for users to complete. This should then be available on the Trust website for users to access. Furthermore, a link to the feedback survey should be sent to all complainants upon resolution 2. All responses to the survey should be collated, and then on a quarterly or biannual basis these responses should be reviewed by the Complaints team to understand any learnings that can be identified.	• The survey will be sent out to complainants to get feedback on the process of their complaint from Q3 23/24 • Feedback on the service will be used to generate improvement as part of the Patient First initiative and reviewed within PEG. • Reports to be included in Q4 report to the Quality Committee.	Medium	Completed and responses received for Q4.
The Trust to ensure that the Complaints Policy is reviewed and updated in line with the agreed frequency, as outlined in the policy. Once updated the policy should be ratified by an appropriate committee or Executive within the Trust.	The Complaints policy has been reviewed and updated to a UHD policy and approved by the Patient Experience Group. The complaints policy has been reviewed by the Policies and Procedures Group and uploaded onto the Trust intranet for staff to access. Old	Low	Completed July 2023

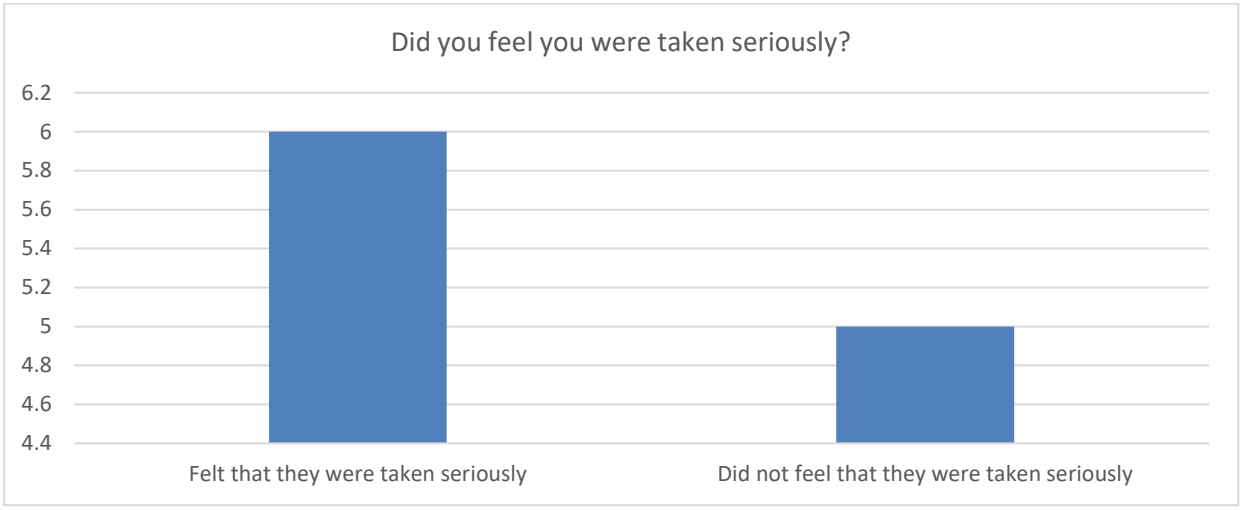
5.2 Complaint handling feedback survey results

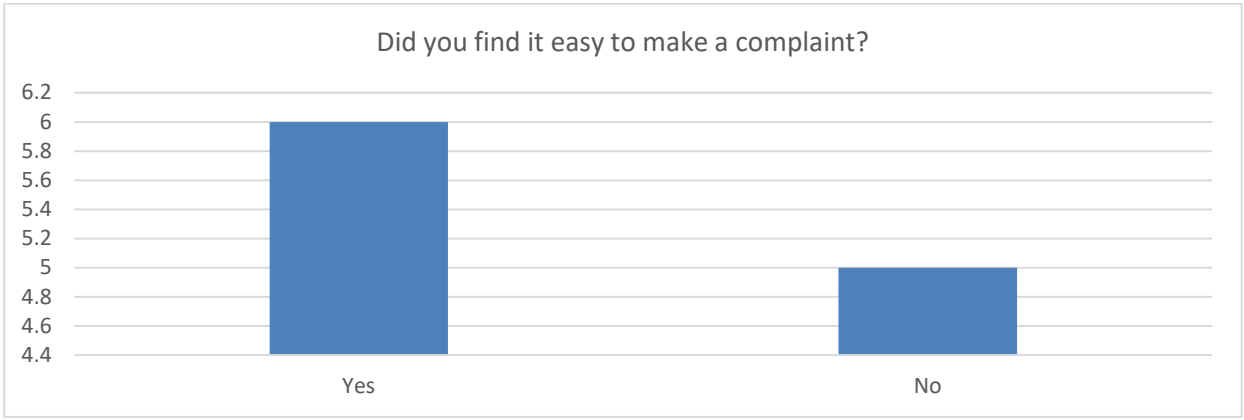
The survey which comprised of 13 questions was sent out to 36 complainants following the completion of the complaint process in Q4. We received 11 responses to the survey. The responses received are below in Fig 13:

The survey is anonymous. 11 out of 11 responders advised that they submitted their complaint via e-mail.

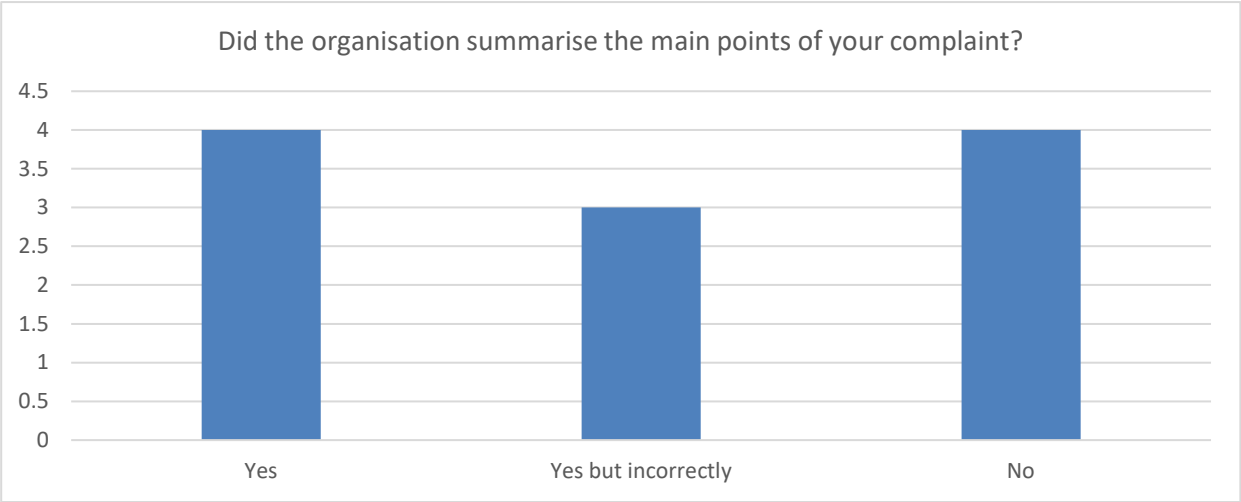
Fig 13: results from complaint handling feedback survey

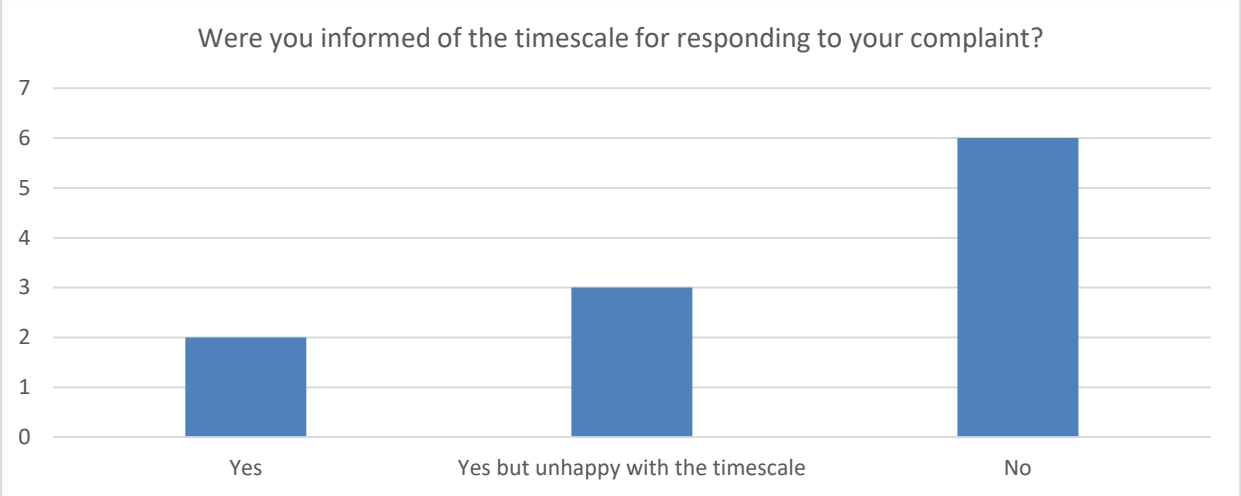


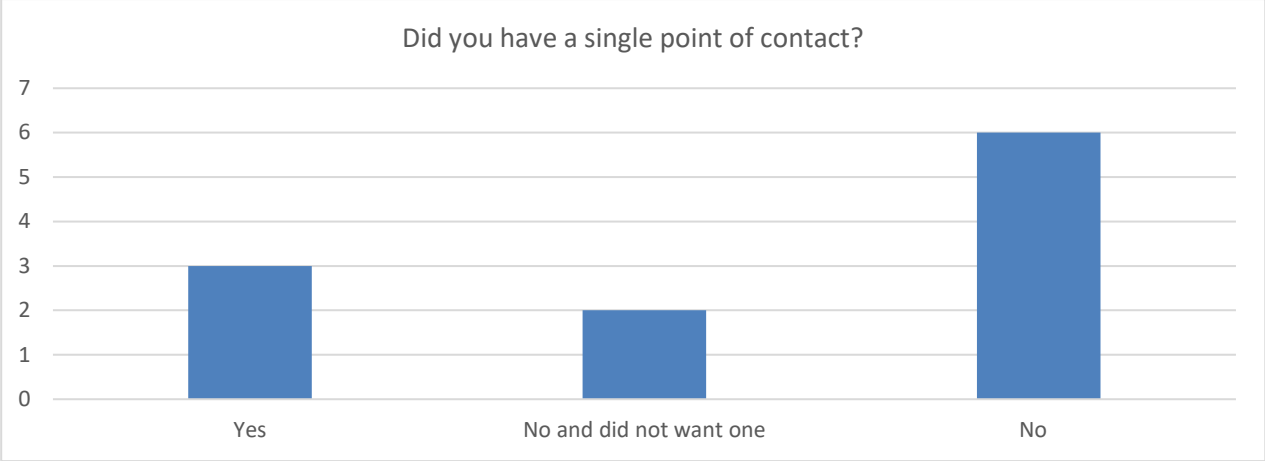


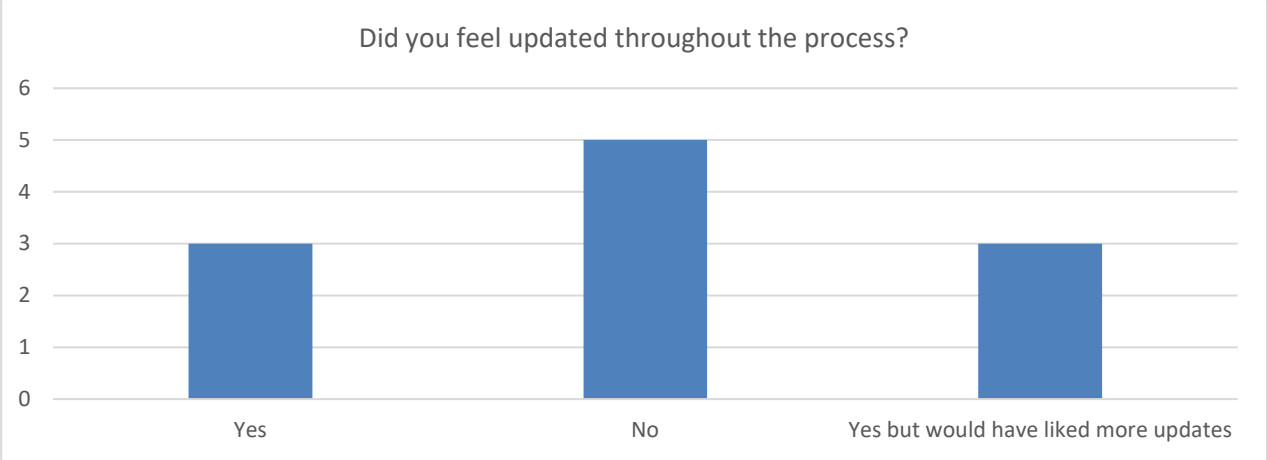


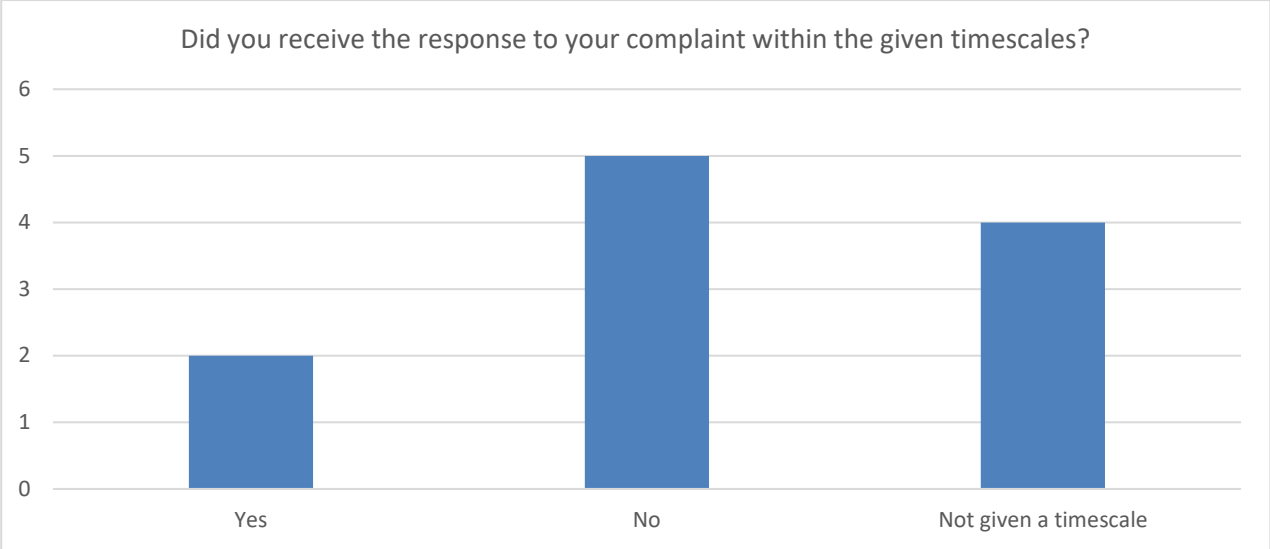

Did a member of staff contact you to give you the opportunity to discuss your complaint?
7
6
5
4
3
2
1
0
Yes
No but would have like this
No

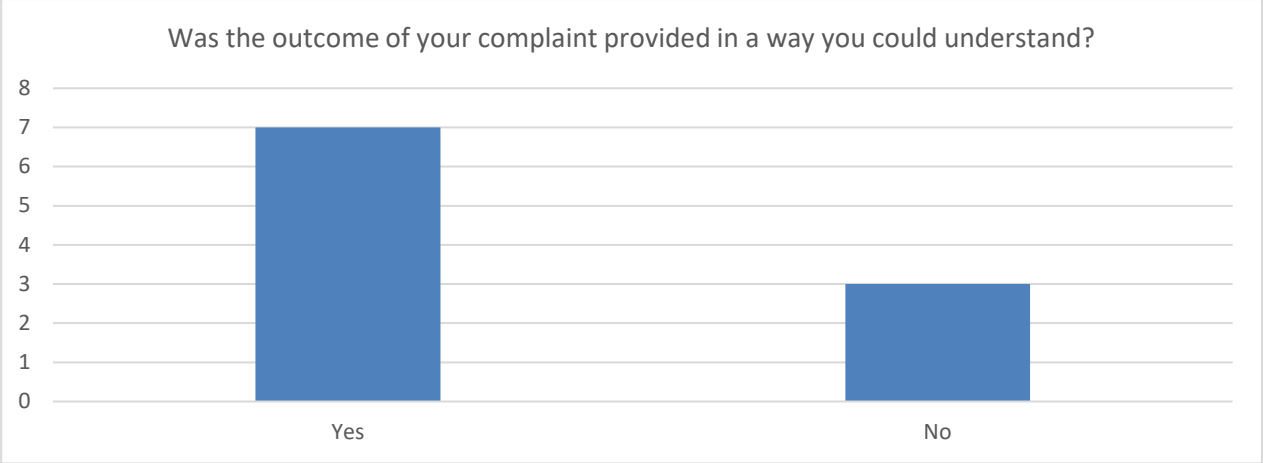

Did the organisation summarise the main points of your complaint?
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
Yes
Yes but incorrectly
No

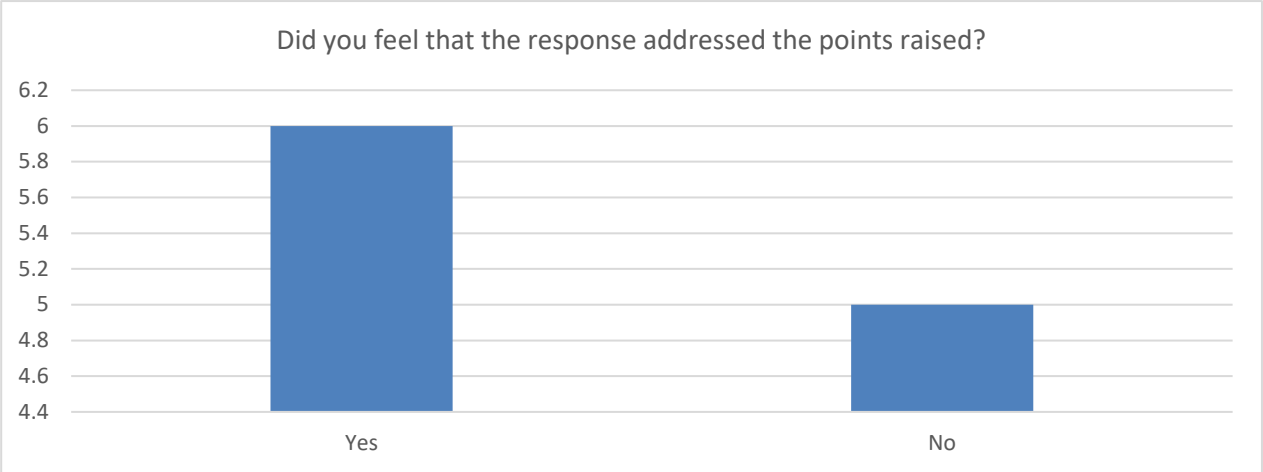

Were you informed of the timescale for responding to your complaint?
7
6
5
4
3
2
1
0
Yes
Yes but unhappy with the timescale
No

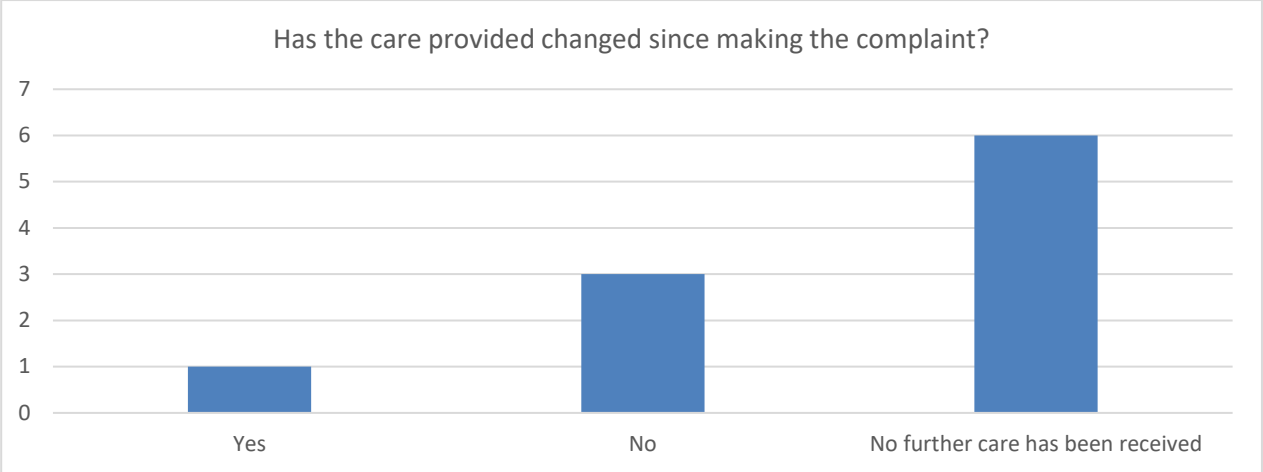

Did you have a single point of contact?
7
6
5
4
3
2
1
0
Yes
No and did not want one
No


Did you feel updated throughout the process?
6
5
4
3
2
1
0
Yes
No
Yes but would have liked more updates


Did you receive the response to your complaint within the given timescales?
6
5
4
3
2
1
0
Yes
No
Not given a timescale







On reviewing the responses provided we have looked at the information shared with complainants when the complaints team receive their complaints and progress them.

Currently the corporate team make every effort to speak with the complainant to talk through the complaint issues being raised. It is believed that the complainants that reported that they did not receive this but would have liked to, had not provided contact telephone numbers when requested by the complaints team and as such the complaints team would have received communication via e-mail. All complaints

are formally acknowledged in writing, via the same method as contact was received, which is usually via e-mail.

All complaints are summarised by the corporate team and these summaries are sent to the complainant for their agreement, if the complainant disagrees then the summary is amended and again sent to the complainant. We are therefore unable to identify why the complainants reported that they did not receive summaries of their complaints.

Previously due to the intended short investigation process associated to an Early Resolution Complaint, within 10 working days, the staff members who were managing this side of the process were not providing the complainant with an expected response date. They were simply advising that a response would be provided within a couple of weeks. This has been amended and the team now provide an expected response date for the final response to the points raised.

It has not been possible to provide a named caseworker to all complainants, however if possible the same caseworker that sent the formal acknowledgement does follow the case through to completion. Complainants are provided the team generic e-mail address should they wish to make contact; this is done so that if the caseworker is not available due to annual leave or unplanned sickness another caseworker is able to review and provide updates on the complaint progress.

We recognise that there have been issues in managing the responses within the given timescales. The complaints team have worked extremely hard to reduce this and since this survey was sent out the team are now providing a high number of final responses to complaints prior to the given response timescales and have reduced the number of complaints that have been waiting over the given timescale.

6.0 THEMES AND LEARNING FROM COMPLAINTS

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

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

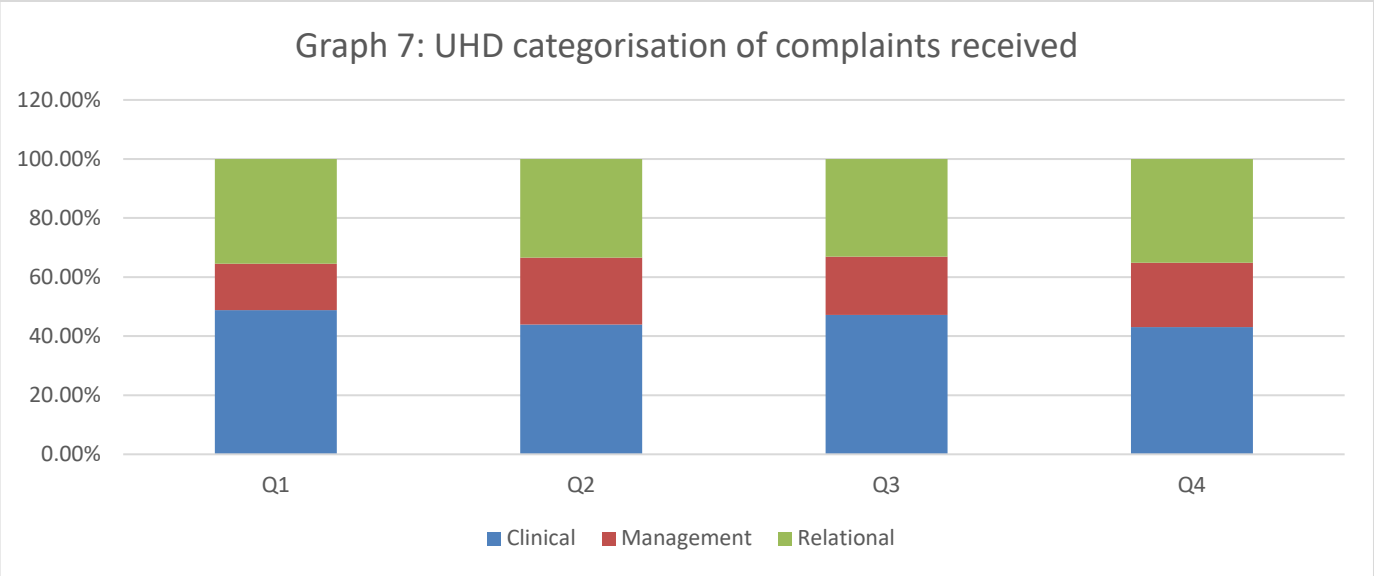
6.3 The data collected from complaints is analysed to help identify themes and emerging trends. The themes are extracted from the complaint narrative, taken from the perspective of the patient or their representative.

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

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

Table 6: UHD complaint theming: categories and themes

6.5 As can be seen in graph 7, the highest proportion of UHD complaints consistently fall into the clinical category; this is similar to the national picture. It should be noted that there are caveats regarding reliability of this comparison: it is collated from the KO41a data collection (community services and NHS hospitals); and secondly, the categories have been manually extrapolated and therefore subjective.



6.6 The data, by complaint category is shown by quarter in Graph 7. The top 3 complaint themes, by category, by quarter are shown in Table 8 overleaf, identifying consistency in many of the top themes reported at Trust level. It is recognised that reporting themes and sub-themes by directorate or specialty will generate more relevant and useable data for tends, learning and improving.

6.7 Patient first has started to be implemented across the Trust in 2023/24 with a drive to put patients first in all aspects of their care. This includes using wider patient feedback such as the Friends and Family Test (FFT) and Have Your Say (HYS) feedback to understand the perspective of our patients, their family and carers.

It remains to be felt that we do not get enough valuable and useful feedback in from our patients and on review it has been identified that:

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

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

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

Table 8: 2023/24 TOP COMPLAINT THEMES, BY QUARTER		
Complaint category	**Quarter**	
CLINICAL **Quality** eg. Clinical standards **Safety** eg incidents, staff competencies **Effectiveness** eg procedural outcomes	Q1	• Error - diagnosis • Inadequate examination and monitoring • Clinical skills and conduct
	Q2	• Inadequate examination and monitoring • Error - diagnosis • Clinical skills and conduct
	Q3	• Clinical skills and conduct • Error - other • Team work
	Q4	• Clinical skills and conduct • Substandard care; neglect – personal care • Inadequate examination and monitoring
MANAGEMENT **Environment** eg facilities, equipment, staffing levels **Systems & processes** eg bureaucracy, waiting times, accessing services **Well led:** eg leadership and decision	Q1	• Delay – access (outpatient) • Discharge • Documentation / records
	Q2	• Discharge • Trust administration and bureaucracy • Delay in accessing emergency / urgent care
	Q3	• Discharge • Administration and bureaucracy • Documentation / records
	Q4	• Discharge • Administration and bureaucracy • Delay in procedure or referral
RELATIONAL **Communication & listening** eg not acknowledging information given **Attitude** eg behaviour **Dignity& respect** eg caring and patient rights	Q1	• Communication absent • Communication breakdown • Caring and compassion
	Q2	• Communication absent • Communication breakdown • Caring and compassion
	Q3	• Communication breakdown • Caring and compassion • Communication absent
	Q4	• Communication breakdown • Caring and compassion • Communication absent

7.0 CONCLUSIONS & RECOMMENDATIONS

7.1 The Trust policy and procedures to manage concerns and complaints meet statutory requirements. The complaints procedure was aligned in 2021/22 following the merger of the legacy Trusts, adopting best practice from both sites as well as phased implementation of national best practice recommendations, and the new PHSO complaints standards framework, UHD will continue to work with the PHSO. This was modified early in 2023 due to staffing and delays and again reviewed and modified mid-2023.

7.2 The Trust has received 581 complaints, 219 early resolution complaints and 5981 PALS enquiries and concerns during 2023/24. This is an increase in the number of complaints received from 2022/23, which is a reflection of the fully merged systems and teams. There continues to be an increase in the cases managed in the PALS service.

7.3 A national comparison of complaints received (NHS Digital) shows that UHD is not an outlier with regards to the number of complaints received but reiterated some opportunity to increase the volume of early resolution complaints which was delayed in 2022/23 but is now being realised in 2024. The delays were caused by the department becoming short staffed, this has now been resolved.

7.4 The Trust underperformed against the statutory target for acknowledgement response time. This was, in part, due to the staffing vacancies in the corporate Patient Experience team. This has improved over the year and the team are now achieving 100%.

7.5 The Trust previously underperformed with the final response timescale of 55 working days. This in part can be attributed to the high clinical demand on our staff that were needed to have input into the responses. A shift to a corporate team investigation and responses has resulted in the minimisation of these delays and an improvement has seen in throughout the year.

7.6 The complaints team will also be adding demographic information within our quarterly reports to understand any specific themes or trends in relation to health inequalities.

7.7 A focus moving to a 35-day timeline for answering complaints as a trust standard will be introduced in 24/25 in partnership with our complaints process working closely with the care groups and corporate teams.

7.8 The complaints process will be subject to a further BDO internal audit in the later part of 24/25.

Appendix A: 2023/24 examples of learning from upheld complaints

Further examples of learning from complaints:		
Complaint	**Action/Learning**	**Status of learning**

Patient who attended for radiotherapy reported the experience was daunting and that they did not fully understand the process on the day	A new patient information screen is being installed in one of the waiting areas and radiotherapy are also increasing the number of staff on duty at reception so that they are able to spend more time supporting and providing explanations to patients.	We now have a named individual for patient information at the Trust and have secured short term funding for support with this.
Concerns raised by family of a patient regarding a lack of support from staff when their relative was nearing the end of their life	Staff on the ward have received advanced end of life training from the practice educator and there are now six end of life care champions on the ward who can in turn share learning with their colleagues to improve care in this area. One nurse has also recently completed a QUELCA course which is a nationally recognised qualification in end of life care.	Completed
Concerns raised by family that a patient's communication difficulties were not being taken into consideration by staff on the ward	Multi-professional education sessions are being arranged for the whole ward team to enable junior team members to develop their skills and understanding, and emphasising the need to regularly liaise with relatives, modifying care according to an individual patient's needs. Trust has launched Oliver McGowan training for all staff and will also continue to offer learning disability training as part of safeguarding training.	Completed
Patient attending for a radiology procedure raised concerns that there were too many trainees present in the room (4).	Moving forwards, radiology will restrict the number of trainees present in examination rooms to a maximum of 2, in order to restore a more relaxed atmosphere to the room.	Completed
Information regarding a patient was conveyed to the wrong family in error.	Care Plans on the ward are now kept in individual patient folders rather than in one folder for the whole bay. It has been reiterated to staff that contact with relatives should be by the nurse looking after the patient for that shift and should not be delegated.	Completed
Patient reported that their endoscopy procedure was	It was highlighted this occurred as a result of lack of knowledge on a staff members part. A training	Completed

cancelled on the day as the correct blood tests had not been carried out.	afternoon was therefore organised for the whole team to increase staff knowledge and prevent future similar occurrences.	
Patient Raised concerns regarding difficulties in contacting the maternity team after her son's birth in order to discuss her experience.	This has been raised with the labour ward matron and lead obstetrician to highlight the importance of women being provided with information on how to contact the Birth Afterthoughts Service. The Maternity Matters website is also being upgraded to make this easier to navigate and to make the Birth Afterthoughts contact information clearer.	Completed
Mother of a patient received a text message reminder about her daughter's ultrasound appointment, as her number was incorrectly listed under 'home telephone number'	Obstetric scans will be removed from the Doctor Doctor reminder system to avoid such confidentially breaches in the future. All obstetric ultrasound appointments can be viewed in the Badgernet app therefore text message reminders are not required.	Completed
Concerns raised by relatives that nurses did not have time to appropriately assist in feeding patients.	Food is now plated up on the ward, with patients able to choose their own portion sizes. Different plate colours have been introduced for patients who require assistance, enabling staff to identify who requires additional support. Volunteers have also been trained in patient feeding and are now in place across areas in the Trust.	Completed
Concerns raised about the limited drinks options available on the ward and the effect on patient's hydration.	Hydration project was launched on the ward and the frequency of hydration rounds was increased. There is now also a more varied drink selection for patients.	Completed

Prepared by Christina Harding
Deputy Head of Patient Experience
June 2024

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 03 July 2024

Agenda item: 8.3.1

Subject:	Key Issues and Assurance Report to Board of the Finance and Performance Committee meetings held on 29 May 2024 and on 24 June 2024
Prepared by:	John Lelliott, Chair of the Finance and Performance Committee
Presented by:	John Lelliott, Chair of the Finance and Performance Committee

Key Issues/matters discussed by the Committee:	At its meeting on 29 May 2024, the Committee received the following: • Operational Performance including Board Assurance Framework Risks 1 and 2; Risks Rated 12 and above • 2024/25 Financial Performance Month 1, including Board Assurance Framework Risk 7; Risks Rated 12 and above • Efficiency Improvement Programme Report 2024/25 • Capital Programme Report • Operational Budget/Medium Term Financial Plan • Consultancy Commitments • Patient Level Information and Costing • Electronic Health Record including Board Assurance Framework Risk 10 • Transformation Update • Capital Estates Sustainability Construction Policy • Contract Decision Timetable. At its meeting on 25 June 2024, the Committee received the following: • Update from NHS Dorset • Sustainability Deep Dive • Private Patients report • Operational Performance including Board Assurance Framework Risks 1 and 2; Risks Rated 12 and above • 2024/25 Financial Performance Month 2, including Board Assurance Framework Risk 7; Risks Rated 12 and above • Efficiency Improvement Programme Report 2024/25 • National Costs Collection pre-submission

	• Electronic Health Record • Cybersecurity report • Data Security and Protection Toolkit • Transformation Update • Annual review of Committee Effectiveness • Contract Decision Timetable • Risk Register Heatmap In addition, 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:	At the May 2024 meeting, the Committee agreed to escalate to the Board improving pathways for patients ready to leave hospital. These were being progressed at a "place" level within the Dorset system. <u>Matters for Board awareness:</u> • The Committee would be focusing in the coming months upon specialties that were underperforming against national best practice targets for theatre utilisation. At its June 2024 meeting, the Committee received assurance in relation to improvement actions being taken. • The Committee is to receive at its July 2024 detailed forecasts, including in relation to the Efficiency Improvement Programme. There was extensive discussion at the meetings in relation to the elective recovery fund income.
Progress of Board Assurance Key Risks Assigned to Committee:	BAF Risk 1 – score remained constant at 12 for April 2024 and May 2024, target of 3 BAF Risk 2 – score remained constant at 12 for April 2024 and May 2024; target of 6 BAF Risk 7 – score remained constant at 16 for April 2024 and May 2024, with a target of 8 BAF Risk 9 – score remained constant at 16 for April 2024 and May 2024, with a target of 12 BAF Risk 10 – score remained constant at 20 for April 2024 and May 2024, with a target of 6

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 03 July 2024

Agenda item: 8.4.1

Subject:	Safe Staffing Report – Nursing
Prepared by:	Tracy Moran, Lead Nurse Workforce
Presented by:	Sarah Herbert, Chief Nursing Officer

Strategic themes that this item supports/impacts:	Systems working and partnership ☐ Our people ☒ Patient experience ☐ Quality: outcomes and safety ☒ Sustainable services ☐ Patient First programme ☐ One Team: patient ready for reconfiguration ☐
BAF/Corporate Risk Register: (if applicable)	None
Purpose of paper:	Assurance
Executive Summary:	This report provides assurance around safer staffing within nursing and demonstrates the ongoing work to maintain oversight and management of safe staffing. The report (part one) covers the period October 2023 - March 2024 and (part two) January – June 2024. The Committee is asked to note: • The position in relation to vacancies for Registered Nurses and Healthcare Support Workers Trust wide and Care Group level • Healthcare Support Worker activity, supported by NHSE Direct Support Team • Reductions in spend on temporary staffing • Activity to address safe staffing risks • Service transformation updates
Background:	The paper is written as part of the Board Assurance structure.
Key Recommendations:	None – for information and assurance only.

Implications associated with this item:	Council of Governors Equality, Equity, Diversity & Inclusion Financial Health Inequalities Operational Performance People (inc Staff, Patients) Public Consultation Quality Regulatory Strategy/Transformation System The provision of safe staffing is essential for patient care and the wellbeing of staff.	☐ ☐ ☐ ☐ ☐ ☒ ☐ ☐ ☐ ☐ ☐
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	01/07/2024	Meeting has not yet taken place at the time of submission of this report.

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

Contents:

	Section	Page Number
	Introduction	2
Part 1.	Update on current nursing workforce	
	• Monitoring	3
	• Red Flags	3
	• Care Hours Per Patient Day	3
	• Nursing Workforce data	4
	• Recruitment activity	6
	• Template reviews	6
	• Premium agency Spend	7
	• Staffing risks	8
	• Conclusion	8
Part 2.	Care Group updates	9
	• Medical Care Group	
	• Surgical Care Group	
	• Women, Children, Cancer & Specialist Services (WCCSS) Care Group	

Introduction

The following report will provide the People & Culture Committee with assurance around the statutory reporting requirements, as outlined in the Developing Workforce Safeguards document published by NHS Improvement in October 2018. This document was developed to support organisations to utilise effective staff deployment by adopting a "triangulated approach" (figure 1) to manage common workforce problems and comply with the Care Quality Commission (CQC) well-lead framework (2018).

Figure 1: Principles of safe staffing

The report (Part one) provides assurance around safe staffing within nursing in the period October 2023 – March 2024. Maternity staffing is reported separately to comply with the Maternity Incentive Scheme reporting requirements. Part two of the report covers quarters 3 and 4 (2023-2024). This report is written specifically as an assurance report around inpatient area staffing; therefore AHP workforce progress is omitted.

Monitoring

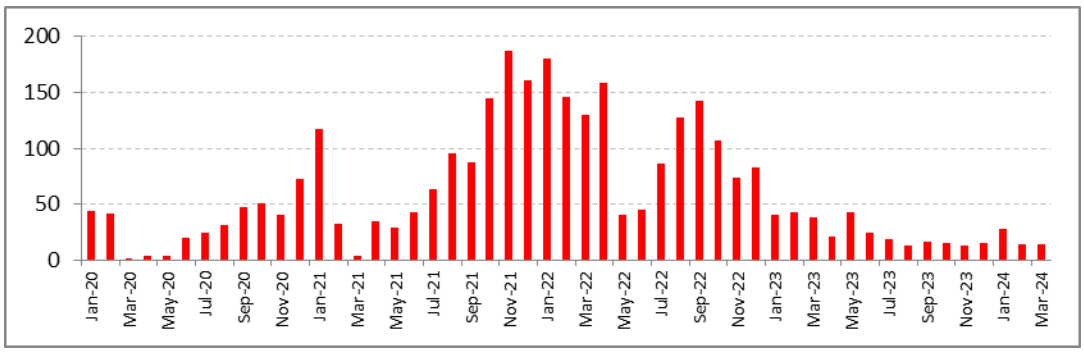
Nursing staffing levels are reviewed twice daily in real time at the safe staffing meetings.

The Trust Board receives monthly assurance from the integrated performance report on the Unify data related to 'care hours per patient day' (CHPPD) and safe staffing red flags.

Red Flags

An element of the National Institute for Clinical Excellence (NICE) guidelines around safe staffing is that staff and patients should be able to raise a nursing 'red flag' if the NICE safe staffing or local agreed criteria are not being met.

There have been a reduced number of red flags raised in Q3 and Q4 compared to Q1 and Q2. The red flags raised most often is inability to provide fundamental care and a lack of enhanced care; impacted by a continued demand for patients requiring a mental health support worker. The reduction correlates with an overall reduction in staff vacancy.



Care Hours per Patient Day

The Trust has maintained the requirement to report externally as part of safe staffing strategic data collection (formerly Unify) and internally as part of the Integrated Performance Report (IPR) on fill rates for registered and unregistered nurses and CHPPD. Any special cause variation is reported on and actions taken.

Our local data for this reporting period is:

	Hospital Site name	Patient Count	Total monthly planned staff hours	Total monthly actual staff hours	Fill Rate %	CHPPD
March 2024	Poole Hospital	17344	143437.9	144140.7	100.5%	8.3
	Bournemouth & Christchurch	17490	131778.2	133159.1	101.0%	7.6
	UHD Total	34834	275216.1	277299.8	100.8%	8.0
February 2024	Poole Hospital	15992	133961.1	133747.5	99.8%	8.4
	Bournemouth & Christchurch	16474	123041.7	124977.2	101.6%	7.6
	UHD Total	32466	257002.8	258724.7	100.7%	8.0
January 2024	Poole Hospital	17711	134986.7	143006.1	105.9%	8.1
	Bournemouth & Christchurch	18043	128295.5	135090.6	105.3%	7.5
	UHD Total	35754	263282.1	278096.6	105.6%	7.8
December 2023	Poole Hospital	17220	131235.4	142297.3	108.4%	8.3
	Bournemouth & Christchurch	17195	126046.9	132458.7	105.1%	7.7
	UHD Total	34415	257282.3	274756.0	106.8%	8.0
November 2023	Poole Hospital	16764	126213.4	136581.6	108.2%	8.1
	Bournemouth & Christchurch	16712	119131.5	126590.6	106.3%	7.6
	UHD Total	33476	245344.9	263172.2	107.3%	7.9
October 2023	Poole Hospital	16897	130757.3	135509.2	103.6%	8.0
	Bournemouth & Christchurch	16068	118858.7	123535.1	103.9%	7.7
	UHD Total	32965	249616.0	259044.3	103.8%	7.9

Monthly exploration of the data has shown that the increased staffing requirements (fill rate greater than planned is due to:

- Staffing cover for surge capacity areas that flex their beds in times of operational pressure.
- Enhanced care provision for patients requiring 1:1 care.

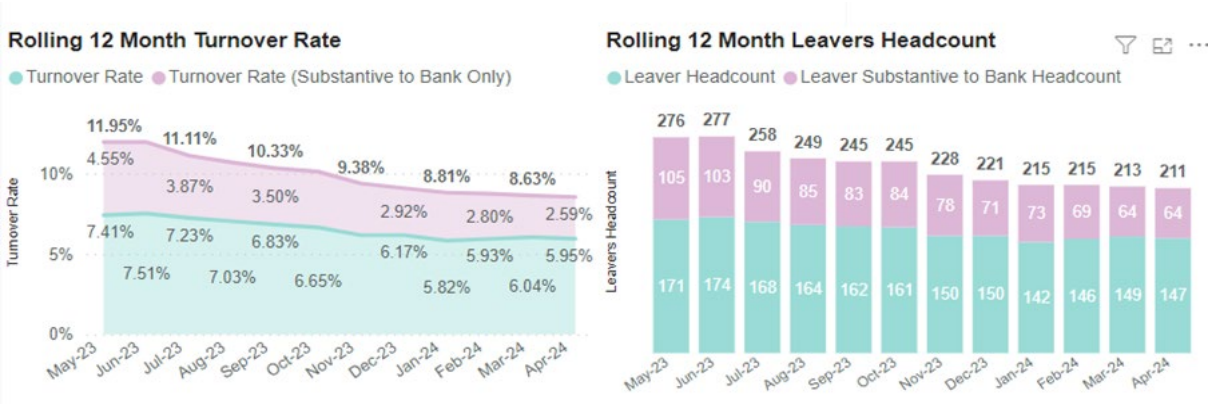
Current position - nursing workforce data

The Cosmos Workforce dashboard provides baseline data for nursing. The below provides an in depth view for the reporting period October 2023 - March 2024.

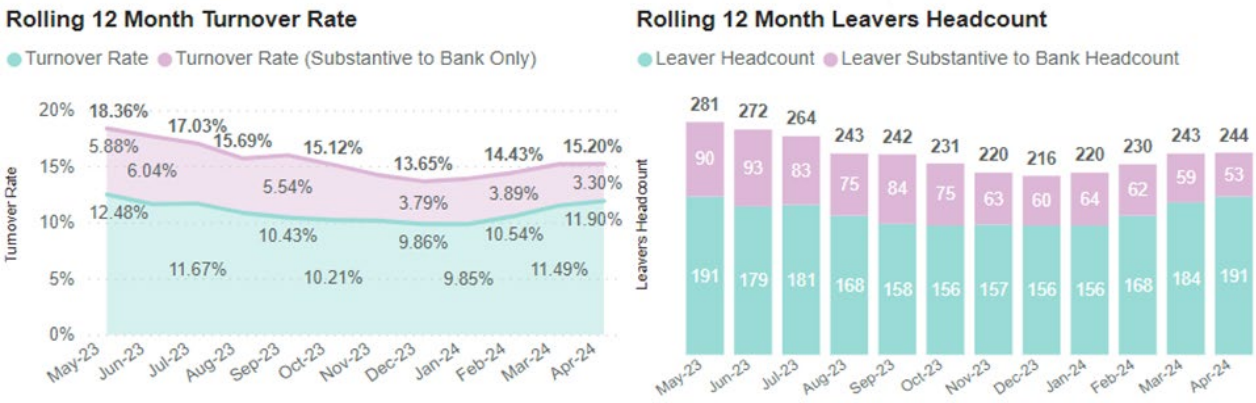
Turnover

RN turnover is currently 8.64%, a continuous improvement since October 2023 but above the Trust target of 5%. HCSW turnover is 15.18%; unchanged since October 2023 against a Trust target of 10%. More detailed information around these changes is provided later in the Care Group reports.

RN turnover



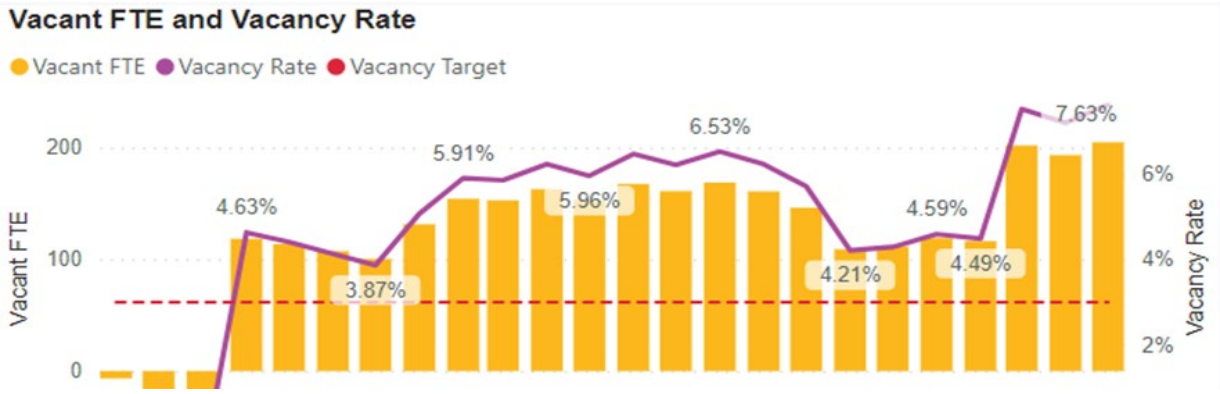
HCSW turnover



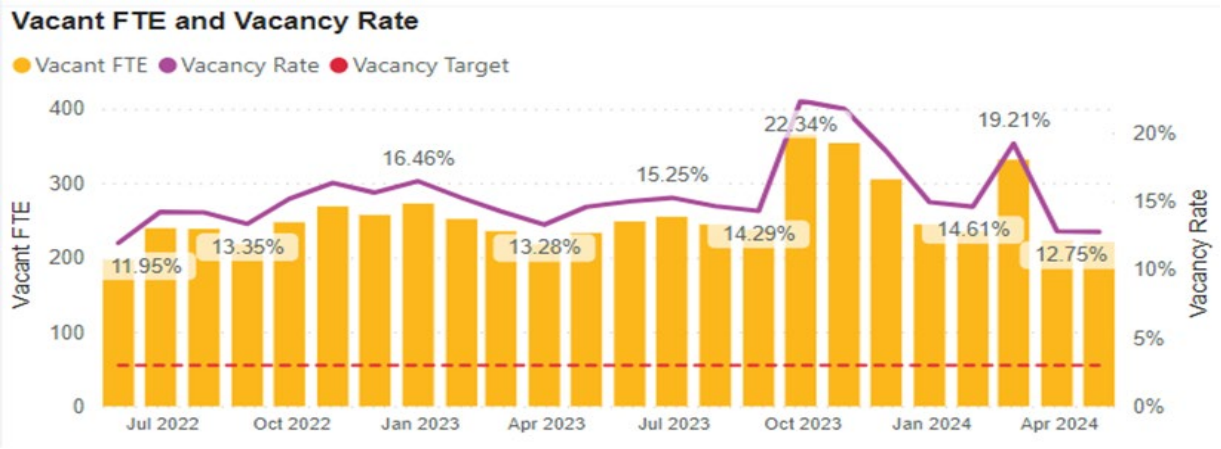
Vacancies

The current RN vacancy rate is 7.2%; an increase of 3% since October 2023. The HCSW vacancy rate is 12.81%; a 9% reduction since October 2023. The Trust target vacancy rate is 3% for RN and HCSW. It is important to recognise within this data that the investment from the inaugural UHD establishment review went into budgets in February 2024. The increase in vacancies is believed to be as a result of this investment.

RN vacancy



HCSW vacancy



Recruitment activity

Internationally Educated Nurse (IEN)

The Trust achieved its commitment to recruit 90 Internationally Educated Nurses (IEN) by December 2023.

Trainee Nurse Associate (TNA) & Registered Nurse Degree Apprentice (RNDA)

A total of 33 trainees are expected to qualify as registered Nurses between April & October 2024 (25 RNDA and 8 RNA Top up). This model of growing our own local, future workforce and attracting new recruits seeking to progress their healthcare career will be maintained in 2024/25.

Health Care Support Workers (HCSW)

NHSE Direct Support Team continues to support the Trust to reduce HCSW vacancies with focus on time to hire, candidate experience and recruitment events. The reduction in HCSW vacancies in early 2024 is reflective of this programme of work.

Template reviews update

Bi-annual Ward Staffing Reviews

One of the recommendations from the Developing Workforce Safeguards is to ensure that a review of staffing is completed twice a year using an evidence based tool; the Shelford Safer Nursing Care Tool is evidence based, endorsed by NICE and supported by the Chief Nursing Officer for England.

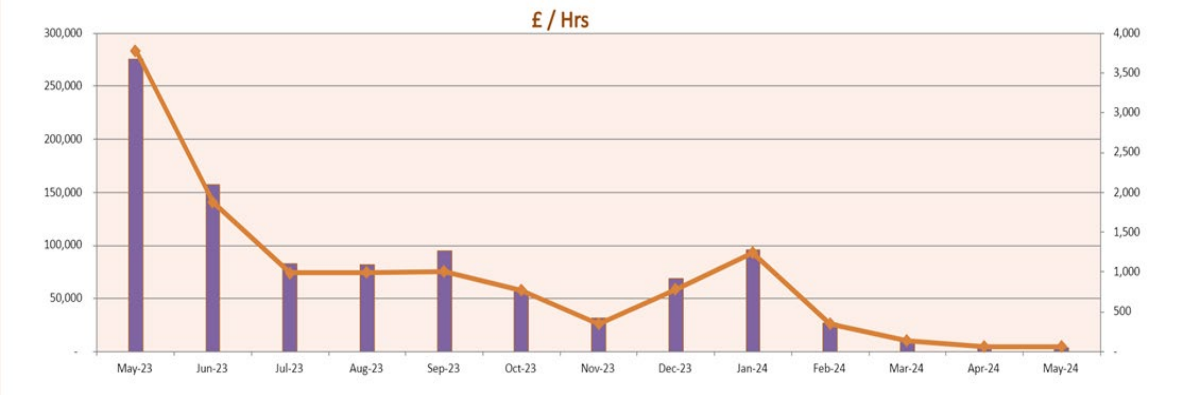
Changes to the funded establishments across ward areas, as a result of the first UHD establishment review, were implemented in February 2024. The second collection of patient acuity and dependency data over 30 days, using the updated Shelford Tool, concluded in March 2024. This data has been triangulated with quality metrics and professional judgment, as per national workforce safeguards recommendations, for all inpatient areas.

Premium Agency Spend

As at the end of April 2024 a cumulative over-spend of £351k for the period April 2024 is recorded for nursing. Agency costs, including RMN, accounted for £778k. This was off-set by underspend on HCAs of £135k. The agency spend is the lowest it has been for 12 months.

Premium Spend April 2024

Staff Type	Budget (£000's)	Substantive (£000's)	Pay Underspend(£000's)	Overtime (£000's)	Bank (£000's)	Agency (£000's)	Variance (£000's)
Registered Nurse/Midwife	12,413	10,742	1,671	34	1,214	778	(351)
HCSW	3,866	3,042	824	6	473	481	135



The Non-medical Workforce Transformation Enabling Group continue to focus on a number of projects, to ensure that we have an understanding of the drivers of our premium spend and work to reduce this. These include:

- Consolidated bank approach
- International recruitment
- Training and apprenticeship roles
- Enhanced care service delivery review
- Review of the Policy for paid carers

The Temporary Staffing Service (Bank) are supporting the reduction of agency spend through a number of strategies, these include

- 3 stage agency rate reduction to bring supply to Cap by July 2024, additional specialist flight path to October 2024 for higher risk areas i.e. ED, Critical Care, Theatres, Child Health
- Shift to agency lead time reduced from 28 days in January to 3 days, ultimately aiming for 2 day lead time
- Refresh of 'Break-glass' standard operating procedure to strengthen controls and scrutiny of requests for escalated shifts, additional duties and banding uplift for bank shifts

- Decrease agency preferred supplier list (PSL) and establishing supplier KPI's
- Increasing bank fill rates through greater engagement of Bank workers and access to available bank shifts
- Campaign to encourage agency workers to move to Bank/substantive
- Streamlined processes for substantive staff to join the Bank on appointment to the Trust

Staffing risks

There are currently two risks on the risk register pertaining to safe staffing in nursing; additional to the staffing risks registered at care group level. Risks are reviewed at Strategic Nursing, Midwifery and Allied Health Professionals group and Nursing Quality, Risk & Governance group.

Risk: 1897 - risk rating 8 - HCSW vacancy above 20% impacting on patient and staff experience. An action plan to reduce the vacancy is recorded on Datix.

Risk: 1056 - **risk rating 9** - Inability to provide a fully established nursing workforce, in accordance with the agreed establishment template. NHSE funding support for international nurse recruitment ceased in 2023; focus on domestic recruitment, widening access, newly qualified nurses and apprenticeship routes to grow and sustain the future nursing workforce.

Conclusion

Monitoring staffing levels and complying with the recommendations outlined in the Developing Workforce Safeguards Guidance remain priorities for the Trust. With transformation comes opportunity to attract new to care workers, grow the domestic pipeline of newly registered Nurses and retain the internationally educated Nurses. Noting the staffing information detailed in this report it can be concluded that the Trust has in place sufficient processes and oversight of its staffing arrangements to ensure safe staffing is prioritised as part of its routine activities.

Part Two - Care Group Updates

The following updates from the Care Groups demonstrate the activity within the divisions and specialist teams for quarters 3 and 4 (2023-2024), to maintain safe staffing and support the staff working operationally, on a daily basis.

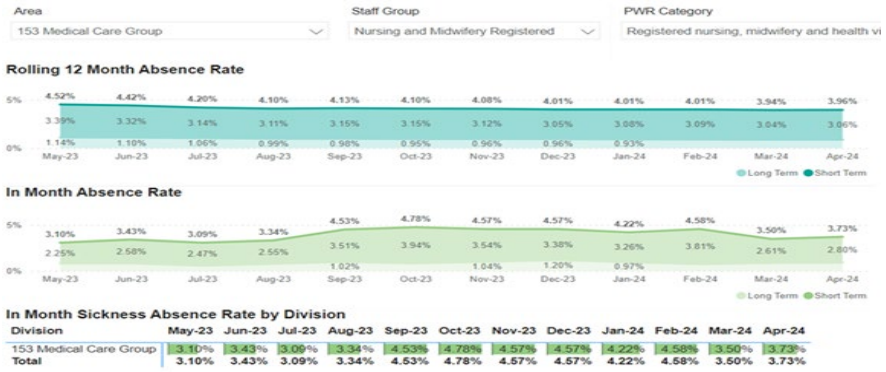
Medical Care Group

We have continued to see dynamic changes in how our workforce is utilised across both sites. We have seen rapid change as transformation of ward areas continues to be realised. We have successfully moved to the new Acute Stroke Unit and we have merged the two TIU's onto a single site. This has bought challenges but also learning for the teams. We have an agreed template for the interim ED model and opened Durlston as a new medical ward with consolidation of ACU and B5.

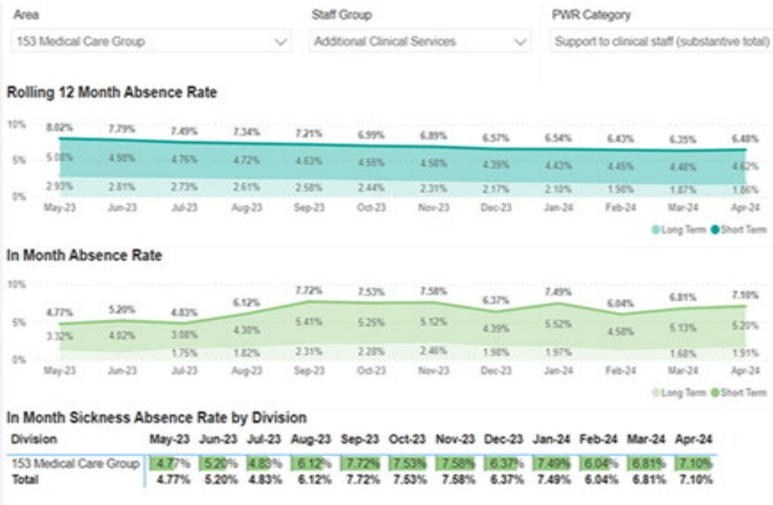
The number of CG leavers has seen a further reduction of 3.74%.

Agency Spend as a percentage of total pay related spend is improving and new controls are in place to review all MHSW and Tier 3b requests. We have new finance meetings in place weekly that will continue to review areas with high usage but also at roster KPI's and management.

Break Level 1	Break Level 2	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24
Total		7.3%	8.8%	7.7%	9.8%	10.1%	9.6%	10.9%	10.0%	7.8%	6.9%
0	Total	7.3%	8.8%	7.7%	9.8%	10.1%	9.6%	10.9%	10.0%	7.8%	6.9%
	0	7.3%	8.8%	7.7%	9.8%	10.1%	9.6%	10.9%	10.0%	7.8%	6.9%



Registered Nurse absence is on an improvement trajectory with a small increase in month for April. We are working closely with OH and HR to ensure we are a supporting all staff to return to work in a timely manner and reviewing themes to provide health and well-being support.



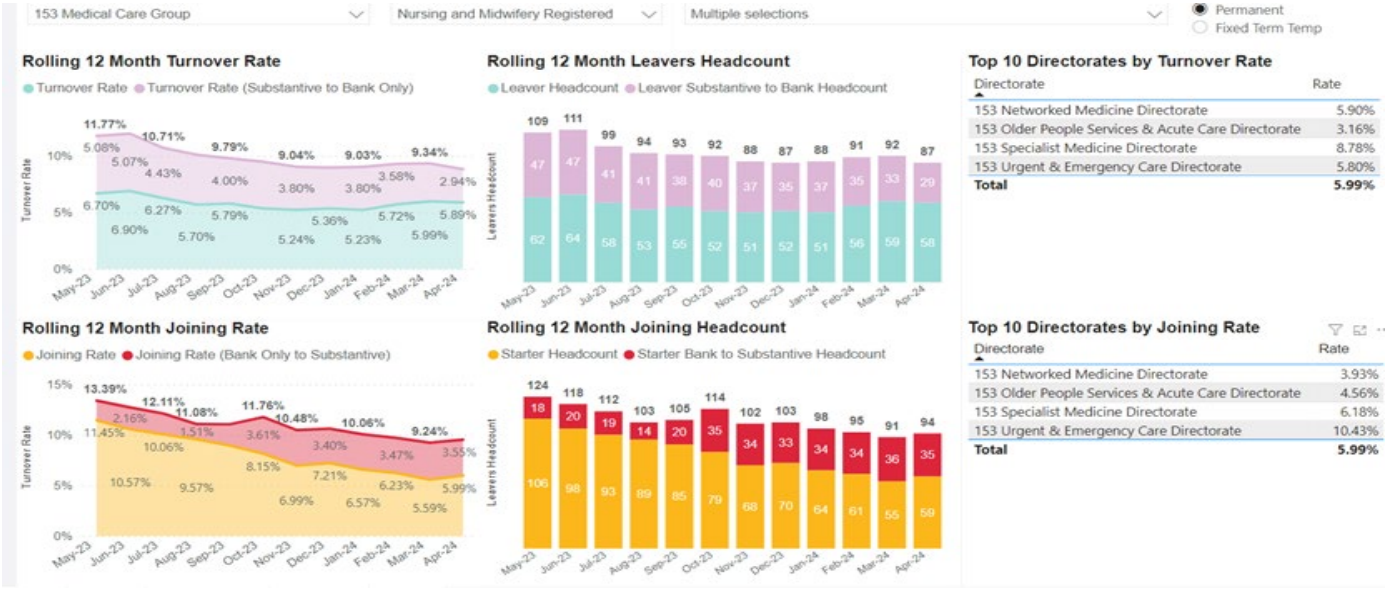
Health care support worker absence remains higher than that for registered Nurses but again is on a downward trajectory with a small in month increase.

The current vacancy position for key areas is looking positive. With recent recruitment days we have had successful campaigns and the focus is now on Healthcare support workers and their retainment.

Ward	RN vacancy (wte)	HCSW vacancy (wte)
A4	0	0.38
A5/B5	0.16	7.79
Ward 1	2.9	1.16
Ward 2	0	2.2
Ward 3	0.4	0
Ward 14	0	7.30
A3 (RACE)	0.87	4.57
Kimmeridge	0.63	10.06
Lulworth	0	0
Lytchett	2.27	6.99
Fayrewood	0	4.3
Brownsea	3.15	8.34

Ward 4	5.45	2.65
Ward 5	5.55	2.99
Ward 22	0.61	6.8
Ward 8	8.92	9.22
OPAU	12.6	9.1
Ward 23	0	2.0
Ward 24	1.0	0.5
CCU	0	0
ASU	1.5	0
Portland	0.5	7
TIU (Both)	2.87	2.35

Registered Nurse turnover is improving and remains sustained



Healthcare Support worker turnover continues to be a challenge and we are acitvely looking at plans to promote training and development to aid retention.

Themes for the future

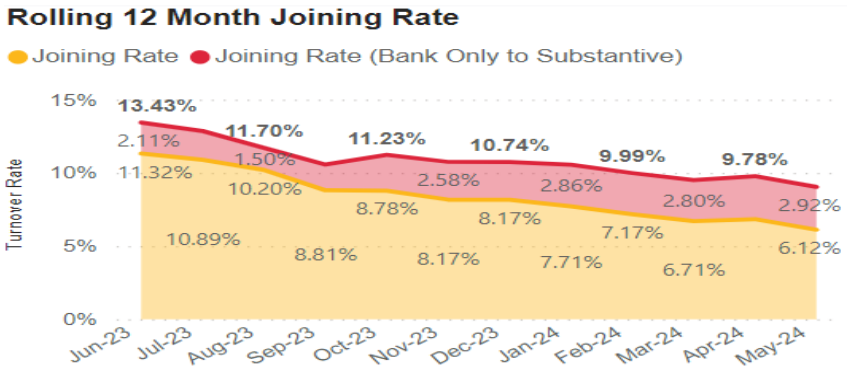
Working with transformation to ensure all workforce plans are service and staff ready, aligning practitioner courses with workforce plans to ensure we have adequate roles for emerging quallifying Adanced Care Practitioners (ACP) and defining where we need Enhanced Care Practitioners (ECP) versus ACP.

Surgical Care Group

Vacancies for the Surgical Care Group (inclusive of nursing, AHP, Medical and administrative staff) is currently 9.56%. Breaking this down to specific Directorates identifies:

Care Group/Directorate	Percentage vacancy rate (inclusive of Nursing, AHP,
Surgical Care Group (Total)	**9.56%**
Anaesthetics Directorate	6.71%
Head and Neck Directorate	10.29%
Surgical Directorate	11.03%
Surgical Management Directorate	0.26%
Trauma and Orthopaedics Directorate	13.78%

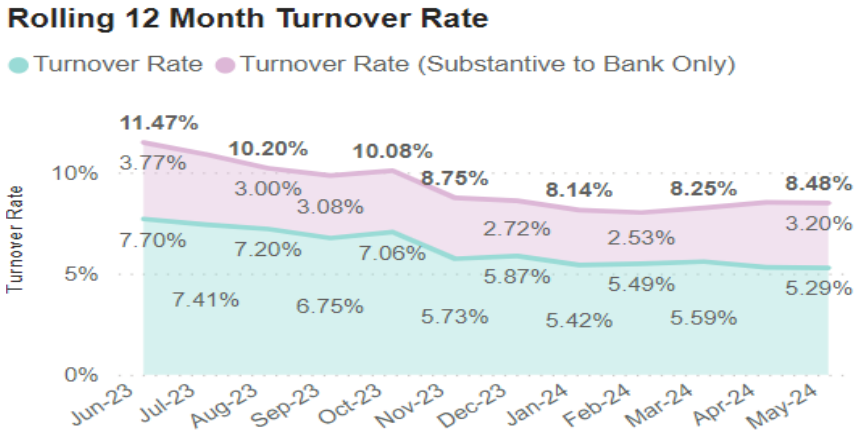
Active recuitment in all areas has been supported with an increase in number of pipeline recruits through standard recruitment pathways and the newly qualified nursing route. Active recruitment across Anaesthetics is evident with the highest joining rate for the Directorates within the Care Group.



Top 10 Directorates by Joining Rate

Directorate	Rate
153 Anaesthetics Directorate	7.22%
153 Head and Neck Directorate	3.70%
153 Surgery Directorate	6.28%
153 Trauma and Orthopaedics Directorate	5.56%
Total	**6.28%**

There has been a general reducing trend in turnover rate for the Care Group; achieving 5.42%, slightly above the Trust target of 5%. The Surgical Directorate maintains the lowest turnover rate for the Care Group.



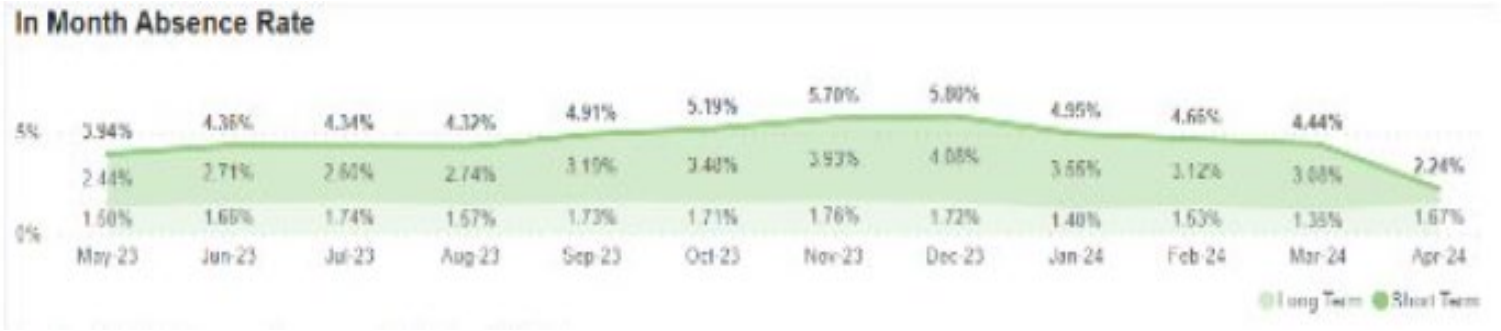
Top 10 Directorates by Turnover Rate

Directorate	Rate
153 Anaesthetics Directorate	6.24%
153 Head and Neck Directorate	6.17%
153 Surgery Directorate	3.86%
153 Trauma and Orthopaedics Directorate	5.56%
Total	**5.42%**

The sickness rate for the Care Group for April 2024 is 2.24% - a fall in every Directorate since the previous month and lowest rate in the last 12 month period. This is a sustained downward trend since December 2023.

In Month Sickness Absence Rate by Division

Division	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
153 Surgical Care Group	3.94%	4.36%	4.34%	4.32%	4.91%	5.19%	5.70%	5.80%	4.95%	4.66%	4.44%	2.24%
Total	**3.94%**	**4.36%**	**4.34%**	**4.32%**	**4.91%**	**5.19%**	**5.70%**	**5.80%**	**4.95%**	**4.66%**	**4.44%**	**2.24%**



Sickness rate per Directorate identified for April as:

Directorate	Percentage
Anaesthetics	1.98%
Head and Neck	4.27%
Surgery	1.77%
Trauma and Orthopaedics	2.2%

Staffing risks

Risk	Rating	Description	Update
1811	9	Staff Vacancies and Skill mix deficit – Theatres (Anaesthetics Directorate)	Vacancy rate reducing, leaver rate reducing discussed at care group governance and board meetings with agreement to reduce risk rating from 15 to 9
1809	4	HCA Staffing shortfall in T&O services (T&O Directorate)	Risk closed as recruitment going well - discussed at T&O clinical governance meeting 19.04.2024
1136	6	Reduction in quality of care to patients across the trauma wards (T&O)	Risk closed 29/05/2024 – continuous recruitment within Trauma/ orthopaedics, RN vacancy zero on all wards, staffing levels safe and patient safety no longer compromised.
1973	8	RBH Eye Emergency unit staffing levels	Risk being reviewed by the team

Updates:

Service Transformation: Surgical workforce consultation successfully completed to support the surgical transformation of wards.

Practitioner workforce: Corporate project continues to align practitioner workforce across UHD in terms of roles and banding.

International recruitment: Nursing and Midwifery Council are following up on nationally reported fraudulent activity by some overseas based test centres (Nurses looking to work in the UK take the required CBT and IELTS/OET exams). This involves a very small number of individuals.

Retention, turnover and recruitment: Weekly meetings continue with matrons to scrutinise and review workforce metrics, in particular agency and temporary spend, against vacancy and absence data. Areas with highest RN vacancy rates are:

Anaesthetics: Poole Emergency theatres (40%)
Actions: this forms part of the major project to enhance and recruit to theatre staffing. Workforce action group in place with corporate support

Surgery: Ward 17 (18%), Ward B2 (13%)
Actions: active recruitment has continued up until January 2024 with launch of bed reconfiguration consultation on RBH site

Trauma & Orthopaedics: Derwent (16%), Ward E3 (18%), TAC team (31%)
Actions: actively recruiting to posts with pipeline

Agency spend: High cost agency utilisation has significantly reduced and sustained over the last 4 months.

Women’s, Children’s, Cancer & Specialist Services (WCCSS) Care Group

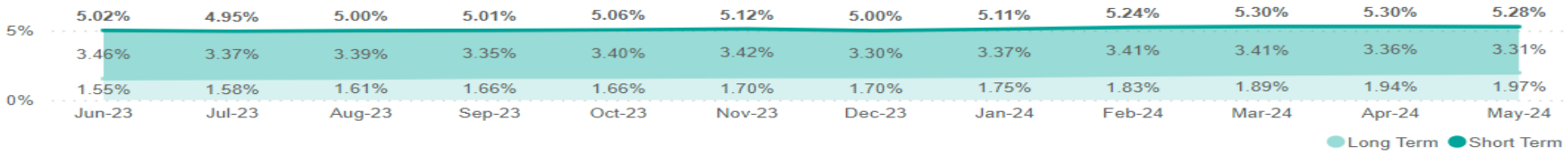
Absence rates are slowly reducing with the support of HR and senior management addressing long-term sickness, grievances and capability concerns.

Area: 153 WCCSS Care Group

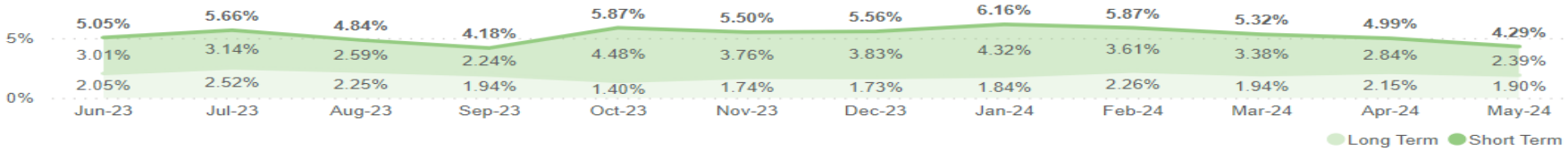
Staff Group: Nursing and Midwifery Registered

PWR Category: Registered nursing, midwifery and health vis

Rolling 12 Month Absence Rate



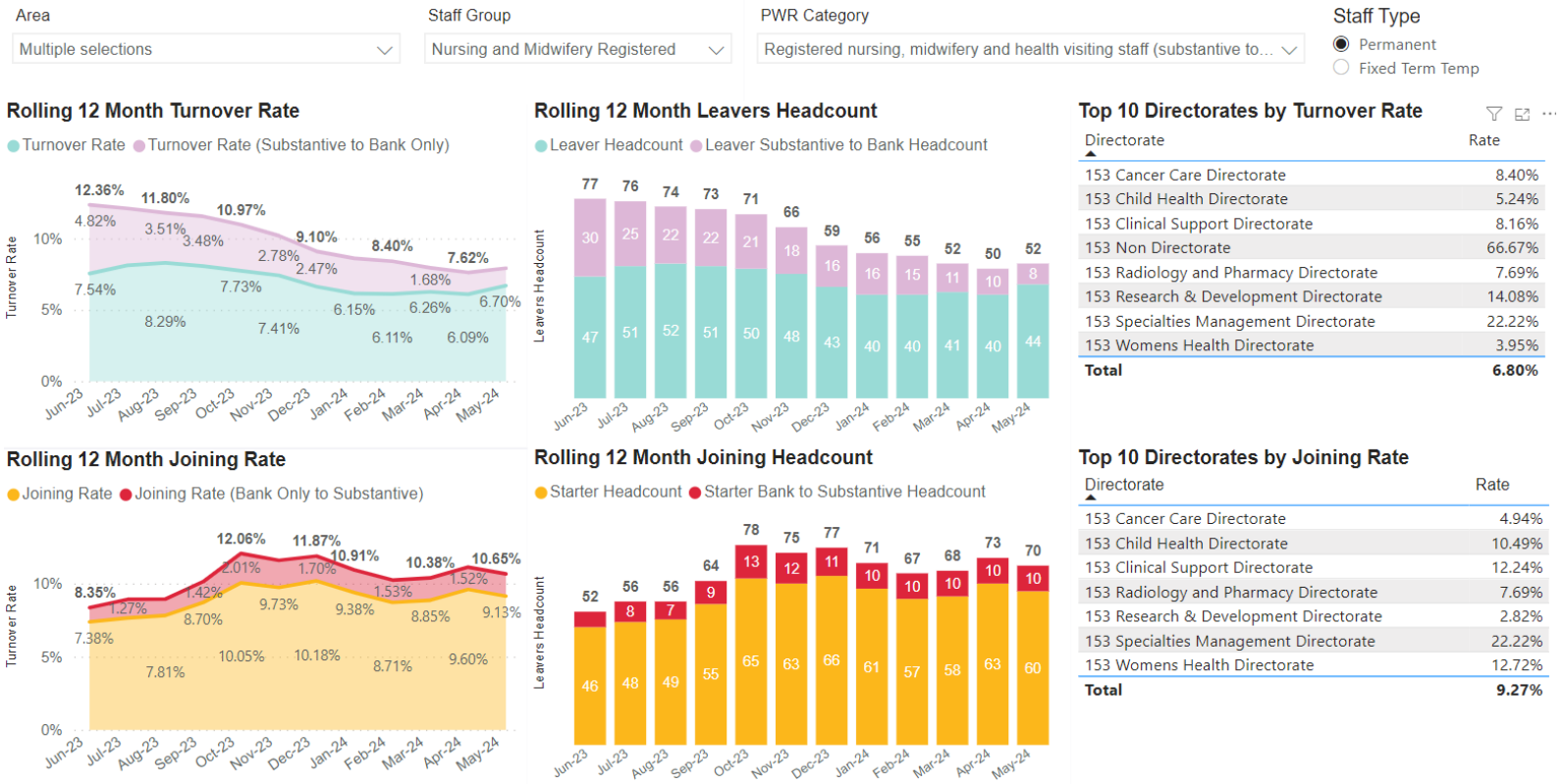
In Month Absence Rate



In Month Sickness Absence Rate by Division

Division	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
153 WCCSS Care Group	5.05%	5.66%	4.84%	4.18%	5.87%	5.50%	5.56%	6.16%	5.87%	5.32%	4.99%	4.29%
Total	**5.05%**	**5.66%**	**4.84%**	**4.18%**	**5.87%**	**5.50%**	**5.56%**	**6.16%**	**5.87%**	**5.32%**	**4.99%**	**4.29%**

Teams are being encouraged to place their vacancies on TRAC early and the Care Group are reviewing how they manage TRAC processes. Matrons are linking with the workforce team to identify appropriate candidates from the Trust recruitment to ensure that these recruits are aware of our specialities and therefore remain recruited into post without any concerns. A review of budgets and finance support has enabled recruitment into vacant Specialist Nurse posts in Cancer Care.

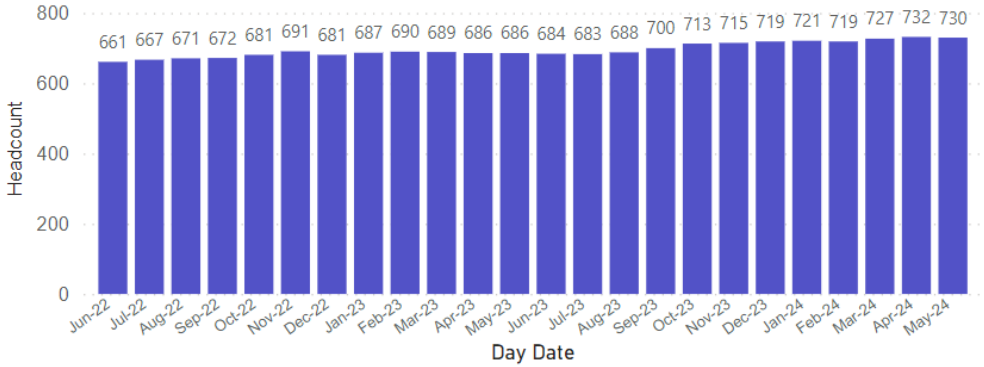


Area: Multiple selections

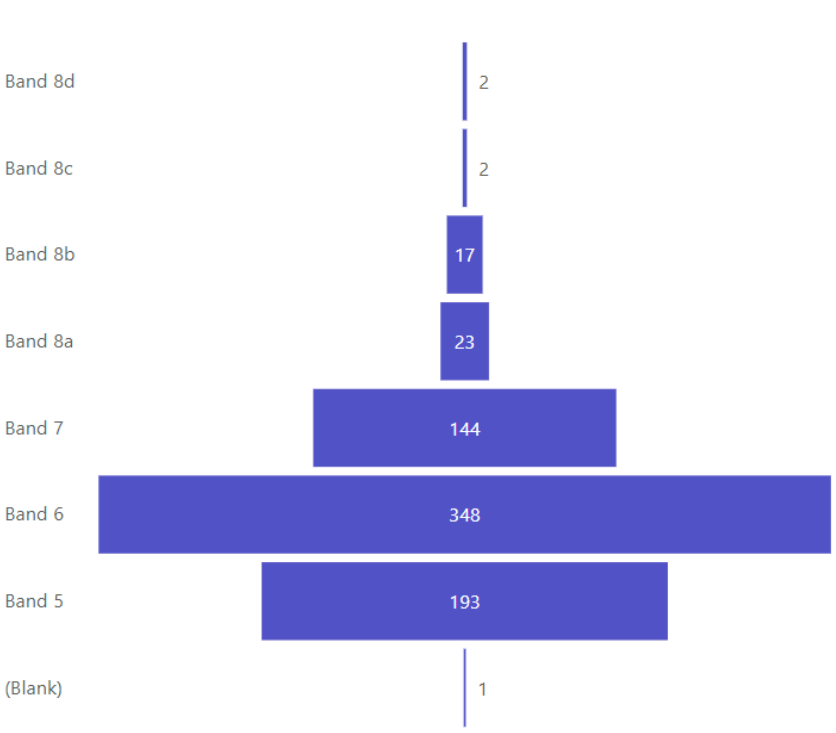
Staff Group: Nursing and Midwifery Registered

PWR Category: Registered nursing, midwifery and health visiting staff (substantive total)

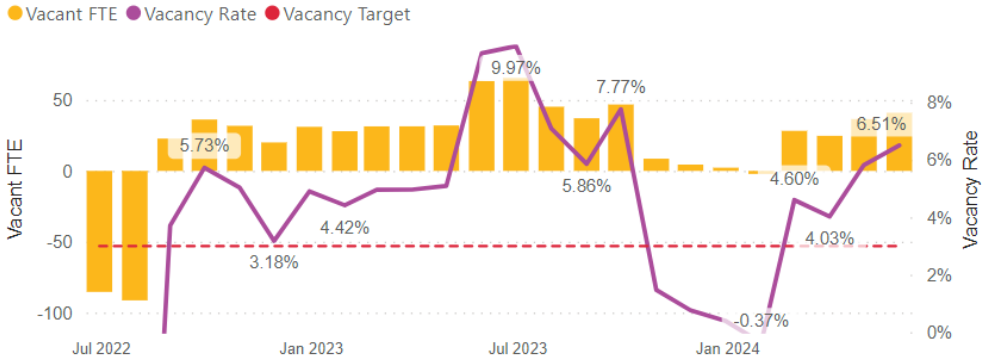
Substantive Staff Headcount



Substantive Staff Headcount by Pay Band



Vacant FTE and Vacancy Rate



Significant staffing pressures across most of the Care Group services, with 54 staffing related risks:

- Haematology ward moves of Durlston moving to Ward 7R coincided with an increased number of admissions and high patient acuity across both wards. The staff are working to align processes and ways of working to improve patient care. The two teams have amalgamated, and all staff work across the 2 wards; this is working successfully to support the Poole staff with the move. The high acuity of Ward 7R is challenging the current agreed template and we are supporting the team with to ensure the care provided to patients is safe. It is anticipated that this will be reflected in the next SNCT audit.
- The OPD nursing structure review has not been commenced due to operational pressures in the Trust. There is currently no Shelford reference framework for an outpatients nursing structure nationally which makes benchmarking for this area more complex. Following the continuation of additional clinic requests of 300 clinics per month, and a number of this requiring support with nursing/ HCSW with identified skills and training, the OPD staffing is in the process of being added to the risk register, whilst current mitigating actions are followed to support the staffing of the clinics.
- There are Phlebotomy staffing challenges across both sites with long term sickness, short term sickness and vacancies. The outcome is impacting our ward areas with support being gained from the other Care Groups. The Temporary Staffing team have sent additional messages to HCSW; changes in HCSW banding (Band 3) have reduced uptake of Phlebotomy (Band 2) shifts. Further recruitment in substantial and bank recruitment on-going, linking with local Universities.
- Interventional Radiology nurse staffing continues to be challenging despite a robust review of options for maintaining a steady workforce going forward.
- As a Care Group we continue to support staff through Trust and Care Group wellbeing initiatives; this work has been triangulated with the staff survey. Professional Nurse Advocates and TRIM Practitioners are in place for staff support and the Care Group has implemented a workforce group.
- Care Group Matrons and Lead Nurses are collaborating to provide a Band 7 (all staff groups) monthly education programme to enhance skills and knowledge, share good practice and improve networking opportunities within the Care Group.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 03 July 2024

Agenda item: 8.4.2

Subject:	Quality Assurance for Responsible Officers and Revalidation
Prepared by:	Rachel Ivamy, Appraisal and Revalidation Officer Mel Martin, Appraisal and Revalidation Officer
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)	None
Purpose of paper:	Assurance
Executive Summary:	The number of appraisals undertaken and connections to Responsible Officer have increased over the last year. A new deputy Responsible Officer has been appointed. The governance has been reviewed and updated to ensure clear lines of responsibility, accountability and reporting. Our appraisal and revalidation numbers have remained static. We have a concern around the number of appraisers available and an action plan is being created.
Background:	Appraisal and revalidation of consultants and SAS doctors is managed through the Chief Medical Officer directorate. The governance for this is through the clinical appraisal group, care groups and trust management group. Assurance is through the People and Culture Committee and the Board. Issues regarding compliance are managed within directorates and care groups and through the MHPS process where appropriate. The Responsible Officer and deputy Responsible Officer meet regularly with the GMC ELA to ensure joint management of difficult cases.
Key Recommendations:	For assurance

Implications associated with this item:	Council of Governors	☐
	Equality, Equity, Diversity & Inclusion	☒
	Financial	☐
	Health Inequalities	☐
	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	01/07/2024	Meeting has not yet taken place at the time of submission of this report.

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

Classification: Official

Publication reference: PR1844

NHS England

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance.

1 April 2023 to 31 March 2024

Version 1.2 Feb 2023

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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.

The AOA exercise has been stood down since 2020, but has been adapted so that organisations have still been able to report on their appraisal rates.

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 in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide 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,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team – of University Hospitals Dorset NHS Foundation Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: To continue to be an active member of the network meetings and update with any training required. Comments: As of 1st April 2023, Dr Peter Wilson was appointed as CMO and RO for the Trust. Action for next year: To remain an active member of the network meetings and all updates cascaded to Revalidation team.

2. The designated body provides sufficient funds, capacity, and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: To review options for appraising and increasing the number of appraisers. Comments: The contract for both appraisals and 360 feedback systems are due to expire in May 2024 and therefore this is currently with procurement. Costs have increased but a 3-year contract will keep costs to a minimum. Two administrators support the appraisal & revalidation process with an FTE of 1.6. Numbers of Medical staff has increased again this year with currently 913 registered on our system as of 02 April 2024 with the majority as Locally Employed Doctors or International Medical Graduates who require additional support and who are more likely to stay for 12 – 18 months before moving on or securing a training programme. We have a group of established appraisers within the Trust, currently standing at 103 active appraisers with current appraisee numbers between 2 and 42. Remuneration for Appraisers is 0.25PA within the SPA allocation of their Job Plan with the expectation that 5/6 appraisals are completed each year. We have trained 3 new Appraisers in the later part of this year, but we are still below the numbers required to match the appraiser to appraisee ratio as set out in our Policy.

Action for next year: To continue to increase the number of Appraisers and look at options and requirements for staff to be appraised.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: Investigate an accessible leavers report and improve new starter information.

Comments: A Leavers report has still not been available, but we have continued to utilise the GMC connection notifications received.

The New Starter reporting is now available on a Teams channel, and we review this report monthly to ensure those new starters who we do not see at Induction are captured.

GMC Connect is reviewed regularly.

Action for next year: Continue to update GMC Connect following induction and New Starter reports. Investigate improvement to Leaver's process.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: To continue to work in line with the policy, a review of the policy will take place in March 2024.

Comments: Review of Policy is underway. Appraisal engagement has stabilised over the last year with the continued support of the team and realistic postponements agreed.

Action for next year: To continue to support doctors' engagement to improve the appraisal completion rate.

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: All Appraisal Outputs continue to be reviewed by Appraisal Lead to ensure high standards are maintained. HLROQR visit set for 23 July 2024 Action for next year: Continue to keep standards high, with continuing reviews.

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: Continue to review the needs of all short-term doctors to ensure their appraisal needs are covered and they are supported with their revalidation. Comments: We continue to ensure that all non-training doctors directly employed on a fixed term contract of at least 4 months are given access to Premier IT and have access to an Appraiser within the Trust. All New starters are invited to an Appraisal Training Session (ATS) All shorter-term contracts or Bank staff are reviewed individually with the majority being given access to the Appraisal process. Anyone working via a Locum Agency will not be offered an appraisal by the Trust. For Doctors working in the Trust but connected elsewhere are asked to provide a copy of their latest appraisal or a letter from their Designated Body confirming no concerns. Action for next year: Continue to review the needs of all short-term doctors and those connected elsewhere to ensure Trust is fully assured.

Section 2a – Effective Appraisal

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.[1]

Action from last year: To ensure all doctors have an annual appraisal as covered within our Appraisal and Revalidation policy.

Comments: We have continued with a 15 months (3 month overdue) escalation plan and regular reviews with Clinical Directors has maintained the level of compliance.

Action for next year: Improve the compliance rate by stronger focus on overdue situations and use of REV 6's.

7. 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: 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.

Comments: Support for those who have not completed their appraisal is offered at induction and IMG Induction to ensure all staff have contact with the team and they feel comfortable approaching us for help.

For those who do not complete the appraisal on time, we contact to offer additional support and ask what is preventing them from completing the appraisal, so we can tailor the support.

Action for next year: Continue to meet at Inductions improve the understanding of approved delays and support available.

8. 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).

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), 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 moved to the revised model may want to describe their plans in this respect.

Action from last year: To complete a review of the Appraisal and Revalidation policy in line with national policy.

Comments: Policy review started in April 2024, along with the PReP system amendments following the GMP changes in January 2024.

Action for next year: Embed any changes or adaptations to Policy.

9. 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: To review the number of appraisers and to look at ways to improve the process and in particular for those doctors on short term contract who are returning to training to see if there is a better way of appraising them and in turn freeing up appraisers' time.

Comments: A review of 'Panel appraisals' for some groups of doctors was investigated, however we felt that this lost the supportive and personal benefits of this meeting alongside the recent changes made to Good Medical Practice.

The number of Appraisers is significantly below the required number based on the policy and with doctor numbers expect to increase this could pose a risk to service.

Action for next year: Team to continue to promote Appraiser Role and discuss with Clinical Directors to support this in order to increase the numbers. Investigate options within other groups of colleagues including non-medical staff.

10. 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: Include a face-to-face meeting as well as a Teams meeting for both Workshops to allow for more networking to take place.

Comments: Appraiser Update Meetings were held on Teams this year due to logistics. However, first face to face one is booked for May 2024.

Action for next year: Continue to offer mix of face to face and Teams meetings. Quality Assurance to continue with Appraisal Lead reviewing all Outputs to ensure they remain assuring.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

11. 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: To review Revalidation Governance Committee meeting with new CMO. Comments: CMO confirmed committee not essential as monthly meetings with senior team (CMO, DCMO, CGD, HR, Appraisal Lead and Admin support) reviews compliance rates, individual cases outstanding by more than 3 months. Bi-monthly workforce report confirms ongoing compliance rate. Action for next year: Review appraisal systems and processes to include feedback from HLROQR visit.

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:	This year (Last year)
Total number of doctors with a prescribed connection as at 31 March 2024	**913 (838)**
Total number of appraisals undertaken between 1 April 2023 and 31 March 2024	**664 (616)**
Total number of appraisals not undertaken between 1 April 2023 and 31 March 2024	**247 (258)**
Total number of agreed exceptions	**216 (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: To continue to improve the first-time recommendations to Revalidate to 85%, keeping focus on 360's in year 3 of revalidation cycle.

Comments: A total of 171 submissions were made to the GMC relating to 154 doctors. Of which 144 were Revalidation recommendations and 130 were first time revalidations giving a rate of 90%.

25 Deferrals were submitted with 3 being deferred more than once.

Action for next year: Ensure 360's are set up in the middle year of Revalidation cycles and maintain similar level of first-time revalidations.

12. 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 increase the number of recommendations made at least 2 months ahead of the submission date.

Comments: All doctors who have a Revalidation recommendation submitted are notified by email from the Revalidation team on the day of submission. Any doctor who is deferred will have been in correspondence with the team to agree and plan and offer support.

Action for next year: Continue to review and prepare for Revalidations 6 months ahead of due dates and submit recommendations when ready.

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, Audit and research & development as appropriate for their grade and specialty. With this being confirmed via the Appraisal process.

Action for next year: Continue with current practice and review as necessary.

13. 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 to review the facilities within each system to ensure they are used to maximum benefit for the doctors. Comments: Information is still available to doctors regarding complaints however the risk team are no longer able to supply details of SUI's. PReP & Edgecumbe continue to be the e-portfolio for appraisals. Action for next year: Continue to review as and when new systems introduced.

14. 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: Continue to review as necessary. Comments: Regular meetings with GMC ELA and RO continue and cover any concerns identified. Maintaining High Professional Standards policy is in place. Action for next year: Continue to review as necessary.

15. 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.

[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.

Comments: The Strategic Workforce Committee receives a report from the CMO on the number and nature of any concerns raised about a doctor that are being investigated under the Trusts MHPS 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: Continue with current practice and review as necessary. This information should include consideration of any protected characteristics and a timeframe for conclusion of investigations.

16. 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 continue with the current established processes.

Comments: We continue to use the Medical Practice Information Transfer Forms (MPIT) to transfer information between RO's. We request information via this form for all new starters at UHD and complete all requests received.

The Company Secretary team hold information centrally through a Declaration of Interest for all 'Decision Making Saff' with an annual return being required.

For doctors working here but connected to another designated body, we request a copy of their appraisal output or a sign off for our records.

Action for next year: To continue with the current established processes.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

17. 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 and review where required. Comments: A UHD policy and procedure for Maintaining High Professional Standards is in place which includes the arrangements for investigating 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 to 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: Continue adhering to NHS Employers guidance and review our practices where required. Comments: The Medical Resourcing Team adheres to the guidance set for NHS Employers for recruitment of doctors. This process includes checking the GMC register and any undertakings they have. References are taken for all staff employed directly by the Trust. Action for next year: Continue to adhere 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**
    - Improve Appraiser issues, following discussions with other local trust and Appraisal Lead forums we looked at an option to carry out Panel Appraisals to reduce the burden on Appraisers. However, we have felt that this would detract from the positive support and wellbeing experience that these doctors need and benefit from.
    - Review PReP ASPAT capabilities, Appraisal Lead has completed ASPAT assessments from May 2023, these are now being sent to Appraisers as their appraisals become due. The pros and cons of these will be discussed at the next Appraiser Update meeting.
- **Actions still outstanding**
    - Appraisal and Revalidation Policy is Under review and to be completed by end of October 2024
- **Current Issues**
    - Number of Appraisers is significantly below the required number and with doctor numbers expected to increase with the opening of the BEACH building this could pose a risk to services.
- **New Actions:**
    - HLROQR visit booked for 23 July 2024.

Overall conclusion:

The overall engagement of the Appraisal and Revalidation process has remained static on last year's compliance. The focus for next year will be on getting greater compliance and we will review all the tools available to us.

There is concern that the number of Appraisers is significantly below that required by the Policy and this could start to impact on the compliance rates for Appraisal and subsequent impact on Revalidation.

We feel, and so do our Appraisers, that it's important for them to receive a positive, supportive and wellbeing led appraisal.

Section 7 – Statement of Compliance:

The Board / executive management team – of 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:

NHS England
Skipton House
80 London Road
London
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This publication can be made available in a number of other formats on request.

Publication reference: PR1844

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 03 July 2024

Agenda item: 8.4.3

Subject:	Annual Security Report 2023/2024
Prepared by:	Stuart Willes, Head of Operations & Facilities Stacey Fuszard, Head of Security and Portering Dave Bennett, 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)	**BAF Risk 3 – Risk of not significantly improving staff experience and retention over the next 3 years (and not being in the NHS staff survey results top 20% of comparator trusts).** **Security Risks - Key Open Risk** **Risk 1873** Behavior/Aggression towards staff, patients and visitors. Increased number of incidents seen throughout Trust and increased number of LERNs reported. Currently rated as 12 (Moderate) **Risk 1767** Loss of service delivery from Portering Department. This risk reflects the impact of Porters delivering core business in support of the Trust when responding to a call for security response. Currently rated as 8 (Moderate) **Risk 1801** Violence and Aggression on AMU Increased number of Violence and Aggression seen on AMU affecting staff and patients. 10 (Moderate) **Risk 2040** Increase mental health/violence & aggression issues for trauma patients 8 (Moderate) **Linked Risks** **Risk 1889 M**ental health patients who have no criteria to reside (8) **Risk 1502** Mental Health Care in a Physical Health environment (15)	
Purpose of paper:	Assurance	
Executive Summary:	This Annual Security Report looks at security governance arrangements and incidents for the past year. It also reviews continuing efforts to keep staff and patients safe as well as securing Trust property and assets.	

Security Management Group (SMG) meets monthly under the Chairmanship of the Deputy Chief Operating Officer and provides bi-monthly reports to the Trust Health & Safety Committee Chaired by the Chief people Officer.

A Board lead for Security Management Matters, this post is carried out by Mark Mould, Chief Operating Officer. A Non-Executive Director to oversee the local Security arrangements, this post is carried out by John Lelliott, Non-Executive Director.

Accredited Security Management Specialist, the Trust currently has two nationally accredited Local Security Management Specialists, these are Dave Bennett and Stacey Fuszard Head of Security and Portering.

In 2023/24, there was an overall 76.0% (1968) increase in the number of violence and aggression / security incidents recorded compared to 2022-23 (1118). Reports indicate most incidents are reported as no harm/near miss with minor severity being around 35%. No reports recorded a severe rating with moderate reports averaging at 3.75% of all incidents a drop from the previous year (5%).

The Trust's national staff survey report includes results on security related questions that helped inform the work plan for 2023/24.

Key Actions taken 2023/24

Development of in house UHD Security team

High risk area assessments

- Targeting high reporting areas, a review of ward and local risk assessments to help tackle violence and aggression.
- Scenario Planning for 'Baby Snatch' - further improvement, changes have been made to the Maternity Unit security provision.
- Where possible, engagement with the Police to prosecute offenders.
- Risk assessments supported by wardbased security workshops.
- Server upgrades to the access control system on RBH site ensuring the system is ready for new builds coming online.

Pro-security culture

- Policy reviews - Reviews of relevant security and violence and aggression policies
- V&A Signage for public/patients being deployed across all sites including.
- Sanctions – Warning letters, Acceptable Behavior Agreements (ABAs), final warning letter process being reviewed giving greater assurance for reporting.
- Body Worn cameras, staff feel supported used in high incident areas.
- 24/7 door access aligned across RBH/PH.
- Restraint training compliance to support security aspects of violence & aggression (V&A).

- Server upgrades to the access control system on RBH site ensuring the system is ready for new builds coming online.

Training compliance

- Conflict resolution Trust wide 93.09%
- Specialist restraint training (PMVA) levels are 87% across all areas with scheduled ongoing training throughout 2024.
- Prevent training at 91.60% compared to the previous reporting period (88.3%).

Violence, Prevention and Reduction Standards (VPRS)

- Engagement with Social Partnership Forum (SPF) for compliance and updates against the VPR standards with VPRS meetings in place to review internal compliance against the standards.

Right Care, Right Person

- Implementation of RCRP across the Trust ensuring those who may otherwise receive help from Dorset Police, and it is likely there will be an impact on NHS as Police decline support (in some instances). RCRP is being implemented across 4 stages with each phase providing differing concern to the Trust. Phase 2 (July 2024) addresses the Police response to AWOL patients, which is likely to see the greatest impact. This is being reviewed by a working group assessing the potential impact and required changes.

Next Steps workplan 2024/25

Area	When
Further develop the of risk assessments process linked to those areas of high reporting areas.	Ongoing
Proposal to enhance the security coverage across sites. Recruit, develop in-house security team across the Trust.	Q1
Work with wider teams to respond to the Right Care, Right Person (RCRP) implementation across Trust	Q1/Q2
Increase communication and visibility of security reporting and response across sites (Pro-security)	24/25
Support the outcome of the HTA compliance report (Mortuary)	Q1/Q2
Input into the changes needed for the emergency & planned care hospital/ consistent approach	24/25
Ongoing Reviews of relevant security and violence and aggression policies ensuring compliance is maintained and any learning considered and introduced	24/25
Review of CCTV across the trust	Q3
Strengthen wider partnership arrangements with partners and link into Operation Cavell – increase prosecutions of those who assault staff	24/25
Reflect on the staff survey results including the free text comments and the quarterly Pulse surveys to agree priority areas of focus	Q2
Focus on improving training compliance	24/25

Background:	1. An annual Security Report is a requirement under Service Condition 24 of the NHS Standard Contract. 2. The Trust has in place a Security Management Group (SMG) that reports to the Health & Safety Group chaired by the Chief People Officer. 3. Under the UHD Trust, there are several items that are held on the Risk Register that have some link to Security and increased Violence and Aggression 'Mental Health behaviors in physical healthcare environment.
Key Recommendations:	The Board is asked to note the contents of this paper and the work proposed for 2024/25.
Implications associated with this item:	Council of Governors ☐ Equality, Equity, Diversity & Inclusion ☒ Financial ☒ Health Inequalities ☐ 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**
• Security Management Group • Health and Safety Group	30/04/2024	Report to be shared with Health & Safety Group Report updated to include staff Survey results, governance update, work plan updated, inclusion of additional actions taken for 23/24, linked risks added and reference to BAF
Trust Management Group		Meeting has not yet taken place at the time of submission of this report.
People and Culture Committee	01/07/2024	Meeting has not yet taken place at the time of submission of this report.

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

Appendix A

Security Briefing Paper 2023/24 onwards

1.0 Background

This annual security report looks at security governance arrangements and incidents for the past year. It also reviews continuing efforts to keep staff and patients safe as well as securing Trust property and assets. The report has been prepared using data collated from the Datix Web reporting system. An annual Security Report is a requirement under Service Condition 24 of the NHS Standard Contract.

The standards require a structure in place for the effective management of the security agenda, to meet this requirement the Trust have in place the following structure:

Security Management Group (SMG) meets monthly under the Chairmanship of the Deputy Chief Operating Officer and provides bi-monthly reports to the Trust Health & Safety Committee Chaired by the Chief people Officer.

Board lead for Security Management Matters, this post is carried out by Mark Mould – Chief Operating Officer. A Non-Executive Director to oversee the local Security arrangements, this post is carried out by John Elliot- Non-Executive Director.

Accredited Security Management Specialist, the Trust currently has two nationally accredited Local Security Management Specialists, these are Dave Bennett and Stacey Fuszard Head of Security and Portering.

Monthly summary of Trust wide violence and aggression and security related incidents, highlighting trends and themes across the care groups. This is shared across the care groups and senior leadership teams raising awareness including any sanctions issued.

2.0 Strategic Governance

2.1 Safe Environment for Staff & Patients

A key principle is that staff working at the Trust and patients and visitors using the Trust, have the right to do so in an environment where all feel safe and secure.

The Trust has a Security Management Policy, which will be continually developed as needs arise. In addition, there are several linked policies:

- Violence Prevention & Reduction Policy
- CCTV Policy
- Lone working Policy
- Prevent Policy
- Missing/Absconding Patient Policy
- Issuing of Identification Badges
- Lockdown Plan

These are all accessible to managers and staff through the intranet.

2.2 Security Risks

Security risks are managed in accordance with the Trust Risk and Governance Policy and entered on to the Datix system where they can be regularly reviewed in addition a system generated electronic alert, with actions applied and tracked through this process. This supports thematic analysis and management of associated risks.

2.3 High risk area assessments

Targeting high reporting areas, a review of ward and local risk assessments to help tackle violence and aggression. Further work will be progressed in 2024 to further improve this process.

2.4 Violence Prevention and Reduction (VPR) Standards

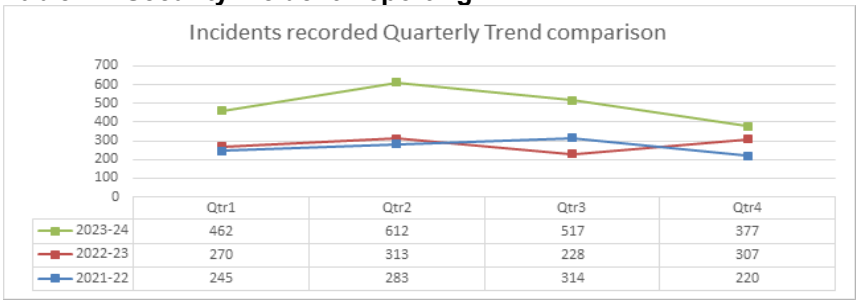
The (VPR) Standards were introduced in January 2021 to provide a risk-based framework to support a safe and secure working environment for NHS staff, safeguarding them against abuse, aggression and violence.

Work remains ongoing to implement the standards which is overseen by the Violence Prevention and Reduction working group. Attendance at Social Partnership Forum (SPF) VPR meetings ensure any document changes are monitored and complied with. At present there is no set standard for Acute Trusts with anticipation further guidance will be issued during 2024. The RAG rating indicates the number of conditions that are met and those requiring additional work in order to move to full compliance.

2.5 Security Incident Reporting

Security incident reporting remains key to the maintenance of a pro-security culture. Safe Environment for Staff & Patients. Comparative figures for 2023-24 are shown in Table 1

Table 1 – Security Incident Reporting



	Qtr1	Qtr2	Qtr3	Qtr4
2023-24	462	612	517	377
2022-23	270	313	228	307
2021-22	245	283	314	220

In 2023-24, there was an overall 76.0% (1968) increase in the number of violence and aggression / security incidents recorded compared to 2022-23 (1118). Of the reported 1968 incidents 1007 occurred at the RBH site, 919 occurred at PH and 13 occurred at Christchurch and 29 off-site.

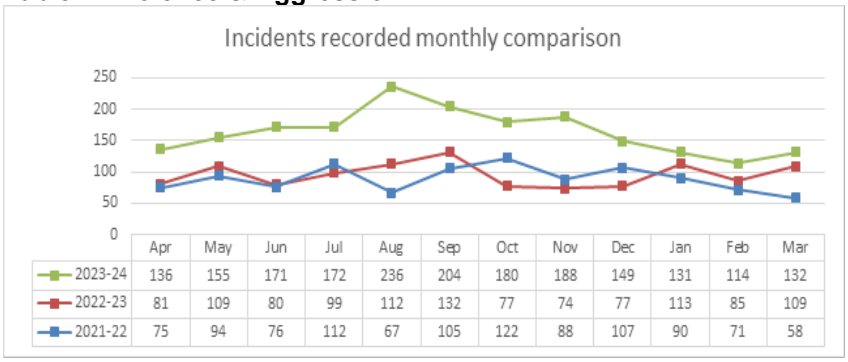
- Reports indicate the majority of incidents are reported as no harm/near miss with minor severity being around 35%.
- No reports recorded a severe rating with moderate reports averaging at 3.75% of all incidents a drop from the previous year (5%).
- 61.5% of Datix incidents received are recorded as ‘No Harm/Near miss’, increased from previous year (60%).

It is anticipated that reporting during 2024 will increase due to a change in reporting categories and how this data is reviewed and presented.

2.6 Violence & Aggression

Violence & Aggression incidents range from acts of physical contact (however minor or inconsequential including spitting) to verbally threatening or intimidating behaviour and racial abuse. incidents are those incidents where the perpetrator was not deemed to have any reasonable excuse for their behaviour e.g. an underlying medical condition or illness such as dementia or toxic infection. Legally excess alcohol and/or drug misuse are not seen as mitigating circumstances for adverse behaviour, but as aggravating factors there are incidents where an individual is deemed to lack capacity and are not therefore held responsible for their actions due to their medical condition, treatment or other underlying medical issue e.g. dementia.

Table 2- Violence & Aggression



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023-24	136	155	171	172	236	204	180	188	149	131	114	132
2022-23	81	109	80	99	112	132	77	74	77	113	85	109
2021-22	75	94	76	112	67	105	122	88	107	90	71	58

Of the reported Violence & Aggression incidents 1098, 569 occurred at the RBH site, 507 occurred at PH and 7 occurred at Christchurch 15 and off-site.

2.6.1 Post Incident Action, Sanction & Redress

- All reported security incidents from either hospital staff or the security teams are individually reviewed by the Trust Security Manager. This includes liaison with staff affected by more serious incident and/or their line management.
- Warnings are issued in line with the Violence Prevention & Reduction Policy with Group Directors of Nursing (GdoNs) 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 advising that non-emergency treatment could be withdrawn if there are any further episodes and support for police action or civil action by the Trust
- 135 warning letters were drafted over the report period This is an increase of 13.44% compared to the previous reporting period (119).
- The Trust supports all police and Court actions when taken.

2.7 Staff survey

The Trust's national staff survey report includes results on security related questions that helped inform the work plan for 2023/24.

Note: There was an error when the results were first made public by Picker in March so they did remove some of the questions under the Safe & Healthy theme. However these have now been updated. Recently. All questions relating to experiencing physical violence or aggression.

Key questions to support the development of 2024/25 plan
Q13d *The last time you experienced physical violence at work, did you or a colleague report it? Improvement in reporting over the last three years from 68.18% to 70.39% in 2023 (Average 69.76%)*

***Q13c** In the last 12 months how many times have you personally experienced physical violence at work from...? Other colleagues.*
Improvement in last three years from 1.77% to 1.45% in 2023 (Average 1.76%)
***Q13b** In the last 12 months how many times have you personally experienced physical violence at work from...? Managers.*
Stayed relatively static over the 3 year period at 0.62% in 2023 (Average 0.68%)
***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. Increase from 14.15 in 2021 to 15.06% in 2023 (Average 13.65%)*

3.0 Key Actions taken 2023/24

Development of in house UHD Security team – Agreement for a dedicated internal UHD security team was accepted and new officers have been recruited/ trained and deployed across the main sites. Further work in 2024 to enhance the coverage of service over the 24 hour / 7 day period.

High risk area assessments

- Targeting high reporting areas, a review of ward and local risk assessments to help tackle violence and aggression.
- Scenario Planning for 'Baby Snatch' - further improvement, changes have been made to the Maternity Unit security provision.
- Where possible, engagement with the Police to prosecute offenders.
- Risk assessments supported by ward based security workshops.
- Server upgrades to the access control system on RBH site ensuring the system is ready for new builds coming online.

Pro-security culture

- Policy reviews - Reviews of relevant security and violence and aggression policies
- V&A Signage for public/patients being deployed across all sites including.
- Sanctions – Warning letters, Acceptable Behavior Agreements (ABAs), final warning letter process being reviewed giving greater assurance for reporting.
- Body Worn cameras, staff feel supported used in high incident areas.
- 24/7 door access aligned across RBH/PH
- Restraint training compliance to support security aspects of violence & aggression (V&A)
- Server upgrades to the access control system on RBH site ensuring the system is ready for new builds coming online.

Training compliance

- Conflict resolution Trust wide 93.09%
- Specialist restraint training (PMVA) levels are 87% across all areas with scheduled ongoing training throughout 2024.
- Prevent training at 91.60% compared to the previous reporting period (88.3%).

Violence, Prevention and Reduction Standards (VPRS)

- Engagement with Social Partnership Forum (SPF) for compliance and updates against the VPR standards with VPRS meetings in place to review internal compliance against the standards.

Right Care, Right Person

- Implementation of RCRP across the Trust ensuring those who may otherwise receive help from Dorset Police and it is likely there will be an impact on NHS as Police decline support (in some instances). RCRP is being implemented across 4 stages with each phase providing differing concern to the Trust. Phase 2 (July 2024) addresses the Police response to AWOL patients, which is likely to see the greatest

impact. This is being reviewed by a working group assessing the potential impact and required changes.

4.0 Next Steps workplan 2024/25

Area	When
• Further develop the of risk assessments process linked to those areas of high reporting areas.	Ongoing
• Proposal to enhance the security coverage across sites. Recruit, develop in-house security team across the Trust.	Q1
• Work with wider teams to respond to the Right Care, Right Person (RCRP) implementation across Trust	Q1/Q2
• Increase communication and visibility of security reporting and response across sites (Pro-security)	2024/25
• Support the outcome of the HTA compliance report (Mortuary)	Q1/Q2
• Input into the changes needed for the emergency & planned care hospital/ consistent approach	2024/25
• Ongoing Reviews of relevant security and violence and aggression policies ensuring compliance is maintained and any learning considered and introduced	2024/25
• Review of CCTV across the trust	Q3
• Strengthen wider partnership arrangements with partners and link into Operation Cavell – increase prosecutions of those who assault staff	2024/25
• Reflect on the staff survey results including the free text comments and the quarterly Pulse surveys to agree priority areas of focus	Q2

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 03 July 2024

Agenda item: 8.4.4

Subject:	Freedom to Speak up – Exception report (April/May 2024)
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)	N/A
Purpose of paper:	Assurance
Executive Summary:	The purpose of exception report is to: • Review our speaking up culture from 1 April to 31 May 2024. • 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:	• Speaking up benefits everyone; it creates learning and improvement, leads to safer care and improved patient experience. • Case headlines; 85 FTSU referrals from 1 April to 31 May 2024; an increase of >102%, same period 2023/4 (42 referrals). • Staff approach the FTSU team for a number of reasons. The greatest theme for April/May had an element of process and policy (34 staff; 40%). This

	is followed by behaviours (29 staff; 34%) and then worker safety and wellbeing (18 staff; 21%).
	• Staff use the FTSU channel more for workplace and relational issues than patient safety.
	• 36% of staff who use the FTSU route is because either their line manager is the issue or not addressing the issue. 15% felt insecure.
	• 16% of staff (14 staff) from our global majorities ethnic minority raised FTSU concern.
	• 8% of FTSU referrals came from staff who have a disability.
	• Ten staff (12%) reported cases anonymously; an increase of 70% same period in 2023.
	• Other points to note:
	  ○ Approved- Mandatory Speak Up HEE/NGO module from October 2024.
	• Learning.
	  ○ The need to have a respectful and civil workplace (28 cases).
	  ○ The need for compassionate and inclusive leadership and better management skill (32 cases)
	  ○ The need to get the basics right (8 cases)
	  ○ The difficulties of team integration and merger (9 cases)
	  ○ The importance of health and wellbeing and looking after each other (6 cases).

Implications associated with this item:	Council of Governors ☒ Equality, Equity, Diversity & Inclusion ☒ Financial ☐ Health Inequalities ☐ 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	1 July 2024	Meeting has not taken place at the time of submission of this report.

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

Supporting you to raise concerns

Freedom to speak up

FTSU data 1 April - 31 May 2024

NHS University Hospitals Dorset NHS Foundation Trust

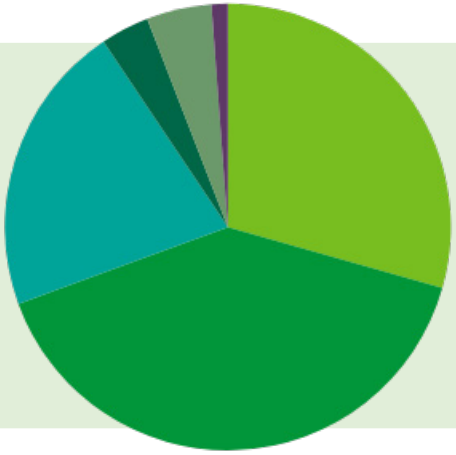
85 staff

came to speak to FTSU*

***This is above average compared to same period in 2023**

Themes

25 referrals for 'attitudes and behaviours'
34 referrals for 'policies and procedures'
18 referrals for 'worker safety and wellbeing'
3 referrals for 'patient safety'
4 referrals for 'bullying and harassment'
1 referral for 'EDI inclusion and belonging'

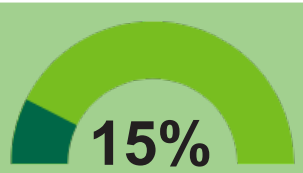


Behaviours

38% of concerns related to incivility
31% of concerns related to toxic workspace / teams
17% of concerns related to complex and longstanding behaviours

36%

of staff came to FTSU because they felt their manager was the issue or was not addressing the issue



15%

of staff came to FTSU because they felt unsafe to speak up

10

anonymous referrals via @UHD app*

*An increase of 70% compared to same period in 2023

16% of referrals came from global majority staff

8% of referrals came from staff who have a disability

What have we learnt?

The need to have respectful and civil workplaces (28 cases).
The need for compassionate and inclusive leadership and better management skill (32 cases).
The need to get the basics right (8 cases).
The difficulties of team integration and merger (9 cases).
The importance of health and wellbeing and looking after each other (6 cases).

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 03 July 2024

Agenda item: 8.4.5

Subject:	Guardian of Safe Working Hours Report
Prepared by:	Julie Mantell, Medical Education Manager Paul Froggatt, Guardian of Safe Working Hours
Presented by:	Peter Wilson, Chief Medical Officer

Strategic Objectives that this item supports/impacts:	Systems working and partnership ☐ Our people ☒ Patient experience ☐ Quality: outcomes and safety ☒ Sustainable services ☐ Patient First programme ☐ One Team: patient ready for reconfiguration ☐
BAF/Corporate Risk Register: (if applicable)	Medical Staffing Risk 1692
Purpose of paper:	Assurance
Executive Summary:	Significant vacancies in doctor in training rotas. Since moving to Locums Nest there is now 80-90% of locums filled. Majority of exception reporting remains working overtime. Majority resolved. Decreasing number of exception reports, possibly due to under-reporting. Rota co-ordinators are now in post and we have a forum which is linked to medical workforce planning. Four reports of safety concerns across site investigated by directorate - no safety issues.
Background:	Guardian of Safe Working is an exceptionally important mechanism to ensure the concerns of doctors in training are heard, collated and addressed. We have recently gone to a single GSW across the organisation. We have strengthened the link between GSW and care groups through the new DDMEs.
Key Recommendations:	For assurance.
Implications associated with this item:	Council of Governors ☐ Equality, Equity, Diversity & Inclusion ☐ Financial ☐ Health Inequalities ☐ Operational Performance ☐

	People (inc Staff, Patients)	☒
	Public Consultation	☐
	Quality	☐
	Regulatory	☐
	Strategy/Transformation	☐
	System	☐
	Improvement of staff satisfaction for doctors in training. Addressing doctors in training concerns re safety	
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 Joint Local Negotiating Committee	21/5/2024 23/5/2024	For information.
People and Culture Committee	01/07/2024	Meeting has not yet taken place at the time of submission of this report.

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

University Hospitals Dorset
NHS Foundation Trust

GUARDIAN OF SAFE WORKING REPORT

1st January 2024 to 31st March 2024

UNIVERSITY HOSPITALS DORSET

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POOLE HOSPITAL OVERVIEW (see page 5 for detail)

There has been a reduction in the number of reports as can be clearly seen from the accompanying data. I suspect this maybe a degree of underreporting but equally the fact that new rota coordinators are becoming more established in their roles and there are fewer gaps in cover. For the 4 the immediate safety concerns (ISC) which relate to A5 I met the F1 doctors concerned and relayed their concerns back to the clinical director for medicine. The concerns have been acted upon and having reviewed the matter with the same cohort of doctors this appears to have been resolved with more appropriate senior support.

Sadly, the first 2 ISCs relate to the problem of available staffing out of hours, and this is not always avoidable at the last minute. However, at each induction of new doctors in training throughout the year and at the main intake in August I will be reinforcing the message that if safety concerns exist the consultant on call/responsible should be informed in real time.

ROYAL BOURNEMOUTH HOSPITAL OVERVIEW (see page 11 for detail)

At RBCH there were 60 exception reports for the quarter 1st January to 31st March 2024, a decrease of 2 from the previous quarter. The main reason for exceptions being raised during this quarter is for doctors working over their contracted hours totalling 80% of the reports access to Education. A small number of exceptions were raised for alterations in Shift Pattern, Service Support and Natural Breaks/Rest, a theme which follows the pattern of the previous quarter. An issue was raised from Surgery that doctors had worked extra weekends which were not factored into the work schedule. This was exception reported and escalated to the surgical directorate for payment as per previous agreement with Trust.

There were four patient safety concerns raised during this quarter. They all related to staff shortages. One ER was from ED and the other 3 related to poor staffing on Cardiology wards. All Exceptions marked as “immediate safety concerns” were raised to the directorates for investigation.

There was an increase of 31% in the number of Bank shifts requested from 2177 to 2853, with 68% of these worked during this period. Of note, there was a significant increase in Emergency Medicine requested shifts of 46%, however a decrease in the percentage of these which were worked. The number of locum shifts requested via agency has decreased by 80% from 529 to 107 during this quarter. The percentage of requested shifts which were worked during this quarter has risen significantly from 20% in the previous quarter to 45%.

Junior Doctors Forum Meetings

During the quarter 1st January to 31st March 2024 there has been 1 meeting which was held on 14th February 2024 in which the following issues were raised and discussed. Also in attendance were Siobhan Harrington and Peter Wilson:

- Discrepancies in breaks deducted on locum timesheets
- Inconsistencies in medicine locum weekend rates at PGH
- Exception reporting change from August 2024
- Changing room update – RBH
- Lack of availability of computers/workspace on the wards

Doctors break payments inconsistent - some paid some not. Doctors are normally paid for their breaks but whilst doing a locum shift should their breaks be paid or not. Locum contract is a separate contract, but during the shifts doctors are still carrying crash bleeps and could be called. This was taken forward for investigation.

Rate Inconsistencies: People that doctors are negotiating rates with do not always have the authority to pay that rate. Hence the reason for lots of different rates. Having rate card publicised well will help with this. Difference in BMA rate card and UHD rate card. This was taken forward for investigation.

Exception reporting: queries with exception reporting to contact GSW

Changing rooms at RBCH: These are currently in portacabins at the West wing entrance. No towels or scrub bags. This was taken forward for investigation.

Computer space: Not enough computer and chairs to do work and causing resentment between rotational staff and ward staff, broken chairs and computers and other things not working as they should. This has been taken forward for investigation.

University Hospitals Dorset: Poole Hospital

High level data

Number of doctors / dentists in training (total): 207.4

Number of doctors / dentists in training on 2016 TCS (total): 207.4

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 January to 31st March 2024	Exceptions raised outside of 14 days from event	Outcome agreed (*not closed*)	Number of exceptions closed	Number of exceptions outstanding
Cardiology	2	1	0	2	0
Gastroenterology	8	0	1	7	1
General Medicine	28	3	4	21	4
General Surgery	6	0	4	0	1
Geriatrics	20	2	4	11	5
Haematology	10	0	7	2	1
Orthopaedics	1	0	0	1	0
Total	**76**	**6**	**20**	**44**	**12**

(Source: Allocate)

Brief Overview of Exception Reports Raised

There was a total of 76 exception reports for the quarter 1st January to 31st March, this is a decrease of 50. The number of reports raised has decreased by 40% compared to the last quarter.

There were six patient safety concerns raised during this quarter.

Patient Safety Concerns Raised

Rota/Dept	Grade	Detail
General Medicine	Foundation House Officer 1	No rota'd SHO over the bank holiday weekend for medicine ward cover, which meant I was working alone for the majority of the day. I was also requested to join the consultant on gastro ward round, which lasted for most of the morning and generated further jobs in addition to having to see around 30 patients from handover web, covering all the medical wards and carrying the crash bleep. This felt like an unsafe amount of work for one person, especially an FY1. Finished half an hour late at 21:30.
General Medicine	Foundation House Officer 1	No Rota'd SHO over the bank holiday weekend which meant there was a lack of senior support for medicine ward cover and I did not feel well supported particularly when there were several acutely unwell patients on A5. I also had to join the consultant for gastro weekend ward round which is a new role and generally not the role of medicine ward cover FY1. Did not have time to take a break all day. Did not get a break and then finished 1 hour late due to having to complete investigation requests/ jobs from the weekend gastro ward round. There was not time to do these jobs during the day due to the number of patients to see on medicine ward cover list and lack of senior support as no SHO had been rota'd. I felt like I could not handover these jobs to the night FY1 as they did not know the patients or reasons for investigation requests.
General Medicine	Foundation House Officer 1	Consultant advised to put immediate safety concerns with anything relating to A5. 1 person was sick, had to cover GJOW by myself, too many patients, no one from the ward could help as they also had to stay 2 hrs longer.
General Medicine	Foundation House Officer 1	Consultant advised to put immediate safety concerns with anything relating to A5. Was on gastro, this WR finished on time and we finished the jobs, gen med however had 4 more pts to see with the cons at 16:30, so I helped the other 2 F1s out and saw 2 of the patients with the cons.
General Medicine	Foundation House Officer 1	Consultant advised to put immediate safety concerns with anything relating to A5. Only 2 juniors on each gen med and gastro, not enough staff to do WR, WR jobs and book bloods for weekend and put patients on handover web.
General Medicine	Foundation House Officer 1	Consultant advised to put immediate safety concerns with anything relating to A5. Helped out gen med ward round which wasn't done – further details emailed to Supervisor

There were 2 further Immediate Safety Concerns which occurred in the previous quarter but not reported until this quarter. They both follow the same lines as the first two ISC reports.

Reasons for Exceptions Raised

Over 84% (64 reports) were in relation to staff working over their contracted hours. These were raised by 20 doctors during this period.

Working over contracted hours	Access to Education	Shift Pattern	Service Support	Natural Breaks/Rest
64	3	1	5	3

(Source: Allocate)

Reporting Grades for this Period

FY1	FY2	GP/ST1/2	Trust SHO	IMT1/ST1	IMT2/CT2	IMT3/ST3	ST4+
48	9	0	0	6	12	0	1

(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
46	12	5	4	1	0	8

(Source: Allocate)

Fines

There were no fines this quarter.

Vacancies – Doctors in Training

Department	Number of vacancies
Anaesthetics	3
General Medicine	3
Histopathology	1
Obs & Gynae	1
OMF	5
Paediatric	3
Radiology	2

(Source: Medical Staffing)

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	6 ↑	6 ↑	43 ↑	43 ↑
Emergency Medicine	951 ↓	475 ↑	9598 ↑	4554 ↑
ENT	86 ↓	56 ↓	809 ↓	518 ↓
General Surgery	65 ↑	25 ↓	705 ↑	262 ↓
Maxillo-facial Surgery	23 ↓	23 ↓	163 ↓	163 ↓
Medicine	978 ↑	558 ↑	9609 ↑	5505 ↑
Obstetrics and Gynaecology	180 ↑	118 ↑	1458 ↑	1077 ↑
Oncology	156 ↑	135 ↑	1402 ↑	1226 ↑
Orthopaedic Surgery	584 ↑	492 ↑	5356 ↑	4556 ↑
Paediatrics	140 ↑	84 ↑	1500 ↑	905 ↑
Psychiatry	2 ↑	2 ↑	18 ↑	18 ↑
Urology	1 ↑	1 ↑	12 ↑	12 ↑
TOTAL	**3,172 ↑**	**1,975 ↑**	**30,673 ↑**	**18,838 ↑**

(Source Temp Staffing Office)

This table depicts the number of shifts and hours worked, arrows highlight comparisons to the previous quarter.

During this quarter there was an increase of 14% in the overall number of locum shifts requested. There has been a notable increase of 56% in Paediatrics (*prev 90 incr to 140*), 64% in Obstetrics and Gynaecology (*prev 110 incr to 180*) and 120% in Oncology (*prev 71 incr to 156*). Continuing the trend of the last quarter, the most unfilled shifts were within Emergency Medicine, General Medicine and General Surgery. Of note, over half of the Emergency Medicine and General Surgery hours requested went unfiled.

The table below shows a different aggregation in which the grades for locum shifts were requested.

Locum bookings (Bank) by Grade				
Grade	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
F1	20 ↓	7 ↓	207 ↓	57 ↓
F2	72 ↑	39 ↑	494 ↑	271 ↑
ST/CMT1/2	2219 ↑	1499 ↑	21,985 ↑	14,518 ↑
ST3+	861 ↑	430 ↑	7986 ↑	3992 ↑
TOTAL	**3172 ↑**	**1975 ↑**	**30,673 ↑**	**18,838 ↑**

(Source Temp Staffing Office)

Of note, over half of the requested ST3+ shifts went unfilled.

The table below depicts the various reason for shifts and hours requested, the arrows highlight comparisons to the previous quarter.

Locum Bookings (Bank) by Reason				
Reason	**Number of shifts Requested**	**Number of shifts worked**	**Number of hours Requested**	**Number of hours Worked**
Adhoc	287 ↑	287 ↑	2424 ↑	2424 ↑
Annual Leave	293 ↑	243 ↑	2468 ↑	2021 ↑
Coronavirus	1 -	0 -	12 -	0 -
Deanery Vacancy	298 ↑	163 ↑	2846 ↑	1667 ↑
Escalations	96 ↑	41 ↑	1030 ↑	442 ↑
LTFT Cover	168 ↓	79 ↓	1735 ↓	852 ↓
Maternity/Paternity Leave	37 ↓	26 ↓	348 ↓	249 ↓
Service Demand (e.g winter pressures)	319 ↑	254 ↑	3159 ↑	2599 ↑
Sickness	183 ↓	95 ↑	1694 ↓	873 ↑
Study Leave	56 ↓	41 ↓	473 ↓	340 ↓
Trust vacancy	972 ↓	513 ↓	9772 ↓	4907 ↓
Urgent Clinical Need	445 ↑	219 ↑	4580 ↑	2360 ↑
Waiting List Initiative	17 ↑	14 ↑	133 ↑	107 ↑
TOTAL	**3172 ↑**	**1975 ↑**	**30,673 ↑**	**18,838 ↑**

(Source Temp Staffing Office)

This quarter, the biggest increase has been for escalations, increasing from 3 to 96 shifts being requested although 43% of these were not worked. Another notable increase is the requests for Urgent Clinical Need bookings, which more than doubled since the previous quarter increasing to 445 shifts from 203 from the previous quarter.

The biggest decrease was to cover absences due to study leave, these have decreased by 49% from 109 from the previous quarter to 56 this quarter.

The usual pattern of annual leave and deanery vacancies have continued to rise.

Locum Bookings via Agency

Locum bookings by Grade		
Grade	**Number of shifts requested**	**Number of shifts worked**
Foundation Year 1	0 -	0 -
Foundation Year 2	69 ↑	56 ↑
ST1/2 - CT1/2	5 ↑	5 ↑
ST3+	99 ↓	99 ↓
TOTALS	**173 ↓**	**150 ↓**

(Source Temp Staffing Office)

The number of locum shifts requested via agency have reduced by 16% whilst the total shifts worked has increased to 87% of the total requested.

University Hospitals Dorset: Royal Bournemouth Hospital

High level data

Number of doctors / dentists in training (total): 184

Number of doctors / dentists in training on 2016 TCS (total): 184

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 January to 31st March 2024	Exceptions raised outside of 14 days from event	Outcome agreed (*not closed*)	Number of exceptions closed	Number of exceptions outstanding
A&E	9 ↑	0	8	0	1
Cardiology	16 ↑	0	0	10	6
General Medicine	13 ↓	1	3	9	2
General Surgery	3 ↓	2	1	1	1
Geriatrics	4 ↓	0	0	2	1
Haematology	14 ↑	1	0	14	0
Vascular	1 ↑	0	0	1	0
Total	**60**	**4**	**12**	**37**	**11**

(Source: Allocate)

Brief Overview of Exception Reports Raised

There was a total of 60 exception reports for the quarter 1st January to 31st March 2024, a decrease of 2 from the previous quarter.

There were four patient safety concerns raised during this quarter.

Patient Safety Concerns Raised

Rota/Dept	Grade	Detail
Accident and Emergency	FY2	Night shift staff only had two SHOs for entire night and clinical site were not willing to raise locum rates for further staff. Needed to work longer to help reduce workload of night staff in addition it was very difficult to refer a patient for urology.
Cardiology	CT1	I was the only junior doctor for ward 24 with 23+ patients. This included a very unwell septic patient who I was getting reviewed by ICU etc after 17.30 and couldn't leave. Stayed over an hour late. Was extremely overworked all day and couldn't provide any safe level of care. GSW – Review meeting The Doctor was on his own on ward 24. This was unsafe and has been escalated as an ISC. Due to the excessive workload, the doctor had to stay late to finish jobs related to several unwell patients
Cardiology	Foundation House Officer 1	Poor staffing, F1 seeing patients with limited support prior to long BH 4 day weekend, limited senior support. Consultant covering ward is actually based at Poole this week and wasn't aware he was meant to be covering ward 23 at Bournemouth, but we made contact with him and he will be coming in Tuesday AM and Wednesday PM. Ward 23 was staffed by only 1 F1 and 1 SHO. I left the ward over 90 minutes late
Cardiology	CT1	For the 4th consecutive day Cardiology staffing was appalling with 2 juniors for 2 wards + outliers. Also no full consultant ward round on ward 24 all week before bank holiday weekend. Unable to leave on time or take rest breaks for sheer volume of work and pt safety clearly affected. Rota and management team aware, poor registrar support

Reasons for Exceptions Raised

The main reason for exceptions being raised during this quarter is for doctors working over their contracted hours totalling 80% of the reports; a theme which follows the pattern of the previous quarter.

Working over contracted hours	Access to Education	Shift Pattern	Service Support	Natural Breaks/Rest
48	5	4	1	2

(Source: Allocate)

Reporting Grades for this Period

FY1	FY2	GP/ST1/2	Trust SHO	IMT1/ST1/CT1	IMT2/ST2	IMT3/ST3/CT3	ST4+
15	14	0	0	26	0	4	1

(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
29	14	6	2	0	0	9

(Source: Allocate)

Vacancies

Department	Number of vacancies
Anaesthetics	1
General Medicine	3
Obs & Gynae	1
Ophthalmology	1
Orthodontics	1

(Source: Medical Staffing)

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 ↓	2 ↓	23 ↓	23 ↓
Emergency Medicine	1088 ↑	668 ↑	10,094 ↑	6153 ↑
General Surgery	284 ↑	214 ↑	3019 ↑	2258 ↑
Maxillo-facial Surgery	1 ↑	1 ↑	4 ↑	4 ↑
Medicine	1151 ↑	796 ↑	11,263 ↑	7820 ↑
Ophthalmology	5 ↓	5 ↓	120 ↓	120 ↓
Orthopaedic Surgery	223 ↑	172 ↓	1527 ↑	1164 ↓
Psychiatry	1 ↑	1 ↑	9 ↑	9 ↑
Urology	97 ↑	84 ↑	1024 ↑	882 ↑
Vascular surgery	1 ↑	1 ↑	12 ↑	12 ↑
TOTAL	**2853 ↑**	**1944 ↑**	**27,094 ↑**	**18,444 ↑**

(Source Temp Staffing Office)

This table depicts the number of shifts and hours worked, arrows highlight comparisons to the previous quarter.

There has been an increase of 31% in the number of shifts requested from 2177 to 2853, with 68% of these worked during this period. Of note, there was a significant increase in Emergency Medicine requested shifts of 46%, however a decrease in the percentage of these which were worked.

Locum bookings (Bank) by Grade				
Grade	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
F1	54 ↑	19 ↓	612 ↑	221 ↑
F2	8 ↓	6 ↓	65 ↓	45 ↓
ST/CMT1/2	2395 ↑	1633 ↑	22,484 ↑	15,415 ↑
ST3+	396 ↓	286 ↓	3932 ↓	2763 ↓
TOTAL	**2853 ↑**	**1944 ↑**	**27,094 ↑**	**18,444 ↑**

(Source Temp Staffing Office)

Of note, there was an increase of 28% in the number of shifts requested compared to the previous period. The majority of shifts requested has once again been for the ST/CMT 1/2 grades.

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	361 ↑	233 ↑	3855 ↑	2524 ↑
Adhoc	306 ↑	306 ↑	3010 ↑	3010 ↑
Annual Leave	99 ↑	69 ↑	880 ↑	606 ↑
Civil Duty	9 ↑	4 ↑	113 ↑	50 ↑
Deanery Vacancy	1 -	1 -	10 -	10 -
Escalations	69 ↑	32 ↑	798 ↑	359 ↑
LTFT Cover	7 ↓	7 ↓	63 ↓	63 ↓
Service Demand (e.g winter pressures)	259 ↓	188 ↑	2432 ↓	1755 ↓
Sickness	228 ↑	122 ↓	2095 ↑	1124 ↓
Study Leave	18 ↓	10 ↓	154 ↓	82 ↓
Trust vacancy	1247 ↑	849 ↑	11,417 ↑	7789 ↑
Urgent Clinical Need	237 ↑	112 ↑	2203 ↑	1019 ↑
Waiting List Initiative	12 ↑	11 ↑	64 ↑	55 ↑
TOTAL	**2853 ↑**	**1944 ↑**	**27,094 ↑**	**18,444 ↑**

(Source Temp Staffing Office)

This quarter, the biggest bank locum bookings increase has been for the 7-day Pilot and Urgent Clinical Need. A significant reduction from 116 shifts to 7 shifts has been noted within the LTFT cover requests.

Locum Bookings via Agency

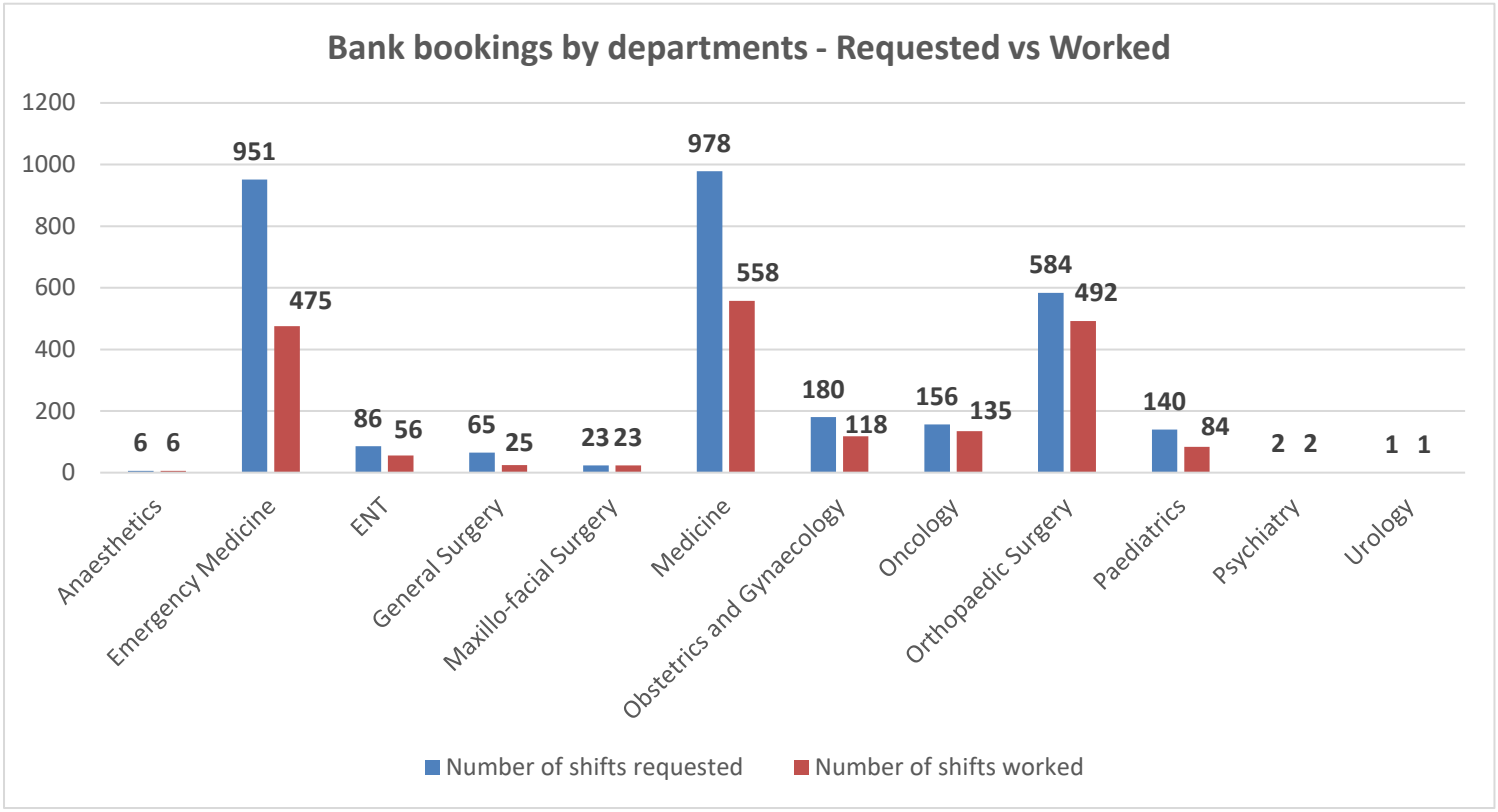
Locum bookings by Grade		
Grade	**Number of shifts requested**	**Number of shifts worked**
Foundation Year 1	0 -	0 -
Foundation Year 2	0 ↓	0 ↓
ST1/2 - CT1/2	0 ↓	0 ↓
ST3+	107 ↓	48 ↓
TOTALS	**107↓**	**48 ↓**

(Source Temp Staffing Office)

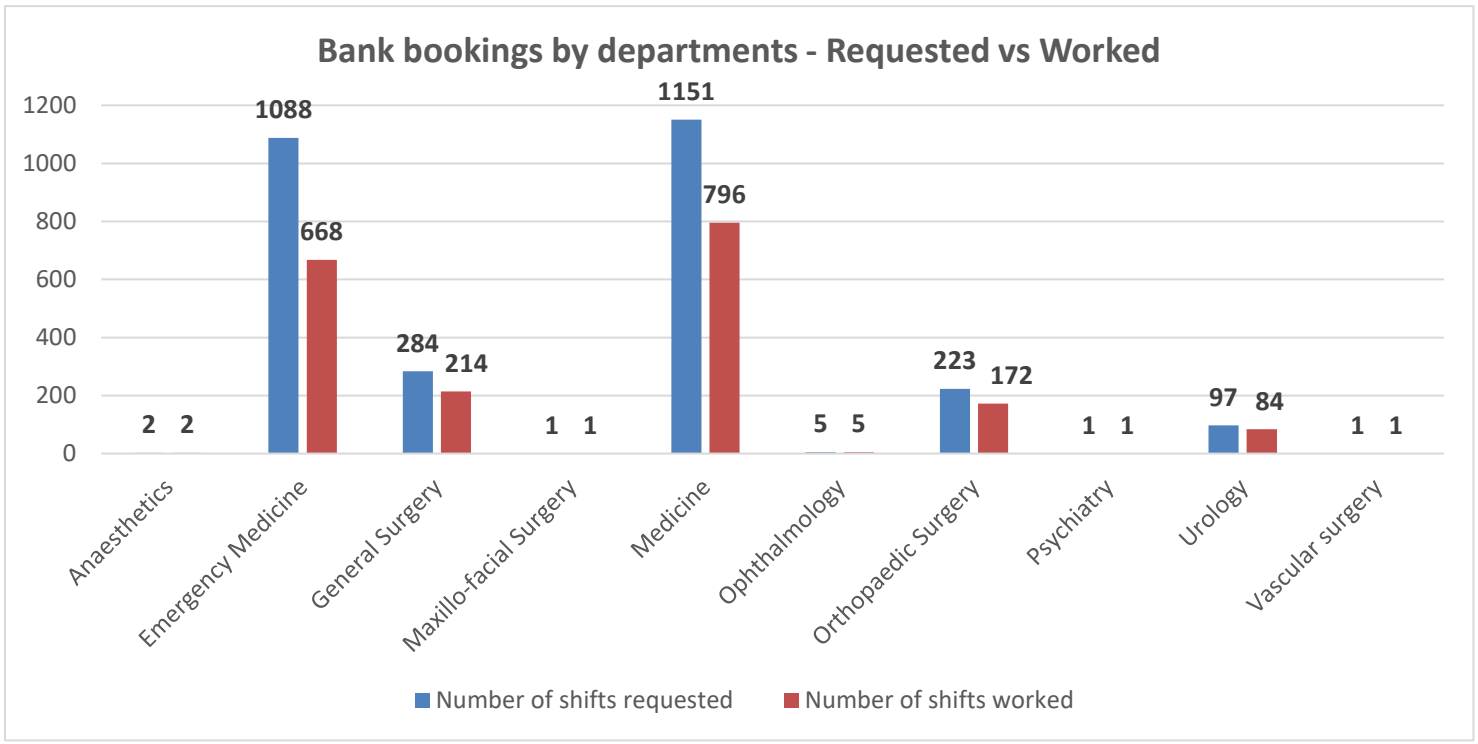
The number of locum shifts requested via agency has decreased by 80% from 529 to 107 during this quarter. The percentage of requested shifts which were worked during this quarter has risen significantly from 20% in the previous quarter to 45%.

Visual Data Representations

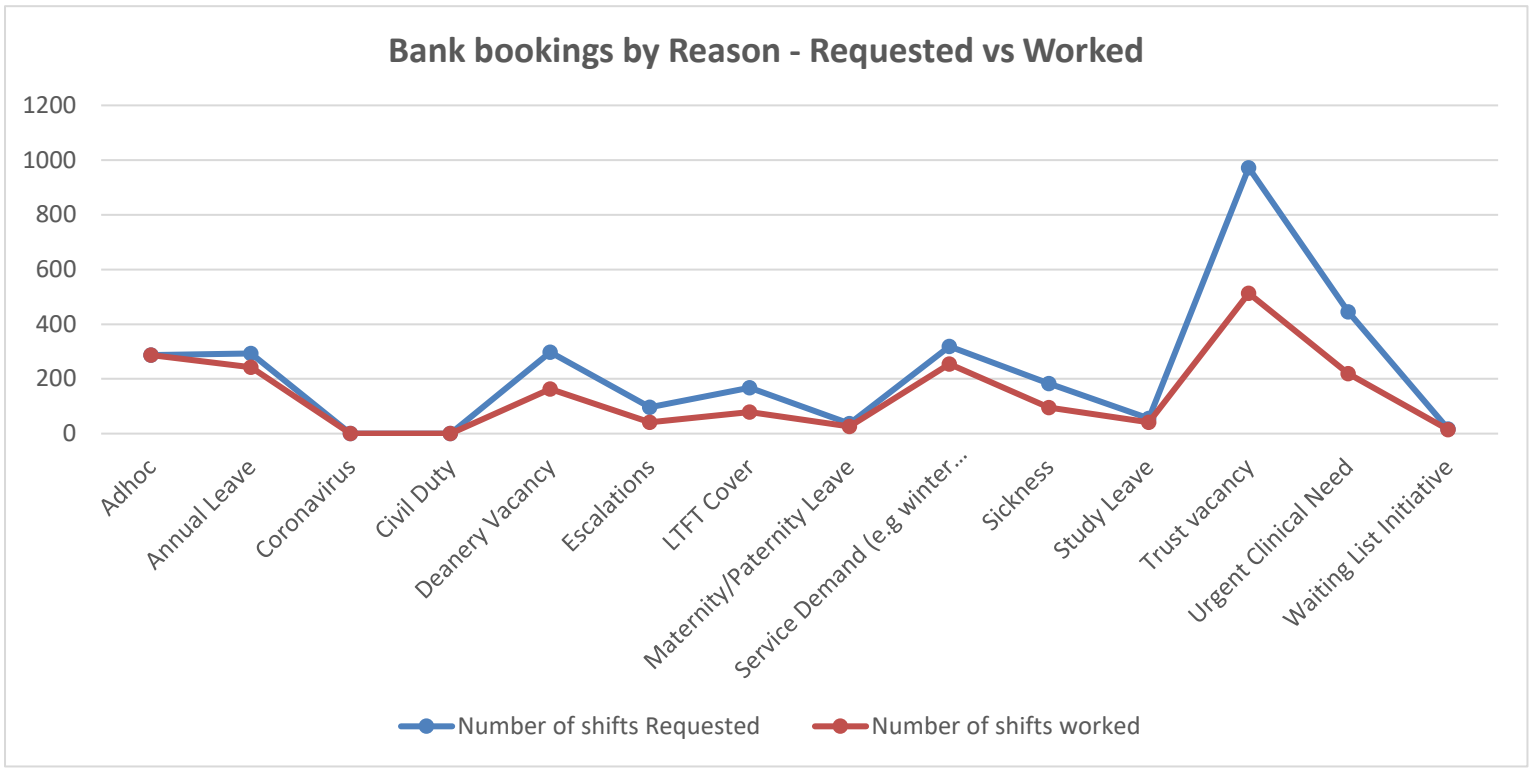
Poole



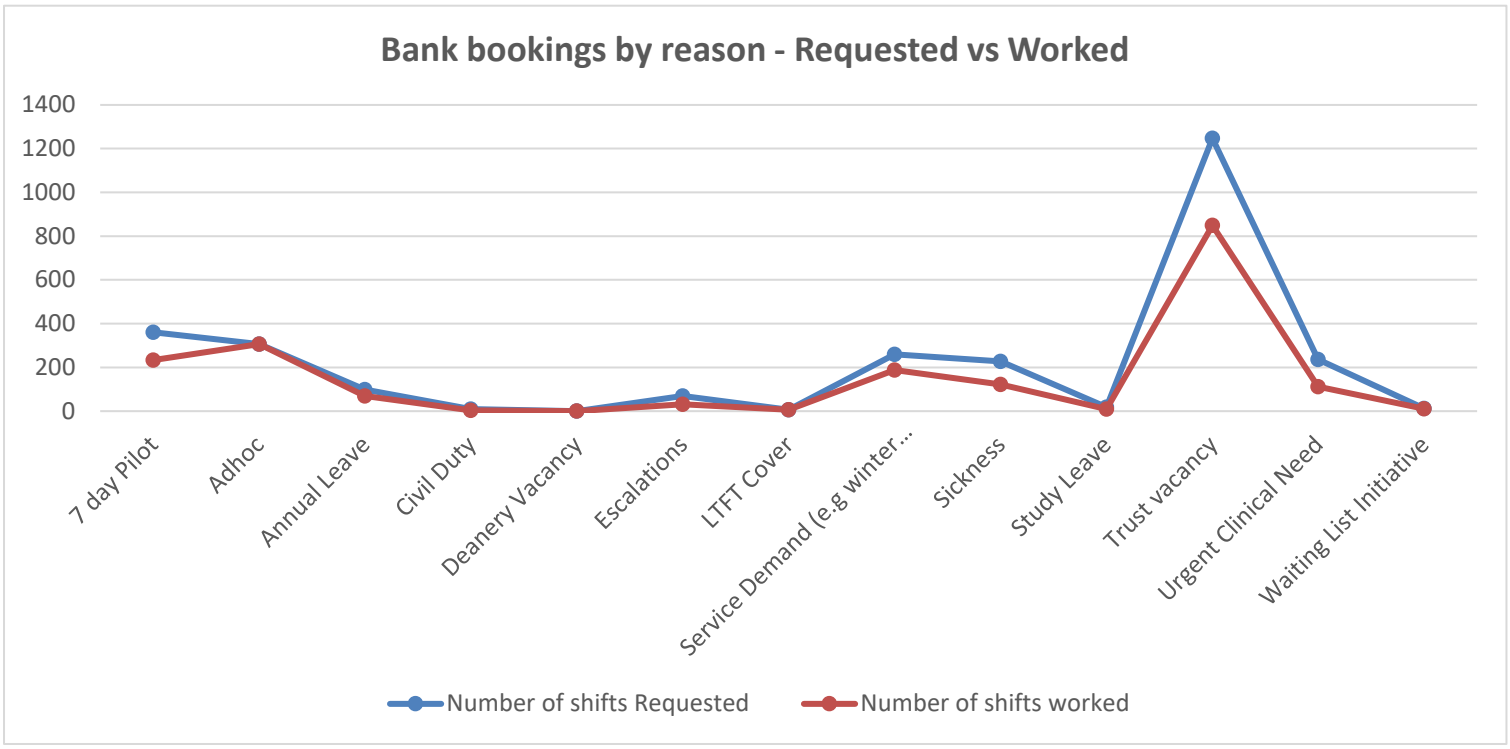
Bournemouth



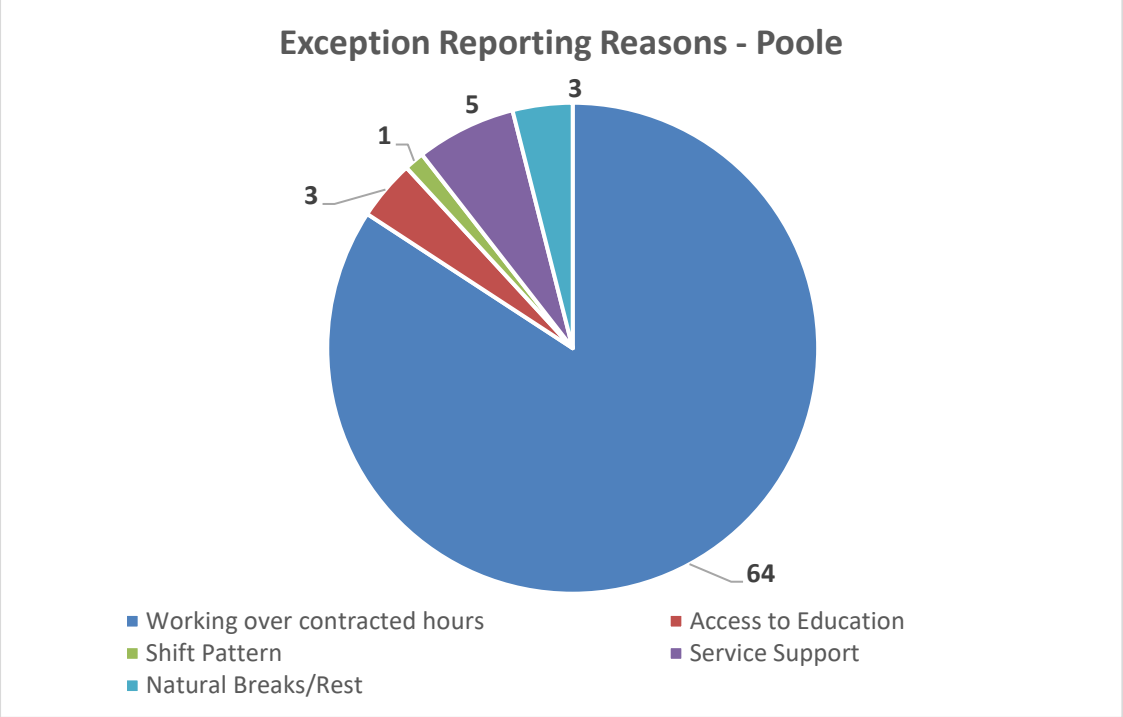
Poole



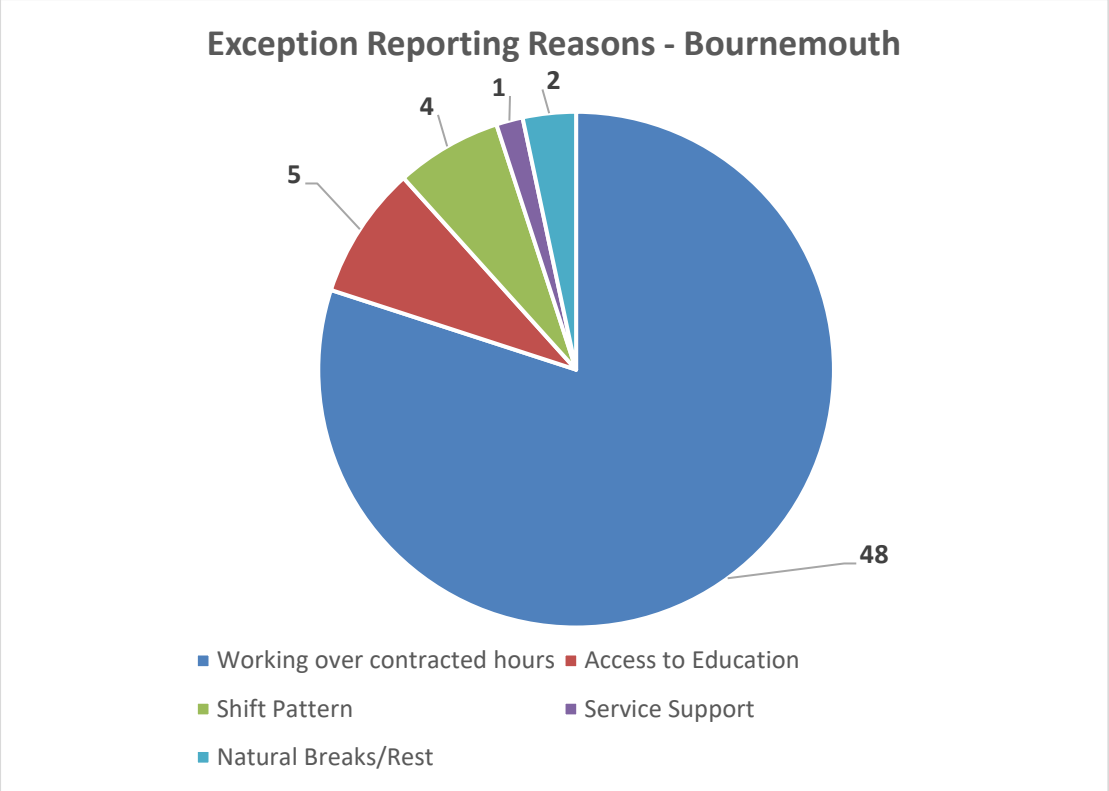
Bournemouth



Poole



Bournemouth



University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 03 July 2024

Agenda item: 8.5

Subject:	Key Issues and Assurance Report to Board of the Population Health & System Committee meeting held on 12 June 2024
Prepared by:	Helena McKeown, Chair of the Population Health & System Committee
Presented by:	Helena McKeown, Chair of the Population Health & System Committee

Key Issues/matters discussed by the Committee:	The Committee received the following: • Update from NHS Dorset presented by Anita Counsell, Deputy Director Health Inequalities and Population Health Management • DiiS Case Study • Health Inequalities in Dorset Annual Report • Operational Update • Anchor Institution report.
Significant issues for escalation to Board for action:	There were no significant issues for escalation to the Board for action. The main focus of the meeting was the update from NHS Dorset and the DiiS Case Study. <u>Matters for Board awareness</u> • NHS Dorset 2023/24 Equality Objectives – objective 1 - "*Our commissioned and provided services will meet the needs of our diverse population".* Embedded equality impact assessment as a core component of new gateway process for approving all new projects in the Integrated Care Board • NHS Dorset 2023/24 Equality Objectives – objective 2 - "*Our workforce will see improvements in health, well-being and diverse representation"*. Deep dive analysis to decrease health inequalities in our workforce. • Improvements in Maternity are an opportunity to prevent obesity and improve oral health in children down the line. https://nhsdorset.nhs.uk/about/equality/#objectives

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 03 July 2024

Agenda item: 8.6

Subject:	Key Issues and Assurance Report to Board of the Audit Committee meeting held on 23 May 2024
Prepared by:	Judy Gillow, Chair of the Audit Committee
Presented by:	Judy Gillow, Chair of the Audit Committee

Key Issues/matters discussed by the Committee:	The Committee received the following:
	• Internal Audit:
	  ○ Progress Report – Health of the Ward, DSP Toolkit
	  ○ Follow Up Report
	  ○ Annual Report
	  ○ Update to Internal Audit Annual Plan
	• External Audit Update
	• Counter Fraud:
	  ○ Progress Report
	  ○ Annual Report
	  ○ Anti-Fraud, Bribery and Corruption Policy and Statement
	• Review of Board Assurance Framework 2023-24 and Draft Board Assurance Framework 2024-25
	• Clinical Audit Workplan
	• Draft Annual Report and Accounts
	• Commercial Compliance Report
	• Annual Review of Losses and Special Payments
	• Register of Interests and Gifts and Hospitality
	• Review of Losses and Special Payments > £15k (none to report)
	• Audit Committee Annual Report
	• Risk Register (including update on action plan).
	
	On 17 June 2024, a joint meeting of the Audit Committee and Finance and Performance Committee was held at which external auditors presented the ISA 260 Report, External Audit Opinion and Letter of Representation. The Committees also considered the Annual Report and Accounts 2023/24 and the Quality Account, each for approval by the Board.

Significant issues for escalation to Board for action:	There were no significant issues for escalation to the Board for action.

	Matters for Board awareness: Internal Audit – Health of the Ward: An area of focus discussed by the Committee was ongoing training, supporting staff development and standard working. Internal Audit Annual Report – As part of the moderate assurance opinion provided, the Committee enquired how the Trust benchmarked against peer organisations. Private practice and job planning – In due course, there would be an opportunity to streamline the declaration of interests process with the job planning process. Complaints Management - The Committee requested that an update on complaints management be presented at its next meeting, also discussing the depth of engagement work being undertaken. Risk Management Strategy - It was reported that the updated Risk Management Strategy was on track for completion. Board Assurance Framework – There was discussion in relation to alignment between Strategy Deployment Reviews and the Board Assurance Framework. Clinical Audit Workplan – A further discussion would take place in relation to best use of the reporting at the Quality and Audit Committees, noting also the flexibility within the most recent HFMA Audit Committee Handbook.
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: 03 July 2024

Agenda item: 8.6.1

Subject:	Clinical Audit Plan 2024-25
Prepared by:	Joanne Sims, Associate Director Quality Governance and Risk; Craig Murray, Clinical Audit and Effectiveness Manager
Presented by:	Peter Wilson, Chief Medical Officer

Strategic Objectives that this item supports/impacts:	Systems working and partnership ☐ Our people ☐ Patient experience ☐ Quality: outcomes and safety ☒ Sustainable services ☐ Patient First programme ☐ One Team: patient ready for reconfiguration ☐
BAF/Corporate Risk Register: (if applicable)	N/A
Purpose of paper:	Review and Discussion
Executive Summary:	The annual Clinical Audit Plan consists of: • All national audits NHS England advises trusts to prioritise for participation and inclusion in their Quality Accounts. • Any other relevant national audits identified by clinical teams as a priority. • Local clinical audits identified by clinical teams as a priority.
Background:	Progress against delivery of the Clinical Audit Plan is undertaken at the end of each financial quarter and reported to the Clinical Audit and Effectiveness Group, Clinical Governance Group and the Audit Committee. An end of year report will be included in the Trust Annual Quality Report.
Key Recommendations:	To approve the Clinical Audit Plan for 2024/25.
Implications associated with this item:	Council of Governors ☐ Equality, Equity, Diversity & Inclusion ☐ Financial ☐ Health Inequalities ☐ Operational Performance ☐

	People (inc Staff, Patients)	☐
	Public Consultation	☐
	Quality	☒
	Regulatory	☐
	Strategy/Transformation	☐
	System	☐
	Clinical Audit measures current practice against best practice and addresses any shortfalls. It is a key quality improvement process, aiming to provide assurance that best practice standards are being met.	
CQC Reference:	Safe	☒
	Effective	☒
	Caring	☐
	Responsive	☒
	Well Led	☐
	Use of Resources	☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Clinical Audit and Effectiveness Group (CAEG)	23/03/2023	Approved
Clinical Governance Group	25/04/2024	Approved
Audit Committee	23/05/2024	Noted.

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

UHD Clinical Audit Plan 2024-25

University Hospitals Dorset NHS Foundation Trust

Directorate	Speciality	Project Title	National Local or Regional	Site	Status
Anaesthetics					
Anaesthetics	Critical Care	Case Mix Programme	National	UHD	In Progress
Anaesthetics	Critical Care	National Cardiac Arrest Audit	National	UHD	In Progress
Anaesthetics	Peri-operative Medicine	Perioperative Quality Improvement Programme	National	UHD	In Progress
Anaesthetics		Free-flap Outcomes Audit	Local	UHD	To be registered
Anaesthetics	Anaesthetics	Re-audit Epidural Waiting Times	Local	UHD	In Progress (304-2324)
Anaesthetics	Theatres	WHO 2024/25 Surgical Safety Checklist: Quality Audit	Local	UHD	To be registered (Previous round 154-2324)
Anaesthetics	Anaesthetics	Perioperative temperature management	Local	UHD	In Progress (020-2324)
Anaesthetics	Anaesthetics	Service Evaluation on Recovery Post-operative Anaesthetic Outcomes	Local	UHD	In Progress (210-2324)
Anaesthetics	Anaesthetics	Recovery Audit for NOF Patients	Local	UHD	To be registered
Cancer Care					
Cancer Care	Haematology/Oncology	National Cancer Audit Collaborating Centre: National Audit of Metastatic Breast Cancer	National	UHD	In Progress
Cancer Care	Haematology/Oncology	National Cancer Audit Collaborating Centre: National Audit of Primary Breast Cancer	National	UHD	In Progress
Cancer Care	Haematology/Oncology	National Cancer Audit Collaborating Centre: National Bowel Cancer Audit	National	UHD	In Progress
Cancer Care	Haematology/Oncology	National Cancer Audit Collaborating Centre: National Kidney Cancer Audit	National	UHD	In Progress
Cancer Care	Haematology/Oncology	National Cancer Audit Collaborating Centre: National Lung Cancer Audit	National	UHD	In Progress

Cancer Care	Haematology/Oncology	National Cancer Audit Collaborating Centre: National Non-Hodgkin Lymphoma Audit	National	UHD	In Progress
Cancer Care	Haematology/Oncology	National Cancer Audit Collaborating Centre: National Oesophago-gastric Cancer	National	UHD	In Progress
Cancer Care	Haematology/Oncology	National Cancer Audit Collaborating Centre: National Ovarian Cancer Audit	National	UHD	In Progress
Cancer Care	Haematology/Oncology	National Cancer Audit Collaborating Centre: National Pancreatic Cancer Audit	National	UHD	In Progress
Cancer Care	Haematology/Oncology	National Cancer Audit Collaborating Centre: National Prostate Cancer Audit	National	UHD	In Progress
Cancer Care	Palliative Care/Hospices	National Audit of Care at the End of Life	National	RBCH & Poole	In Progress
Child Health					
Child Health	Acute Paediatrics	Epilepsy 12	National	Poole	In Progress
Child Health	Acute Paediatrics	National Respiratory Audit Programme: Children and Young People's Asthma Secondary Care	National	Poole	In Progress
Child Health	Acute Paediatrics	National Child Mortality Database	National	Poole	In Progress
Child Health	Acute Paediatrics	National Paediatric Diabetes Audit	National	Poole	In Progress
Child Health	Acute Paediatrics	Paediatric Intensive Care Audit Network (PICANet) - Level 2 HDU	National	Poole	In Progress
Child Health	Acute Paediatrics	UK Cystic Fibrosis Registry – Paediatric service	National	Poole	In Progress
Child Health	CDU/NICU	National Neonatal Audit Programme	National	Poole	In Progress
Clinical Site Management					
Clinical Support					
Therapy	MSK / ED	Compliance of use of VTE e-form in ED	Local	UHD	Pending
Therapy	MSK	Dorset LBP pathway audit	Local	UHD	Pending
Therapy	Orthopaedics	A retrospective review of the inpatient Therapy provision to patients post-operatively who have sustained a fractured neck of femur or shaft of femur against NICE and CSP guidelines	Local	Poole	Pending
Therapy	Acute inpatient	Documentation including new communication standards audit	Local	UHD	Pending

Therapy	SALT	IDDSI compliance across modified texture meals at UHD	Local	UHD	Pending
Corporate					
Emergency and Urgent Care					
Emergency and Urgent Care	Emergency Department	National Major Trauma Registry (TARN)	National	UHD	In Progress
Emergency and Urgent Care	Emergency Department	Sepsis Management in the Emergency Department	Local	RBH	In progress (rolling audit)
Emergency and Urgent	Emergency Department	Frailty - Care of the Elderly Audit	Local	RBH	To be registered
Emergency and Urgent	Emergency Department	Audit of CTPA Imaging	Local	RBH	To be registered
Emergency and Urgent Care	Emergency Department	NEWS2 Emergency Department Audit	Local	UHD	To be registered (rolling audit) Current round 381-2324. To be a rolling audit from 24_25
Facilities					
Head and Neck					
Head and Neck	Ophthalmology	National Ophthalmology Database: Age-related Macular Degeneration Audit	National	RBCH	In Progress
Head and Neck	Ophthalmology	National Ophthalmology Database: National Cataract Audit	National	RBCH	In Progress
Head and Neck	Ophthalmology	Annual Re-Audit of Endophthalmitis After Anti-VEGF Intravitreal Injections	Local	RBCH	
Head and Neck	Ophthalmology	Annual Re-Audit of Endophthalmitis After Cataract Surgery	Local	RBCH	
Head and Neck	Ophthalmology	National Ophthalmic Database reported outcomes for Cataract Surgery	National	RBCH	
Head and Neck	Ophthalmology	National Ophthalmic Database reported outcome for ARMD	National	RBCH	

Head and Neck	Ophthalmology	Annual audit of preschool vision screening service	Local (pan Dorset)	Led by RBCH (UHD)	
Head and Neck	Ophthalmology	Annual audit of Stroke service - Access and outcomes	Local (UHD area)	Led by RBCH (UHD)	
Head and Neck	Oral and Maxillofacial Surgery	Quality and Outcomes in Oral and Maxillofacial Surgery: Oncology & Reconstruction	National	UHD	TBC
Head and Neck	Oral and Maxillofacial Surgery	Quality and Outcomes in Oral and Maxillofacial Surgery: Trauma	National	UHD	TBC
Head and Neck	Oral and Maxillofacial Surgery	Quality and Outcomes in Oral and Maxillofacial Surgery: Orthognathic Surgery	National	UHD	TBC
Head and Neck	Oral and Maxillofacial Surgery	Quality and Outcomes in Oral and Maxillofacial Surgery: Non-melanoma skin cancers	National	UHD	TBC
Head and Neck	Oral and Maxillofacial Surgery	Quality and Outcomes in Oral and Maxillofacial Surgery: Oral and Dentoalveolar Surgery	National	UHD	TBC
Networked Medicine					
Networked Medicine	Cardiology	National Audit of Cardiac Rehabilitation	National	UHD	In Progress
Networked Medicine	Cardiology	National Cardiac Audit Programme (NCAP): National Heart Failure Audit	National	UHD	In Progress
Networked Medicine	Cardiology	National Cardiac Audit Programme (NCAP): Cardiac Rhythm Management	National	UHD	In Progress
Networked Medicine	Cardiology	National Cardiac Audit Programme (NCAP): Myocardial Ischaemia National Audit Project	National	UHD	In Progress
Networked Medicine	Cardiology	National Cardiac Audit Programme (NCAP): National Audit of Percutaneous Coronary Interventions (PCI)	National	RBCH	In Progress
Networked Medicine	Neuro Rehab	Time to referral, assessment and admission standards for neororehabilitation	Local	PGH	To be registered
Networked Medicine	Neuro Rehab	Neurorehabilitation patient complexity	Local	PGH	To be registered
Networked Medicine	Rhuematology	Falls and Fragility Fractures Audit Programme – Fracture Liaison Service Database	National	Poole	In Progress

Networked Medicine	Rheumatology	National Early Inflammatory Arthritis Audit (NEIAA)	National	UHD	In Progress
Networked Medicine	Rheumatology	An audit of the Rheumatology in-patient referrals across both acute sites	Local	UHD	
Networked Medicine	Rheumatology	An audit of the UHD Young Adult Rheumatology service (audit of the first year of the service)	Local	UHD	
Networked Medicine	Stroke	Re-admission re-audit (following merger of 2 wards in RBH)	Local	UHD	To be registered
Networked Medicine	Stroke	Antibiotic Prescribing Audit	Local	UHD	To be registered
Networked Medicine	Stroke	Sentinel Stroke National Audit Programme	National	UHD	In Progress
Nursing and Quality					
Nursing and Quality	Health and Safety	First Aid	Local	UHD	029-2425 Audit tool being created
Nursing and Quality	Nursing and Quality	Falls and Fragility Fractures Audit Programme – National Audit of Inpatient Falls	National	UHD	In Progress
Nursing and Quality	Nursing and Quality	Audit of preparedness of HCPC registered staff for revised standards of conduct performance and ethics	Local	UHD	To be registered
Nursing and Quality	Nursing and Quality	National Patient Safety Alert - Bed Rails NatPSA/2023/010/MHRA	Local	UHD	To be registered
Nursing and Quality	Quality Governance	Quality Governance Toolkits	Local	UHD	To be registered Audit tool being created
Nursing and Quality	Safeguarding	Learning from lives and deaths of people with a learning disability and autistic people (LeDeR)	National	UHD	In Progress
OPS and Acute Care					
OPS and Acute Care	Acute Medicine	Society for Acute Medicine's Benchmarking Audit (SAMBA) This will be the registration for the Acute Medicine Team	National	UHD	To be registered

OPS and Acute Care	Acute Medicine	The management of hypertension (HTN) in acute medicine	Local	UHD	To start 3/4/24 (004-2425)
OPS and Acute Care	Acute Medicine	AMU Day 2+ Ward Round Template	Local	UHD	In Progress (6611)
OPS and Acute Care	Acute Medicine	Re-audit of Hyperkalaemia	Local	UHD	In Progress (035-2324)
OPS and Acute Care	Acute Medicine	Subarachnoid Haemorrhage	Local	UHD	In Progress (267-2324)
OPS and Acute Care	Acute Medicine	Ambulatory management of Cellulitis	Local	UHD	In Progress (219-2324)
OPS and Acute Care	Acute Medicine	Review of patients referred into medical SDEC from AMU	Local	UHD	In Progress (400-2324)
OPS and Acute Care	Acute Medicine	PE Treatment	Local	UHD	To start 1/4/24 (002-2425)
OPS and Acute Care	Acute Medicine	Self-Harm	Local	UHD	In Progress (036-2324)
OPS and Acute Care	Older People Services	National Audit of Dementia	National	UHD	In Progress
OPS and Acute Care	Older People Services	Society for Acute Medicine's Benchmarking Audit (SAMBA) This will be the registration for the Older People Services Team	National	UHD	To be registered
OPS and Acute Care	Older People Services	EPMA Pharmacy Queries	Local	UHD	333-2324 Sathyabama Loganathan
OPS and Acute Care	Older People Services	HOTW + Reducing Length of Stay	Local	UHD	237-2324 Sally Mitchell
OPS and Acute Care	Older People Services	Improving Early Mobilisation in OPS Patiets	Local	RBH	159-2324 Rebecca O'Connor
OPS and Acute Care	Older People Services	Traumatic Hemopneumothorax Re-Audit	Local	UHD	To be registered (Original round 133-2324 Gillian Cumming)

OPS and Acute Care	Older People Services	Older People's Services Outliers Audit	Local	RBH	In Progress - rolling audit (090-2324 Claire Spake)
Pathology					
Pathology	Pathology services	National Comparative Audit of Blood Transfusion: National Comparative Audit of NICE Quality Standard QS138	National	UHD	In Progress
Pathology	Pathology services	National Comparative Audit of Blood Transfusion: National Comparative Audit of Bedside Transfusion Practice	National	UHD	In Progress
Pathology	Pathology Services	Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	National	UHD	In Progress
Radiology and Pharmacy					
Radiology and Pharmacy	Pharmacy	Controlled Drugs Audit (every 6 months) – National requirement	Local	UHD	To be registered
Radiology and Pharmacy	Pharmacy	Auditing the compliance of completing the Cold Chain Record Booklet in clinical areas storing refrigerated medicines	Local	UHD	To be registered (Rachel Richardson Current 344-2324)
Radiology and Pharmacy	Pharmacy	Medicines Management Audit	Local	UHD	To be registered (Chris Bleet Previous round 5341)
Radiology and Pharmacy	Radiology	REALM attendance audit			425-2324 completed. To be re-audited after 6 months
Radiology and Pharmacy	Radiology	Core biopsy audit			To be registered
Radiology and Pharmacy	Radiology	GP access to CT KUB			To be registered
Radiology and Pharmacy	Radiology	HCC surveillance	National		To be registered

Radiology and Pharmacy	Radiology	Cystograms post surgery BSUR			To be registered
Radiology and Pharmacy	Radiology	Lung biopsy			To be registered
Radiology and Pharmacy	Radiology	Rectal cancer staging ERUS			To be registered
Radiology and Pharmacy	Radiology	Biliary pain / pancreatitis service evaluation			To be registered
Radiology and Pharmacy	Radiology	Overnight CTPA request			To be registered
Radiology and Pharmacy	Radiology	Cardiac radiation dose (BSCI/BSCCT)			To be registered
Radiology and Pharmacy	Radiology	CES			In progress (414-2324? Dr McAlinden)
Radiology and Pharmacy	Radiology	Shoulder dislocation (QA)			To be registered
Radiology and Pharmacy	Radiology	CT/MRI referrer satisfaction Apr 24			In progress (016-2425 Dr J Jones)
Radiology and Pharmacy	Radiology	CT colo audit			To be registered
Radiology and Pharmacy	Radiology	Improving parathyroid SPECT CT with addition of iodinated contrast			In progress (231-2324? Dr A Parekh)
Specialist Medicine					
Specialist Medicine	Diabetes and Endocrine	National Adult Diabetes Audit: National Diabetes Core Audit	National	UHD	In Progress
Specialist Medicine	Diabetes and Endocrine	National Adult Diabetes Audit: Diabetes Prevention Programme (DPP) Audit	National	UHD	TBC
Specialist Medicine	Diabetes and Endocrine	National Adult Diabetes Audit: National Diabetes Foot Care Audit	National	UHD	In Progress

Specialist Medicine	Diabetes and Endocrine	National Adult Diabetes Audit: National Diabetes Inpatient Safety Audit	National	UHD	In Progress
Specialist Medicine	Diabetes and Endocrine	National Adult Diabetes Audit: Transition (Adolescents and Young Adults) and Young Type 2 Audit	National	UHD	TBC
Specialist Medicine	Diabetes and Endocrine	National Adult Diabetes Audit: Hybrid Closed Loop Audit	National	UHD	To be registered - in progress
Specialist Medicine	Respiratory	National Respiratory Audit Programme: COPD Secondary Care	National	UHD	In Progress
Specialist Medicine	Respiratory	National Respiratory Audit Programme: Pulmonary rehabilitation	National	RBCH	In Progress
Specialist Medicine	Respiratory	National Respiratory Audit Programme: Adult Asthma Secondary Care	National	UHD	In Progress
Surgery					
Surgery	Breast Care	Breast and Cosmetic Implant Registry	National	UHD	In Progress
Surgery	Emergency Surgery	National Emergency Laparotomy Audit	National	UHD	In Progress
Surgery	GI Surgery	National Bariatric Surgery Registry	National	UHD	TBC
Surgery	Vascular Surgery	National Vascular Registry	National	RBCH	In Progress
Surgery	Urology	BAUS Data & Audit Programme: BAUS Penile Fracture Audit	National	RBCH	TBC
Surgery	Urology	BAUS Data & Audit Programme: BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices)	National	RBCH	To be registered (001-2425)
Surgery	Urology	BAUS Data & Audit Programme: Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	National	RBCH	TBC
Surgery	Surgery	British Hernia Society Registry	National	UHD	TBC
Trauma and Orthopaedics					
Trauma and Orthopaedics	Trauma	Falls and Fragility Fractures Audit Programme – National Hip Fracture Database	National	Poole	In Progress
Trauma and Orthopaedics	Trauma	National Joint Registry	National	UHD	In Progress
Women's Health					

Women's Health	Maternity	Maternal and Newborn Infant Clinical Outcome Review Programme	National	UHD	In Progress
Women's Health	Maternity	National Adult Diabetes Audit: National Pregnancy in Diabetes Audit	National	UHD	In Progress
Women's Health	Maternity	National Adult Diabetes Audit: Gestational Diabetes Audit	National	UHD	TBC
Women's Health	Maternity	National Maternity and Perinatal Audit	National	UHD	In Progress
Women's Health	Maternity	Perinatal Mortality Review Tool	National	UHD	In Progress
Women's Health	Maternity	Antenatal Fetal Monitoring CTG Audit			
Women's Health	Maternity	Intrapartum Fetal Monitoring CTG Audit			
Women's Health	Maternity	Intermittent Auscitation Fetal Monitoring Audit			
Women's Health	Maternity	MEOWS Audit			
Women's Health	Maternity	SBAR Audit			
Women's Health	Maternity	Situations Consultant Must Attend			
Women's Health	Maternity	Translation Services: Use within Maternity for non-English speaking patients			
Unknown					

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 03 July 2024

Agenda item: 8.7

Subject:	Key Issues and Assurance Report to Board of the Transforming Care Together Group meeting held on 24 June 2024
Prepared by:	Rob Whiteman, Chair of the Transforming Care Together Group
Presented by:	Rob Whiteman, Chair of the Transforming Care Together Group

Key Issues/matters discussed by the Group:	The Group received the following:
	• Build Ready Update
	• Service Ready Update
	• People Ready Update
	• Deep Dive session:
	  ○ Workforce Planning
	  ○ Staff "welfare" factors

Significant issues for escalation to Board for action:	<u>Matters for Board awareness:</u>
	• Build Ready:
	  ○ Build Ready was proceeding well. We have the next tranche of resources confirmed through the New Hospitals Programme; and the Finance and Performance Committee would receive proposals on its governance. Some reprofiling was needed against original plans which would be taken forward by the Chief Finance Officer, Chief Strategy and Transformation Officer and Transformation Director.
	  ○ The Group asked for some development work on when and how common areas, staff rooms, team rooms and study facilities would be provided, particularly at Royal Bournemouth hospital where space is limited.
	  ○ An element of cost escalation was being seen in relation to endoscopy, partly attributable to delays.
	  ○ Two projects had been shortlisted for external awards: Pathology Hub and Poole Theatres.

	• Service Ready:
	  ○ Service Ready was now very much the focus of attention. Gateway reviews were taking place to determine service re-design and move readiness, which included aligning staff requests to budget and agreed benefits realisation.
	  ○ Stakeholder engagement, including related to how services may be affected during the transition, were discussed, with the Group asking that the Executive Team to consider how communication and engagement capabilities were optimised during this time.
	  ○ Safety continues to be managed through business as usual.
	• Workforce Ready:
	  ○ Workforce Ready was in development stage. Data was being assembled to understand the implications of the many moves to take place to guide workforce planning.
	  ○ Toolkits were under development for managers to handle the range of issues, linked to streamlining policies and procedures between sites. The offer to staff was under development to assist with issues such as childcare and transport.
	  ○ The Group discussed the importance of developing the provider collaborative to utilise staff resources.
	  ○ The Group was assured that the intended themes of this workstream appear complete.

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: 03 July 2024

Agenda item: 8.8

Subject:	Key Issues and Assurance Report to Board of the Charitable Funds Committee meeting held on 08 May 2024
Prepared by:	Claire Whitaker, Chair of the Charitable Funds Committee
Presented by:	Claire Whitaker, Chair of the Charitable Funds Committee

Key Issues/matters discussed by the Committee:	The Committee received the following: • Investment Update • Fundraising Report – Q4 • NHS Charities Together Fund Allocation Update • Transformation Programme -Role of the Charity • Cancer Care spend plan • Seasonal Staff benefits update • Risk Register • Charity Annual Report Narrative • Charitable Funds Committee Annual Report. In addition, 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:	<u>Matters for Board awareness:</u> • Investment Update – The Committee noted the positive performance by value to the end of Q1 2024. • Fundraising Report Q4 – An update was provided in relation to the progress against strategy and forecast for the year. The BEACH appeal had been launched. • NHS Charities Together Fund Allocation Update – an update was provided to the Committee on the plan for use of the remaining funds and remaining activity. A Thrive Live Wellbeing Fair had been held in March 2024, which was reported to be a notable success from staff comments. • Cancer Care spend plan – A presentation on recent use of cancer care funds was provided to the Committee, with plans to focus on the environment for cancer care services at Poole hospital.

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: 03 July 2024

Agenda item: 8.9

Subject:	Risk Register Report
Prepared by:	Natasha Sage, Head of Patient Safety and Risk Jo Sims, Associate Director for Quality Governance and Risk
Presented by:	Sarah Herbert, Chief Nursing Officer 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:	All
Purpose of paper:	Review and Discussion
Executive Summary:	

Current risks rated at 12 and above on the risk register	**32**
Potential new risks for Approval	**12**
12+ Risks that have changed score	**0**
Reduced, closed or suspended risk(s) no longer 12+ to note	**0**
Risks scoring 20+	**2**

To note – Risking Scoring 20+

Risk no:	Title	Risk Owner	Objective/ Lead
1460	Ability to meet UEC National Standards and related impact on patient safety, statutory compliance and reputation.	Rathbone, Leanna	Population and System-COO

Current controls listed:
Daily breach analysis
Patient pathways and streaming process to SDEC's and UTC
Patient assessment form (SHINE)
ED Trigger tool/ Delayed Care pathway
TAD Process evoked
ED Escalation plans/SOPs
ED Primacy
IPS optimisation
Diagnostic delays standards (blood tests/x-ray and CT)

‘Surge Management’ criteria and plan
External transfers procedures (SWAST/EZEC/Other) compliant with patient category
UHD ambulance divert policy.
4-hour performance metrics linked to ED escalation
SWAST Corridor SOP

Gaps in controls;
Gaps in assurance for sustainable delivery of 4-hour standard.
SDEC pathways not in place 12 hours a day 7 days a week across all services.
Revised Escalation processes (ED and wider organisation) not yet embedded.
Gaps in recruitment remain a key challenge.
Capacity across the organisation to respond to the issues and take necessary action, including change management capacity, noting deployment of new ED IT System in June 2023 requiring priority.
UEC growth, MRTL numbers and industrial action could expose the Trust to reduced patient flow and performance
Type 3 data from MIU and UTC remains a manual process needs to be automated for new standards
ED Action plan to be reviewed and recast to reduce to a smaller number actions over 30/60/90 days.
Clinical Engagement on supporting the Trust 4hour safety standard and further work on ensuring the Interprofessional standards are being followed.
Agyle IT ED System: Review of the operational configuration to ensure it supports the operational flow.

Open Actions
4-hour standard 60-day plan – due date 31/8/2023
ED 4-hour standard implementation plan – due date 31/3/2024

Last update:
- Maintenance in improved position for April. Performance in April anticipated to be in line with Trajectory.
-Trajectory for improvement with associated amendments to action plan on a page outlined.
- Improvement in the ACA performance in month, with a reduction in the overall patients, showing benefit of ED streaming pathway.
- Further requirement for to improve the streaming pathways available to ED. Outlined in action plan.
- Focus to identify root cause of OOH performance (>50% of 4hr breaches occurring prior to 8am/carry over from previous day).
- Work in month against the medical staffing consultation to ensure stable senior medical workforce cover.

1950	Graphnet Electronic Patient Record (EPR) is not fit for purpose	Sarah Hill	Sustainable Services- CFO

Current controls listed:
Most of the trust IT systems that make up the EPR ecosystem have the following controls in place:
Underpinning legal contracts with software suppliers
Immutable backups (i.e. cannot be affected by malware)
Staff training programmes
Active Information Asset Owners who undertake appropriate audits in line with the Data Security and Protection Toolkit
UHD wide Business Continuity Plan
Dedicated Subject Matter Experts in the clinical applications who maintain them in their optimal state
Teams of people working to ensure that the underlying IT Infrastructure is maintained in an optimal state

Gaps in controls;
Substantial gaps in the functionality of our EPR ecosystem relating to the management of the workflow of diagnostic results and reports and assured clinical transactions generally (e.g. therapy input and interprofessional referrals).
No effective single user interface for clinicians to manage their core care processes.
Local departmental Business Continuity Plans are not yet in place

Open Actions

EPR internal mitigation	Establish a programme of work to mitigate the risk of the loss or unavailability of clinical information and record functionality when the G-EPR becomes out of effective support.

Risk sponsorship for risks associated with each Patient First objective has been aligned as per below:

Population and System	COO CSTO	Finance and Performance Committee
Our People	CPO	People and Culture Committee
Quality (Safety and outcome)	CMO/CNO	Quality Committee
Sustainable Services	CFO	Finance and Performance Committee
Patient Experience	CNO/CMO	Quality Committee

Background:

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

The report provides details of the risks rated 12+ on the UHD NHS Foundation Trust risk register.

Key Recommendations:

To approve new risks 12-25 presented in the report.

Implications associated with this item:

Council of Governors	☐
Equality, Equity, Diversity & Inclusion	☐
Financial	☐
Health Inequalities	☐
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	21/05/2024 18/06/2024	New risks presented
Quality Committee	28/05/2024 25/06/2024	New risks discussed and recommended for Board approval

University Hospitals Dorset
NHS Foundation Trust

Risk Register Report

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

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

For the period to end May 2024 (as on 03/06/2024)

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	32
Potential new risks for Approval	5
12+ Risks that have changed score	0
Reduced, closed or suspended risk(s) no longer 12+ to note	0

DEFINITIONS
Movement in month - Key:

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

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

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

Risk Rating Status

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

Risk Matrix and Risk Scores
See Appendix B and C

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

Risk Register Report

1. **There are 12 new risks rated as 12 and above to be reviewed and approved by the Board of Directors.**

<u>Population and System</u>:

Risk Ref	**2052**
Risk Rating	20
Risk Title	Care of patients in non-clinical areas in the Emergency Department
Risk Description	A lack of capacity in the hospital and a requirement to release ambulance crews in a timely manner has led to an increase in the use of non-clinical areas, particularly corridors for patients awaiting a trolley/chair space in both Emergency Departments. This creates a risk of harm to patients, a compromise to privacy and dignity and an increased risk of obstruction of thoroughfares and escape routes.
Risk Background	The expectation is that ambulance crews will handover their patients and be released within 15 minutes of arrival. Whilst both departments have sufficient capacity for this under normal operating conditions, crowding in the department, caused either by poor flow out or internal issues, leads to a lack of major's spaces for patients. Non-clinical areas are any areas that have not been designed, equipped or staffed for the care of patients, e.g. corridors, bereavement rooms, seminar rooms or waiting areas. Rather than patients being held on ambulance vehicles, which creates a broader system risk due to the non-availability of ambulance resource, it is often judged as preferential to care for patients in non-clinical areas whilst awaiting capacity. This non-clinical space is staffed by UHD staff from either the Trust bank or agency. If no UHD staff are available, the space is made available to SWAST to cohort their patients in this area. The specific areas and staffing levels are listed in the ED SOP. Non-clinical areas that are not designed for patient care and may therefore lack specific facilities such as oxygen or suction equipment. Non-clinical areas may also present a risk to patient privacy and dignity as the corridors are thoroughfares and are visible to other patients and staff not involved in their care. Conversely, some corridor areas, particularly those in Bournemouth are also affected by poor clinical visibility.
Exec Sponsor	Mark Mould (COO)
Controls in place	SOP on corridor use. Ambulance handover SOP Divert procedures including dynamic conveyancing. Escalation process
Gaps in controls	Staffing levels not always met. Additionally, where the corridor is under the care of SWAST, there is the risk of a lack of clinical oversight from UHD.
Action plan(s)	• Bournemouth corridor needs to be assessed for the possibility of private spaces for patient care and assessment when it is used for patient care • To decompress the ED to prevent crowding. Specific actions to aid this are: Improved use of alternate pathways such as SDEC; Improved streaming; Earlier senior reviews and medical plans; Improved time to referral; Improved flow out of the department for referred patients

Risk Register Report

Risk Ref	**2072**
Risk Rating	12
Risk Title	Inability to meet weighted value elective activity plan leading to adverse impact on patient access and financial income
Risk Description	If the Trust does not deliver its weighted value elective activity plan (109% of 2019/20 baseline) there will be a loss of elective recovery funding to the Trust and the length of waits for patients and/or volume of patients waiting to be seen will increase providing a poor patient and staff experience and increasing the potential for harm.
Risk Background	The Trust's 2024/25 Operational plan established a plan to deliver 109% elective recovery of activity against the baseline year 2019/20. This contributes to the Dorset ICS operational plan. Elective Recovery Funding will be awarded to Dorset ICS on achievement of 104% weighted value elective activity and the System has assumed additional benefit to its financial operational plan by achieving above 104%. An activity tool has been developed to monitor delivery against this. The activity delivered in April 2024 fell short of the planned activity levels. Care Groups have been asked to develop detailed activity plans to mitigate against the underactivity in April and to provide a forward plan against the Trust trajectory. A review of the plans developed to date in May 2024 has identified a risk to delivery of the operational plan activity levels.
Exec Sponsor	Mark Mould (COO)
Controls	The Trust's Strategic breakthrough objectives have been updated to include the delivery of 109% elective activity as a key area of focus in 2024/25. An activity planning tool has been provided to Care Groups to map their delivery plan against the target and understand any gaps at point of delivery level (First OPA, Day case, Elective Inpatient) An activity tracking tool in also in place to provide a weekly update of activity delivered against the target at Care Group and Directorate level so that remedial actions can be put in place where specialties are off plan. Full award of elective recovery funding has been assumed to allow the Care Groups to seek funding to enable delivery of their activity plans and there is a process in place to track activity and spend against this fund. As part of the Patient First Improvement programme in the Trust, the breakthrough objective is a driver metric for all Care Groups and will be monitored at Care Group and Trust level Strategy Deployment Reviews on a monthly basis. Counter Measure Summary reports will be required where plans are off track to detail recovery actions. The Operational Delivery Group forum will be used in Q1 to support Care Groups to further develop their delivery plans. Planned Care Improvement programme in place Productivity and GIRFT opportunities have been modelled
Gaps in controls	Current Care Group activity plans do not provide full assurance against the operational plan.
Action plan(s)	• Develop Care Group/speciality level activity plans which describe the additional activity (by POD: Ordinary Electives, First OP and Daycase), productivity improvements and/or counting/coding improvements that deliver an overall increase of 109% elective activity compared to 2019/20. • Demonstrate delivery of activity plans in line with the Trust's operational plan trajectory (109% in 2024/25)

Risk Register Report

Risk Ref	**1855**			
Risk Rating	15			
Risk Title	Lack of Breast Radiologists			
Risk Description	If we do not increase the number of breast radiologists we will be unable to sustain the demands of the service.			
Risk Background	Since 2010 the symptomatic workload (non-breast screening) has increased with no additional Radiologists in the team. As well as an increase in sessions the examinations are now more complex and interventional requiring more time. This increase has been absorbed without extra investment by staff being flexible and regularly doing extra hours to cover. The staff are very tired with the focus having been on breast screening recovery, with staff sickness related to stress. A balance of utilising staff as best as possible means they are stretched thinly. Allocation of staff is micromanaged to ensure a fair distribution between screening and symptomatic services. The service provides one-stop breast clinics for fast-track patients and must also adapt to the needs of the surgical service and support the cancer targets with additional one-stop clinics. In 2019 the QA visit recommended an extra 3 WTE Radiologists. The business case was not supported. The team is currently fully established with a recent retirement being replaced by a returning locum. A further retirement is due in May 2023 and the team remain with fewer than the recommended number of Radiologists and an increase in workload and complexity.			
Exec Sponsor	Peter Wilson (CMO) • It is recommended that this is changed to the COO to ensure links to the relevant strategic objective and Board sub committee for monitoring purposes			
Controls	Cancer targets Recruitment/retention plans Waiting list (backlog) processes			
Gaps in controls	Staff sickness levels			
Action plan(s)	Dorset Breast Screening Service	Increase Radiology capacity DBSU	1. Extend current Locum contract (for 1 year mat leave cover) and seek further locum support (extended on a 3 month rolling basis) whilst awaiting recruitment of substantive breast consultant. 2. Continue to displace Film reading for extra sessions (currently 2 per week) and in addition displace SPA to fill clinical gaps during periods of annual leave. 3. Support new business case to recruit 2 new Consultant Radiologists and 1 Consultant Mammographer. 4. Evening/ weekend clinics using own staff. Due to the urgent nature of the situation, we would recommend option 1 to cover off the immediate problem. This is whilst going out for a substantive Breast Consultant (hence additional locum on a 3-month rolling basis). In the meantime, whilst awaiting an additional Locum then we will use a combination of option 2 and option 4. Whilst the safest and most efficient option is using our own staff, we have such a small team and therefore there is a significant risk of burn out and we must support the wellbeing of our staff. For the long term stability of the Breast Service (Screening and Symptomatic), we need to ensure the Business Case for additional Breast Radiologists and Consultant Mammographers is approved and the resultant substantive roles appointed to.	Meeting KPIs and FDS targets. Clinics no longer being cancelled. All clinics fully staffed. Remove the need for reporting displacement
	Dorset Breast Screening Service	Reduce Symptomatic Patient Backlog (Jigsaw/LBU)	1. Evening/ weekend clinics using own staff 2. Outsourcing via 18 weeks or similar.	Meeting KPIs Clinics no longer being cancelled. All clinics fully staffed. Remove the need for reporting displacement. Fast-track breast patients to be seen within clinics, not rebooked for another day.

Risk Register Report

Risk Ref	**1835**
Risk Rating	12
Risk Title	Cancelled elective procedures due to escalation in CIU
Risk Description	Frequent escalation into elective day case ward (CIU) is resulting in the cancellation of elective procedures, increased elective and inpatient waiting times, poor patient experience of those bedded in a recovery area, poor staff experience, increased complaints and cost pressure from use of unfunded bed space.
Risk Background	These cases are a mix of P2-P4 clinical priority and the cancellations are affecting RTT performance - some of these patients are already long waiters. The patients escalated into CIU are often not appropriate for that area as the area is not clearly visible from the nurses station and has minimal patient facilities such as no patient lockers, no patient TVs and limited access to bathroom/shower facilities. The patients often have high care needs and are high falls risks so really should be in a ward where they can be better cared for. The patient experience is not ideal in this area and we have received patient complaints in relation to the environment. CIU, being a day case unit is also not staffed during the evenings or weekends therefore staffing is often pulled from the adjacent ward (Ward 23) which leaves them managing more patients per staff member than ideal, or requires bank/agency cover which is having a financial impact on the Directorate.
Exec Sponsor	Mark Mould (COO)
Controls	Clinical validation and triage of elective waiting lists Prioritisation of inpatients Monitoring of patient complaints and feedback Monitoring of DATIX incidents Management of RTT performance Recording and escalation of number of cancellations and last minute elective cancellations Monitoring of LOS and transfer times for patients outside of RBH, particularly PH PP capacity and impact on income Recovering patients out of CIU where possible (on the wards, in CCU or in the labs itself) Support from the CG to manage patient flow
Gaps in controls	Despite the above actions a high number of patients are being cancelled which is resulting in them breaching their clinical waiting times and becoming more unwell before their procedures including needing to be admitted on an emergency pathway.
Action plan(s)	

David North	Cardiology	Review escalation space environment	For patients recovering post cardiac procedure the environment in CIU is fit for purpose however that is not the case for inpatient outliers due to the lack of bathroom and shower facilities, the size being designed to accommodate trollies not beds, lack of TVs/bedside lockers and proximity to the Cath Labs. This is not how the space should be used but tiven the ongoing use as inpatient escalation, are there adjustments required? Review and further discussion needed.	Review, agreed/not agree.
Rohana Lustig	Cardiology	Trust de-escalation plan of unfunded capacity	There are actions agreed by the MCG to support the Trust plan to de-escalate unfunded capacity in the organisation as a priority in Q4 23-4 going into Q1 24-25. Whilst there is an order of priority that must be actioned in line with patient safety, this should result in improved patient flow and step-down of inpatient escalation into the CIU recovery area.	No elective cancellations Increase inpatient procedures CIU not routinely used for outlying inpatients
Samantha Sweeney	Cardiology	Clinical review of elective cancellations	All patients who are under review for cancellation need a clinical review to identify those who are highest risk and need to be prioritised for admission.	Cancellation lists and P codes escalated through the CG to be reported externally.

Risk Register Report

Risk Ref	**2015**			
Risk Rating	15			
Risk Title	Paediatric MRI under GA Capacity			
Risk Description	Shortfall in number of MRI slots under GA leading to delays in both emergency and routine scan requests.			
Risk Background	Currently we have 3 slots per week on one set day (Weds). Current wait time for routine MRIs under GA is 10-14 weeks (NICE guidance - 6 weeks). Failure to complete urgent scans within 72 hours on current schedule. L71728 & L119396 demonstrate issues related to access to appropriate & timely MRI GA capacity. Action from most recent SI scoping panel was to formally log this as a Trust risk.			
Exec Sponsor	Peter Wilson • It is recommended that this is changed to the COO to ensure links to the relevant strategic objective and Board sub committee for monitoring purposes			
Controls	Clinical review of waiting list, urgent requests taking priority over routine requests. Temporary increase in capacity by additional MRI lists Access to CEPOD list for emergency MRIs.			
Gaps in controls	Waiting list continues to remain significantly above NICE guidance and national standards. LERNS due to gaps in processes			
Action plan(s)	MRI (Poole)	Business case for additional MRI GA list	Business case for submission to Care Group - will link to risk assessment and plan to reduce incidents related to delays getting MRI GA slots for both urgent and routine capacity.	Approval of business case supporting the uplift in both theatre and anaesthetic staffing to allow additional planned MRI GA list per week.
	MRI (Poole)	Review of theatre staffing to arrange ad-hoc sessions	Continual review of theatre lists and consideration of allocating staff to additional MRI GA lists as and when availability allows.	Arranging additional MRI lists
	MRI (Poole)	Clinical review of MRI GA waiting list	If urgent MRI required and no capacity then clinical review of booked patients in order to safely re-arrange list to accommodate more urgent case	Urgent MRI successfully accommodated

Risk Register Report

Quality (Safety and outcome):

Risk Ref	**1974**
Risk Rating	16
Risk Title	Significant time delays for macular injection treatment
Risk Description	If patients do not receive their macular injection within 2 weeks (NICE guidance), then they may have a deterioration in their vision. The reasons patients are not receiving their appointments in the recommended timeframe include; increased demand, lack of staffing (nursing and medical), lack of suitable environment space.
Risk Background	The process for all new referrals from the ICB has been changed, so that appropriate patients can be treated in a timely way. The process involves completion of a criteria-based proforma. If the appropriate criteria haven't been met, the team are triaging via an OCT investigation. An email account has been set up for the consultants to review referrals from Opticians, to ensure that only appropriate patients are seen by the macular team. First appointments are being triaged out to the Health Village where they are seen by an Ophthalmic Technician for imaging and other diagnostic tests, not a clinician. Patients then await virtual review from a clinician. Extra clinics have been put on throughout the year. The 3rd Macular Nurse Practitioner has completed their practical training and competency sign off and is now able to carry out injection lists independently. The number of appointments will increase over the coming months. Theatre 3, in Eye Outpatients, will be fully utilised for Macular injection lists as required. Delayed appointments for macular injections are having an impact on patient's treatment plans. There is an average delay of 4 weeks for macular injection appointments. The Macular clinics are all fully booked for the next 5 weeks. Currently, the backlog stands at 289 patients, who require an appointment in October, and don't have their next appointment booked in. 361 patients, who require an injection slot appointment in October, don't have their next appointment booked in. Every year there is growth of approximately 25% new patients that require macular intervention. Once on treatment, some patients may need interventions for up to 15 years plus, and the rate of patients who can be discharged from the service means that the pressure on the service increases year on year. Due to the workload, some staff are working 6 days a week. This is a cost pressure, as the service only has the budget to run clinics 5 days a week.
Leads	Peter Wilson (CMO)
Controls	Theatre 3, in Eye Outpatients, to undertake Macular injection lists as required. Appointed a fourth Macular Nurse Practitioner Additional lists added, when staffing allows. Ophthalmology ED for emergency cases email account set up for the consultants to review referrals from Opticians, to ensure that only appropriate patients are seen by the macular team. First appointments are being triaged out to the Health Village where they are seen by an Ophthalmic Technician for imaging and other diagnostic tests, not a clinician. Patients then await virtual review from a clinician. 2 x macular coordinators reviewing patient wait times and prioritising. Direct line to macular coordinators who can escalate to Clinicians. Spreadsheet available for range of clinicians to review for oversight. Regular Macular meeting to focus on long waiters and agree actions required (monthly and weekly meetings)

	Creating a 'core team' within outpatients to work in macular. training needs identified and started to roll out. This will also support retention. contacted reps to identify if they can support training and funding
Gaps in controls	Additional sites to be identified to undertake additional lists/ full lists that has a 'clean' space, accessible (for staff and patients) and large enough waiting area. Budget to be identified to enable estates work to be completed and training to be given The 4th Macular Nurse Practitioner will require a full training program. Recruitment for replacement consultant needs to be undertaken (finance agreed)
Action plan(s)	• Recruit 1 x WTE ophthalmology consultant with specialty in Macular • Consider ways to create more capacity/ space for macular service. • Look at Somerset nurse-led system Identify appropriate training courses (and funding) Core team to be created within outpatient's review job description for lead macular nurse define clear expectations including roles and responsibilities within the macular team MDT • Daily review of the waiting lists for macular appointments, undertaken by the Macular coordinators. • To put in the Business Case for HC support workers, secure funding, advertise and recruit Establishment review to be considered

Risk Ref	**1925**
Risk Rating	12
Risk Title	Emergency gynaecology Consultant cover
Risk Description	If we do not have a consultant-delivered emergency gynaecology service during core weekday hours covering Early Pregnancy Assessment Unit, Emergency Gynaecology Clinic, direct emergency referrals from GPs, patients referred from ED and patients referred from other medical specialties junior doctors will continue to cover the rota leading to delays in treatment and disruption to the elective workload affecting patient care and causing patient harm.
Risk Background	Since the decision to reconfigure hospital services across Dorset was made, the gynaecology department has considered new options for the provision of consultant cover of emergency gynaecology with all Women's Health Services on a single hospital site, serving the whole county. In addition, other factors such as more stringent guidelines for the management of acute gynaecological conditions, reduced surgical experience of juniors and changes to the way other linked specialties such as urology and general surgery provide emergency cover – dictate that we plan for a consultant-delivered emergency gynaecology service on the Bournemouth site from Q1 2025. The agreed model for providing cover across the week is for all of the gynaecology consultants to rotate through an emergency gynaecology 'Hot Week' 1 in 16 with prospective cover. This will consist of 5 consecutive days, commencing 08.00 with a handover from the previous nights on call consultant and finishing at 18.15 having handed over to the following nights on call consultant.
Exec Sponsor	Peter Wilson (CMO)
Controls	Safe staffing standards Proactive rota management to identify and management gaps. Transformation plans, RCOG standards, Prompt HR recruitment processes
Gaps in controls	Currently 2.0 wte gynaecologist's gap. 1 locum joining in April.
Action plan(s)	Recruitment of X3 WTE consultant Gynaecologists, Adverts for 2 WTE currently out on TRAC.

Risk Register Report

Risk Ref	**2013**
Risk Rating	12
Risk Title	UHD Medicines management storage
Risk Description	Current storage facilities across UHD for medications is below required standards, Risk to Patients due to inappropriate storage of Medications. Reputational risk to organisation that could include improvement notifications and increased external audits. Potential Financial loss
Risk Background	Medicines are used in all healthcare settings and the safe and secure handling of medicines is essential to ensure patient safety. The Royal Pharmaceutical Society professional guidance on the safe and secure handling of medicines 2018 requires all NHS Trusts to establish, document and maintain an effective system to ensure that medicines are handled in a safe and secure manner. The medicines cabinets on both sites are not up to standard. The design of some medicine's storage rooms around clinical areas at Bournemouth site do not meet regulations. they do not have doors, the storage cabinets are see-through, with non-secure locks. Poole site has doors with glass windows and keypad style lock that are both not compliant with safe storage of medicine. Medicines need to be stored in a lockable and locked metal cupboard that complies with the following minimum standards: British Standard 2881 (1989) cupboards for the storage of medicines in health care premises Sold Secure 314 silver level – Specification for security cabinets (higher security standard), such as CD cupboards. British Standard 3621 (2007) for thief resistant locks – patients' own medicine lockers are excluded. Standard keypads where a number is shared with multiple users are not secure and therefore unsuitable for accessing medicine cupboards or medicine storage rooms. The appointed nurse/midwife/ODP in charge of a clinical area has responsibility for controlling access (by keys or other means) to medicines cupboards (including the CD cabinet). Requirement to store medications at specific temperatures in line with manufactures guidelines.
Exec Sponsor	Peter Wilson (CMO)
Controls	1. Policies in place 2. Clinical audit plan in place 3. Medicine safety group convenes on a monthly Basis with escalation to CGG and MGG 4. Monthly fridge temperature audits in place 5. Cold chain annual record booklets in in all clinical areas. 6. Ambient room temperature guidelines implemented. 7. Weekly drug trolley checks for expired medications and loose blister packs have been implemented across the trust. 8. Monthly documented changes of keypad codes requested across all clinical areas. 9. CD audits 6 monthly
Gaps in controls	Alignment of Policies Layout of some wards prevents compliance with best practice standards Documented risk assessments

Risk Register Report

Action plan(s)	Pharmacy	BEAT eLearning package	Review of existing Medicine Management eLearning module - out of date. Needs updating, new controlled drug learning module and new cold chain module.	Completion of eLearning packages on BEAT UHD relevant Staff evidence of completion Monitoring of incidents related to medicines management.
	Pharmacy	Staff training implementation	All staff involved with handling medication products must be assigned medicines management training on BEAT. UHD education team to assign to relevant roles.	BEAT report.
	General Areas speciality level	Completion of trust wide medicines storage audits	To ensure outstanding clinical area's across UHD have medicines storage audits completed.	Documented Evidence of current medicines storage facilities and practices for all clinical area's within UHD.

Sustainable services:

Risk Ref	**1556**
Risk Rating	12
Risk Title	Risk of Aseptic Pharmacy CliniCHEMO Software crashing
Risk Description	If the Aseptic Pharmacy CliniCHEMO Software crashes, worksheets to prepare chemotherapy would have to be prepared manually as Word documents. This would be very time consuming and runs the risk of errors being made as CliniCHEMO has standard treatment templates. So there would be a potential risk to patient safety relating to the safe management of chemotherapy. Also there would be no electronic record of the worksheets kept, other than scanned copies, requiring time consuming searching when queries arise. This would impact on patient safety and could impact on funding.
Risk Background	Currently IT support is ongoing, but it is a temporary fix that could fail at any time. Contingency system of manually prepared handwritten worksheets as word documents is available. CliniCHEMO is a Dorset-wide system, so any solution needs to fit all 3 acute Trusts. CliniCHEMO is vital for the workflow of the APU. It records previous doses and dose changes for patient's treatment and is pre-programmed with regimens of treatments that are agreed with and funded by NHS England and the CCG. The MHRA are concerned that CliniCHEMO is not GAMP5 (Good automated manufacturing practice) compliant. Alternative software systems are being implemented. o JAC CIVAS at RBH o BD Cato at PH
Exec Sponsor	Pete Papworth (CFO)
Controls	One computer is allocated only to being used only for the software; no updates are allowed to avoid crushing.
Gaps in controls	Lack of reliable software Lack of resources/staff to work on new software (BD Cato) due to delayed merger of aseptic unit
Action plan(s)	• Replace CliniCHEMO with BD Cato at Poole Aseptic unit Pharmacy Team allocated to support the work including IT support. Will start with a single product to support training and education of the team then rolled out to the full product list. • All aseptic pharmacy staff to be fully trained on using new software BD Cato. Validation record to be put in place for each member of staff.

Risk Register Report

Risk Ref	**1994**
Risk Rating	12
Risk Title	Brachytherapy LDR and HDR US equipment
Risk Description	The risk is the loss of the brachytherapy service due clinical equipment being end of life and patients breaching their CWT. The brachytherapy equipment that is end of life, LDR Ultrasound, HDR Ultrasound and transabdominal transducer.
Risk Background	The Ultrasound (US) unit used for Low Dose Rate (LDR) prostate brachytherapy was obtained in March 2014. This equipment is leased through the supplier BD and the lease arrangement is finishing. A new supplier or equipment is yet to be confirmed. This leaves the service vulnerable. For HDR prostate brachytherapy there is a separate US unit. This is on the Radiotherapy Physics asset register and overdue for replacement in 2022. A replacement needs to be found and a business case submitted. The High Dose Rate cervical brachytherapy service uses image guided US to help the consultant to guide the applicator into the cervix to avoid perforation. A transabdominal US transducer was purchased 10 years ago and is no longer providing optimal functionality and requires placement. This is currently on the asset register and states was due for replacement in 2022. Both US units are independent of each other and calibrated to specialist brachytherapy planning systems and 'stepper' equipment so if either fails this would be detrimental to either of the services and cannot be used across the different HDR or LDR services. The gyn transducer is currently only calibrated to be used only on the LDR US. If the equipment fails, there is an immediate loss of service and associated costs due to waste of radioactive sources.
Exec Sponsor	Richard Renaut (CSTO)
Controls	LDR tender process is being undertaken HDR Cervix if the transducer failed, we would need to seek assistance from a Sonographer
Gaps in controls	Currently there are no plans for replacement for HDR US Charitable funding has been agreed to support the replacement of the transducer. This cannot be purchased until a decision has been made on what LDR and HDR equipment is being purchased
Action plan(s)	

David Frost	Radiotherapy	Replacement of equipment	Replace equipment	Procurement process started and going out to tender. Once tender complete and reviewed will continue with business plan/cost pressure report

Risk Register Report

Risk Ref	**1997**
Risk Rating	12
Risk Title	Loss of Radiotherapy service and non-compliance with CWT due to machine breakdown
Risk Description	This risk is the complete loss of the radiotherapy service due to LINAC breakdown and multiple breaches of CWT and the adverse outcome to patient's prognosis. The service contract with LINAC manufacturers does not include spare parts. The department has limited inventory of spare parts. There is the risk that all LINACS could breakdown and there would be a delay in return to clinical service as the department does not hold a comprehensive service contract or the trust does not have the budget to purchase the required parts.
Risk Background	In August 2023 a linear accelerator (linac) broke down and didn't return to full clinical use for a 2-week period. The impact of this was a 30 hour loss of linac capacity and 15% reduction in new courses started. This loss of capacity took 8 weeks to recover from. The delay was caused by the delay of approving spare parts from the LINAC manufacturer. This risk remains.
Exec Sponsor	Richard Renaut (CSTO)
Controls	The department has a limited budget for spare parts. The Radiotherapy Physics' department has 5 engineers to support the planned service and maintenance for the machines.
Gaps in controls	Lack of service contract to cover spare parts to cover breakdowns. Engineers require additional training to improve their skill levels now that the service contract does not include manufacturer onsite technical support.
Action plan(s)	David Frost / Radiotherapy / Lack of suitable manufacturer service contract will lead to loss of service when unplanned downtime occurs / SBARN submitted to Care group management in November 2023 to highlight risk to service, and guidance sought on how to proceed before submitting business case / Guidance from care group board management with support for business case.

Risk Ref	**1992**
Risk Rating	12
Risk Title	Mosaiq software for radiotherapy radiation delivery
Risk Description	The use of Mosaiq in radiotherapy at UHD poses a risk of harm to patients due to several factors. Transfer of imaging data between Mosaiq and the treatment units (linacs) is sometimes incomplete, resulting in additional images being required during radiotherapy delivery. This is a direct result of the use of Mosaiq. This has occurred for multiple patients; the CQC has been notified as part of our obligations under the Ionising Radiation (Medical Exposure) Regulations. The performance of Mosaiq can prevent radiation oncologists from reviewing patients' on-treatment images in a timely manner. This could cause harm to a patient if there is a delay to a clinical decision due to this. The use of Mosaiq for radiotherapy poses a data transfer hazard. Radiotherapy treatment data and images are imported from different systems and there are opportunities for unintentionally changing treatment parameters upon import or for data to be lost. Processes have been put in place to minimise the risk, but it carries a serious risk of harm for a patient, as well as likely action from a regulatory body.

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	Considering the other systems used within radiotherapy, the use of Mosaiq puts UHD as a national outlier. There is a risk of future incompatibility between Mosaiq and our other equipment, resulting in the service being unable to use important features. This could impact the efficiency and reputation of the service.
Risk Background	Mosaiq is an oncology information system used across UHD by radiotherapy, oncology and pharmacy. There is growing concern amongst all stakeholders that Mosaiq is no longer fit for purpose in its current state. Within radiotherapy, the use of Mosaiq has been attributed to several safety incidents, requiring additional processes to ensure safe care. Mosaiq was not designed for use with our other equipment and results in inefficient workflows, as well as making us an outlier both nationally and internationally due to the mix of equipment here. A number of highly regarded Trusts in the field of radiotherapy have recently made the decision to switch from Mosaiq to integrated solutions due to these concerns.
Exec Sponsor	Pete Papworth (CFO)
Controls	Extensive procedures and work instructions have been implemented as part of the radiotherapy Quality Management System. Additional systems have been purchased to mitigate the likelihood of data transfer errors.
Gaps in controls	Mosaiq was not designed for use with the other equipment used in radiotherapy. The transfer of images from Mosaiq to the linacs is a recurring theme and has resulted in additional images being required for multiple patients. The CQC has been notified according to our obligations under the Ionising Radiation (Medical Exposures) Regulations. Incorrect treatment recording, whereby the definitive record of a patient's treatment is incorrectly recorded by Mosaiq, is another recurring theme. Incorrect recording of treatment could result in a patient receiving the incorrect radiation dose, which could be reportable to the CQC under the Ionising Radiation (Medical Exposures) Regulations.
Action plan(s)	Radiotherapy | Investigate alternative to Mosaiq | Identify other potential suppliers of the record and verify (R&V) system required for radiotherapy treatment. Determine whether switching manufacturers is a reasonable and viable option. | Decision on whether changing manufacturer is the best option for UHD.

Risk Register Report

1. Risk updates.

Risk Number	Title	Rating (current)	Last review date	Review for Board	Handler	Executive lead
Population and System						
1460	Ability to meet UEC 4-hour safety standard and related impact on patient safety, statutory compliance and reputation.	20		Maintenance in improved position for April. Performance in April anticipated to be in line with Trajectory. -Trajectory for improvement with associated amendments to action plan on a page outlined. - Improvement in the ACA performance in month, with a reduction in the overall patients, showing benefit of ED streaming pathway. - Further requirement for to improve the streaming pathways available to ED. Outlined in action plan. - Focus to identify root cause of OOH performance (>50% of 4hr breaches occurring prior to 8am/carry over from previous day). - Work in month against the medical staffing consultation to ensure stable senior medical workforce cover.	Bradley, Richard	Chief Operating Officer
1784	Risk of not integrating teams and services and then reconfiguring to create the planned and emergency hospitals	16	21/05/2024	Risk remains the same per March 2024. Review in June 2024	Killen, Stephen	Chief Strategy and Transformation Officer
1053	Lack of capacity for elective & non elective activity and associated risk to patient harm due to LLOS and NCTR patients	16	31/05/2024	May 2024 has seen ongoing challenges with operational flow at periods with OPEL4 being recorded on sites. Elective activity has been maintained, although this has required patients to remain in the Recovery area overnight at the Poole site on occasion. In May the 2024/25 capacity plan was approved and will be implemented by mid-June (aligned to bed reconfiguration required for CSR enabling works). The 2024/25 Capacity Escalation plan is being reviewed to align with the Capacity Plan, and external reporting will be updated to new guidance. This will see a reduction in reported escalation beds, but potentially reporting of more core beds than funded for (due to changes in NHSE definition). This will also reduce the overall OPEL position as the occupancy numerator is reduced. Work continues with system partners to embed a transfer of care hub, however there is currently no benefit being achieved at UHD with discharge profiles unchanged	Gabrielli, Antonia/ Alex Lister	Chief Operating Officer
1483	Pharmacy vacancies are affecting patient care	16	06/06/2024	5 new B6 recruited, cancer services challenged by recent staff resignations, leaving over the next 4 months.	Bleakley, Stephen	Chief Operating Officer

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1970	Glaucoma Virtual Review Backlog	16	28/05/2024	Virtual Glaucoma clinics took place in May 2024 with a Consultant, Junior Doctor and two Nurse Specialists. This helped to support virtual reviews, reducing the number of patients waiting a review from over 600 to approximately 100 patients. Based on this excellent result, the risk scoring now needs to be reviewed. There were 2 Saturday clinics (Consultant led) in May (11th and 18th). Along with the joint virtual clinics (week beginning 13th May) this helped to reduce the numbers of patients waiting for a review to a total of 227 (153 for April and 74 for May). Risk score reviewed with consultant lead for Glaucoma. Decision made to not change the risk score at present (currently 16). This is because there is still a Consultant Glaucoma vacancy. The number of patients being seen in the Dorset Health Village for their investigations has temporarily been reduced. However, this is not a long-term solution and once this increases again this will impact the number of virtual reviews required. The Saturday clinics are an adhoc temporary solution and not sustainable.	Christopher, Lucinda	Chief Operating Officer
1697	Increased waiting list for SACT treatment/ Capacity on Day units	15	04/06/2024	Pathway and utilisation of capacity works continue, which has reduced our waits for new patients to and average of 4 weeks. Chris Senior continues to collect data and work with all areas and communicates to Cancer care and executive lead on updates and actions.	Bundy, Daniel	Chief Operating Officer
1502	Mental Health Care in a Physical Health environment	15	06/06/2024	Mental Health meetings have commenced on a monthly basis. There is now an exec-to-exec meeting on a fortnightly basis to establish workstreams. Senior resource now in the organisation has commenced. T&F groups established for ligature, Data and RCRP	Aggas, Leanne	Chief Operating Officer
1665	School age Neurodevelopmental service	15	31/05/2024	Business case for 'Pilot assessment scheme' presented at Directorate Performance and Care Group Board in May - further work up required on how much activity is needed to close the gap. Further meeting with ICS colleagues 12th June to agreed the clinical model for ND assessments to form the basis of NHS Dorset business case. On going concerns around maintaining some service whilst needing the headspace to support whole scale change - we may need to revisit closing the service to free up clinical time to do this.	Hannington, David	Chief Operating Officer
1429	Ambulance handover delays - risk to patient harm, performance and organisational reputation	15	07/05/2024	Delays against national standards remain, although improving. Handover time's reduced by approx 50% but 74% of handovers on average over 15mins and 27% over 30mins. Total of 360hrs lost over 5hr period across the two sites, versus SWAST regional average of 1378hrs. Separate risk of care in non-clinical areas has been created and is awaiting approval meaning that this risk focusses on the risk to ambulance service provision	Bradley, Rick	Chief Operating Officer

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1395	Lack of Capacity in Cellular Pathology Causing a Delay in Processing and Reporting.	15	31/05/2024	3 offers have been made for the 3 Band 5 posts and an external candidate from UHS has been selected for the Band 6 post	Massey, Paul	Chief Operating Officer
1292	Outpatient Follow-Up appointment Backlog - Insufficient capacity to book within due dates	12	06/06/2024	Awaiting confirmation of planned date for e-outcomes form from IT Development Team. Delayed due to testing issues which would cause organisational risk if implemented in current state. Waiting list validation ongoing through access/validation team Process mining intervention includes testing of digital PIFU through Dr Doctor. to be trialled in physiotherapy Further work to be done to identify specialties with no improvement in FU backlog to target specific areas Need to chase leads to complete Care Group risk actions	Curtin, Sara	Chief Operating Officer
1303	Therapy Staffing	12	03/06/2024	Risks remain as described May 2024 - OPS and medical beds without therapy templates are putting increasing pressure on in-patient therapy teams and 20% of urgent and high priority work is not being done same day. Work underway to develop in-patient therapy activity dashboard to capture unmet need as well as liaison with matrons in medicine and OPS to discuss staffing mitigation for unfunded ward areas	Godden, Rebekah	Chief Operating Officer
1409	Radiotherapy Ventilation/Capacity & Demand	12	17/05/2024	Been informed that the permit request went in beginning of May which potentially may push the works back to nearer September for the works. Once permit approved will need to have a lead time estimate for obtaining materials and organising clinical work elsewhere	Thomas, Gillian	Chief Strategy and Transformation Officer
1872	Patient Flow: Risk to patient safety, statutory/performance compliance - downstream capacity/front door crowding	12	17/05/2024	Internal audit of HoTW identified gaps in consistent use which could impact on bed management and flow.	Wersby, Stuart/Alex Lister	Chief Operating Officer
2000	Lack of substantive consultants in restorative dentistry and delay to patient's consultant-led reconstructive treatments	12	26/05/2024	SLA Recommendation report approved by GM/Finance and is currently with CFO for approval - to insource consultant locum for a period of 3 months to see/review/treat restorative dentistry patients	Crooks, Rachel	Chief Medical Officer

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1966	Review and treatment time delays in Dermatology, particularly for Skin Cancer	12	07/06/2024	Enhanced support meetings still undertaken weekly with the Cancer Team. Insourcing clinics continue for June/Jul 2024. Additional clinics being scheduled by own UHD team in addition. FDS Performance for Skin for April 24 was 86.9%, 88.2% for May (provisional).	Roberts, Hayley	Chief Operating Officer
Our People						
1221	Medical Staffing Shortages - Medicine and Older Persons Medicine	15	27/05/2024	Risk continues at 15 with significant gaps. Due to covering sickness gaps we have used more clinical sessions so far this calendar year than we should which will leave us short later in the year. TO cover some of this we have had to employ two locums and thus increasing our locum spend further for consultants. The Staff Survey for Consultants in OPS does not make for good reading and is indication of the toll that chronic understaffing has taken.	Pigott, Lisa	Chief People Officer
1283	Radiotherapy staffing and service demands	12	04/06/2024	Successful recruitment campaigns. New staff will join over a 6m period. The department does have a high turnover rate of 21%	Tanner, Mandy	Chief People Officer
1492	Resourcing Pressures - Staffing	12	11/06/24	Reviewed, no change, Workforce planning cycle is still in progress	Gill-Parker, Tracy	Chief People Officer
1692	Safe Staffing - Medical Workforce	12	22/05/2024	Continue to be on track for junior doctor rostering. Locums-Nest work- there is still a lot of ad-hoc timesheets being submitted. This will be stopped on 01.07.24 Leading South West region bank and agency rate card, hope to be in place October 2024. Consultant job plans on HealthRota still for 30.06.24	Jupp, Becky	Chief People Officer
1771	Radiology Service Demands/ Radiologist staffing	12	09/05/2024	Reviewed at Radiology Q+R Meeting. Audit of outsourcing figures to be undertaken to assess trends. Risk rating remains the same.	Knowles, James	Chief People Officer
1933	Medical Workforce ED	12	30/04/2024	Current recruitment at MG has improved the position with regards to consistent cover. Reduction in current consultant cover overnight as MG inboarded. Recruitment plan currently in draft but needs to be linked to the, current budget opportunities. SBARN drafted linked to bank rates against clinical backfill by RCEM credentialed ACP posts.	Bradley, Richard	Chief People Officer
1202	Medical Staffing Women's Health	12	24/05/2024	Risk to remain the same at 12. consultant level - there are 5 vacancies, x1 returned from sick leave and is on a phased return. x1 locum supporting this process. out to advert for x2 consultant obstetricians and a replacement urogyne post is on TRAC but not been published. Next month we expect x1 further phased return. JR dr rota challenging 25% gaps predicted in the next 2 months. we are exploring putting the ACP on the out of hours rota.	Taylor, Mr Alexander	Chief People Officer

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Quality (Safety and Outcomes)						
1214	Risk of misdiagnosis/ incorrect treatment from use of ungoverned Point of Care devices.	16	06/06/2024	Reviewed at POCT group 3/6/24. Risk score unchanged. Blood gas contract now signed but glucose/ketone contract not signed off as yet. Regular LERN reports submitted (4 in last week - 281497, 281432, 281427, 281420). Alternative resourcing of device audit to be pursued.	Pickett, John	Chief Medical Officer
1276	Unsafe and delayed patient care due to delays in surgery for # Neck of Femur patients	15	13/05/2024	Despite continued sustained performance there is an increasing challenge to provide consistent orthogeriatric care due to workforce reduction across OPS, therefore the risk remains unchanged.	West, John	Chief Medical Officer
1378	Lack of Electronic results acknowledgement system	15	24/05/2024	There is a request for IT to develop a solution to the closed loop / notification. This is being further investigated but there is still a lot of work for that option to be realised. The alternative is allowing Edit permissions on the stand alone ICE solution which could support the process of marking results as Filed (actioned). Meeting being arranged to look at next steps for a solution around this but either option will be slower for clinicians than a pile of paper which is their current process.	Hill, Sarah	Chief Medical Officer
1397	Provision of 24/7 Haematology/ Transfusion Laboratory Service	15	31/05/2024	Another substantive BMS joining the Out of Hours (OOH) rota from the beginning of April, we have recruited into our final vacancies but there is a lag from recruitment to onboarding and the a significant time commitment to the training to enable participation on the OOH. Overall the risk rating won't be able to be downgraded until we transition more onto the rota. The department is hopeful that by the end of the summer at least one further substantive member of the team will join the OOH roster and the risk can be re-assessed with a view to potentially lowering the risk.	Macklin, Sarah	Chief Nursing Officer
1690	Interventional Radiology Nurse Staffing	12	09/05/2024	Reviewed at Radiology Q+R Meeting. Changes to agency rates at UHD will mean we lose agency support to other hospitals, rooms will have to be closed due to staffing levels. Room closures to be reviewed. Risk remains the same.	Jenkins, Anne-Marie	Chief Nursing Officer
Sustainable Services						
1950	Graphnet Electronic Patient Record (EPR) is not fit for purpose	20	24/05/2024		Hill, Sarah	Chief Finance Officer
1595	Medium Term Financial Sustainability	16	03/06/2024	The Risk was reviewed by FPC as part the financial report, no changes were noted.	Papworth, Pete	Chief Finance Officer

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1594	Capital Programme Affordability (CDEL)	12	03/06/2024	The Risk was reviewed by FPC as part the financial report, no changes were noted.	Papworth, Pete	Chief Finance Officer
1924	Risk of not successfully and sustainably adopting the patient first approach across UHD	12	03/05/2024	Consultant support for year 2 now agreed.	Matthews, Deborah	Chief Executive

Risk Heat Map- UHD

Current Risk Grading		Likelihood				
		No Harm (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Severity	Almost Certain (5)	2	10	8	2	
	Likely (4)	1	34	11	6	
	Possible (3)	3	30	43	5	1
	Unlikely (2)		10	24	10	3
	Rare (1)		1	3	2	1

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

Current Risk Score– UHD total	**Jun 23**	**Jul 23**	**Aug 23**	**Sept 23**	**Oct 23**	**Nov 23**	**Dec 23**	**Jan 24**	**Feb 24**	**Mar 24**	**Apr 24**	**May 24**
Very Low (1-3)	4	5	3	3	3	5	8	6	6	6	6	**7**
Low (4-6)	63	72	76	80	74	74	72	78	76	72	74	**70**
Moderate (8-10)	78	82	86	86	84	91	89	91	97	97	101	**100**
Moderate (12)	21	22	21	19	19	21	21	20	19	16	15	**15**
High (15 -25)	21	20	22	23	23	23	23	21	19	19	17	**17**
Total number of risks under review	187	201	208	211	203	214	213	216	217	210	213	**210**

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Compliance and Risk Appetite

Summary of compliance UHD overall:

Current Risk Grading	*No: of risks under review*	*Number of Risks compliant with Risk Appetite timescales*	*% of Risks Compliant with Risk Appetite timescales*	*Month on month position*
12 and above	32	30	94%	↓ 6%
8 to11	100	77	77%	↓ 14%
4 to 7	70	56	80%	↓ 9%
1 to 3	7	4	57%	↑ 24%
Total	**210**	**190**	**90%**	↑ **3%**

2. **Recommendations**
   - Approve new risks presented
   - Consider the adequacy of the risk rating, controls and mitigations of all the 12+ risks
   - Consider any additional risks graded 12+ for inclusion on the Trust Risk Register

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

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

Risk Register Report

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

Risk Register Report

Appendix B: Matrix for Risk Register Assessment

Table 1 Consequence scores

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

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

Table 2 Likelihood score (L)

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

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

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 03 July 2024

Agenda item: 9.1

Subject:	Annual Committee Effectiveness Reviews
Prepared by:	Ewan Gauvin, Acting Deputy Company Secretary
Presented by:	Committee Chairs Yasmin Dossabhoy, Associate Director of Corporate Governance

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:	Decision/Approval
Executive Summary:	A review of each Committee's compliance with its own terms of reference was undertaken (by the Company Secretary Team to support the Committees) by scrutinising the agendas and minutes meetings which took place between 1 April 2023 and 31 March 2024. The reports evidence how the Committees have discharged their respective responsibilities. Members and attendees of each of the Committees have been invited to participate in an effectiveness questionnaire to inform the Committees' continuing development. The questionnaires are based on the Good Governance Institute's "Meeting Maturity Matrix", and Appendix B of the Healthcare Financial Management Association (HFMA)'s NHS Audit Committee Handbook in the case of the Audit Committee. The results will be shared with the Committees.
Background:	There should be a formal and rigorous annual evaluation of the Board of Directors and its Committees. (Code of Governance C4.5).
Key Recommendations:	The Board is asked to review and approve the Annual Committee Effectiveness Reviews.
Implications associated with this item:	Council of Governors ☐ Equality, Equity, Diversity & Inclusion ☒ Financial ☒

	Health Inequalities	☒
	Operational Performance	☒
	People (inc Staff, Patients)	☒
	Public Consultation	☐
	Quality	☒
	Regulatory	☐
	Strategy/Transformation	☒
	System	☒
CQC Reference:	Safe	☐
	Effective	☐
	Caring	☐
	Responsive	☐
	Well Led	☒
	Use of Resources	☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Charitable Funds Committee	08/05/2024	Report approved for presentation to the Board.
Audit Committee	23/05/2024	Report approved for presentation to the Board.
Quality Committee	31/05/2024	Report approved for presentation to the Board.
Population Health & System Committee	12/05/2024	Report approved for presentation to the Board.
Finance & Performance Committee	24/06/2024	Report approved for presentation to the Board.
People & Culture Committee	01/07/2024	Meeting not yet taken place at the time of submission.

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

QUALITY COMMITTEE ANNUAL REPORT 2023/24

1 PURPOSE OF THE REPORT

1.1 The Quality Committee (the "Committee") has prepared this report for the Board of Directors. It sets out how the Committee satisfied its terms of between 1 April 2023 and 31 March 2024. The Committee seeks to provide the Board with evidence that it has met its responsibilities as set out in its terms of reference during the relevant period.

2 MEETINGS

2.1 Twelve formal meetings were held during the year, all of which were quorate[1]:

- Tuesday 18 April 2023
- Tuesday 16 May 2023
- Tuesday 20 June 2023
- Tuesday 18 July 2023
- Tuesday 15 August 2023
- Tuesday 19 September 2023
- Tuesday 17 October 2023
- Tuesday 21 November 2023
- Tuesday 19 December 2023
- Tuesday 23 January 2024
- Tuesday 27 February 2024
- Tuesday 26 March 2024

2.2 Meeting attendance is detailed in **Appendix 1.**

3 MEMBERSHIP

3.1 Membership of the Committee comprises three Non-Executive Directors (one of whom will be a member of the Audit Committee), the Chief Nursing Officer, the Chief Medical Officer, the Chief Operating Officer and the Chief People Officer.

Membership of the Committee in 2022/23 comprised of:

- Cliff Shearman, Non-Executive Director and Chair
- Karen Allman, Chief People Officer *(until 30 Nov 2024)*
- Judy Gillow, Non-Executive Director *(from 24 May 2023)*
- Irene Mardon, Acting Chief People Officer *(from 1 Dec 2023 to 25 Feb 2024)*
- Helena McKeown, Non-Executive Director *(from 1 Oct 2023)*
- Mark Mould, Chief Operating Officer
- Stephen Mount, Non-Executive Director *(until 30 Sep 2024)*
- Tina Ricketts, Chief People Officer *(from 26 Feb 2024)*

[1] The meetings held on 23 January 2024 and 26 March 2024 were inquorate for part of the meeting. All necessary decisions were taken during the time a quorum was in place.

- Paula Shobbrook, Chief Nursing Officer
- Caroline Tapster, Non-Executive Director *(until 31 Dec 2023)*
- Peter Wilson, Chief Medical Officer

Cliff Shearman, Judy Gillow and Stephen Mount were members of the Audit Committee during the period.

4 COMPLIANCE WITH TERMS OF REFERENCE

4.1 A review of the Committee's compliance with its own terms of reference was undertaken (by the Company Secretary Team to support the Committee) in May 2024 by scrutinising the agendas and minutes of the twelve Committee meetings which took place between 1 April 2023 and 31 March 2024. This evidences how the Committee has discharged each of its responsibilities:

4.1.1 **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.**

During 2023/24, the Committee was the Lead Committee for:

- **Board Assurance Framework Risk 4:** Risk that not every team is empowered to make improvements using patient feedback, in order that all patients at UHD receive quality care, which results in a positive experience for them, their families and/or carers.
- **Board Assurance Framework Risk 5:** Risk of not improving hospital mortality and being in the top 20% of trusts in the country for HSMR over the next 3 years.
- **Board Assurance Framework Risk 6:** Risk of not managing patient safety in a manner that decreases unwarranted variation leading to worsening outcomes.

4.1.2 **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.**

The Committee reviewed the above Board Assurance Framework risks at each meeting, monitoring progress and controls/gaps in controls.

4.1.3 **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.**

As above.

The Committee conducted deep dives into the specific risks relating to the Emergency Department, hospital flow and theatres.

4.1.4 **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.**

The Committee received reporting of new and current risks rated 12-25. New risks were presented to the Committee by the relevant Executive Lead.

4.1.5 **To review the annual quality report.**

The Committee reviewed the Quality Account 2022/23 in June 2023, recommending it for approval by the Board of Directors.

4.1.6 **To review the quarterly and annual mortality reports.**

The Committee received a dedicated mortality report on a quarterly basis. Mortality was otherwise reviewed monthly through Board Assurance Framework Risk 5 and the Integrated Performance Report.

4.1.7 **To review the annual adult and children safeguarding report and statement.**

The Committee reviewed the annual safeguarding report in September 2023 and the annual statement in July 2023, recommending it to the Board of Directors for approval.

4.1.8 **To review the annual reports on claims.**

The Committee reviewed the annual claims and litigation report in May 2023.

4.1.9 **To review the annual infection prevention and control report and statement.**

The Committee reviewed the annual infection prevention and control report and statement in July 2024.

4.1.10 **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.**

During the period, the Committee received internal audit reports on risk maturity and the Maternity Incentive Scheme from the Trust's internal auditors, BDO.

In December 2023, assurance on maternity incidents was reviewed from a peer review conducted by the Somerset Local Maternity & Neonatal System.

4.1.11 **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.**

The Committee has received monthly updates on progress against the action plans in response to the CQC inspections.

4.1.12 **To receive and monitor the CQC Insight Model Report.**

No insight reports were produced by the CQC during the period.

4.1.13 **To receive and monitor the CQC in-patient survey reports and associated action plans.**

In June 2023, the Committee reviewed the Adult Inpatients Survey for 2022 and in February 2024 it reviewed the Maternity Survey for 2023.

4.1.14 **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.**

The Committee received:

- Through the Clinical Governance Group, a monthly report on Learning Event Report Notifications (LERNs), including serious incidents and never events;
- Quarterly mortality report;
- Claims and litigation report in May 2023.

4.1.15 **To receive reports including 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).**

The Committee received a monthly report from the Clinical Governance Group and reports from other groups on a “by exception” basis.

4.1.16 **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.**

The Committee reviewed the quality impact assessment report quarterly. Enhancements to this report have been requested for 2024/25 to focus more specifically on quality and thematic analysis.

4.1.17 **To obtain assurance that robust safeguarding structures, systems and processes are in place to safeguard children and adults.**

The Committee received a quarterly safeguarding report. In September 2023, it also received the annual safeguarding report.

4.1.18 **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.**

The maternity safety champion’s report was presented to the Committee at each meeting, including the maternity perinatal quality surveillance dashboard.

4.1.19 **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.**

The Committee received a quarterly report on end of life care.

4.1.20 **To obtain assurance in relation to the safe delivery of the Trust's resuscitation services.**

Through the Clinical Governance Group Report, the Committee received a report on the Trust's resuscitation services in October 2023.

4.1.21 **To obtain assurance in relation to the safe delivery of the Trust's children's services**

The Committee received an update on paediatric services in August 2023.

4.1.22 **To obtain assurance in relation to the delivery of the Trust's falls and dementia services.**

The Committee received a dementia report in October 2023. In 2024/25 this would become a quarterly report to the Committee.
It also reviewed the falls report in November 2023.

4.1.23 **To review reports in relation to Getting It Right First Time.**

Through the Clinical Governance Group Report, the Committee received a quarterly report on Getting it Right First Time (GIRFT).

4.1.24 **To receive relevant reports from national bodies in relation to standards or practice of clinical care.**

No such reports were received during the period.

4.1.25 **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.**

The Committee received a report on Clinical Audit in November 2023, in addition to regular updates as part of the Clinical Governance Group report.
The Clinical Audit Plan for 2024-25 would be reviewed in May 2024 (outside the scope of this report).

4.1.26 **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.**

In February 2024, the Committee reviewed a specific incident relating to patient nutrition and the actions resulting from this.

4.1.27 **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.**

The Committee received a quarterly report on complaints and patient experience.

4.1.28 **To consider the results of issues raised and the trends in patient surveys of inpatients 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.**

As part of the quarterly complaints and patient experience report, the Committee reviewed the results of and considered trends in the Friends & Family Test, “have your say” survey and other NHS England patient surveys.

As per 4.1.13 the Committee received the results and subsequent recommendations from the CQC surveys published during the period.

The Committee reviewed the results of PLACE in March 2024.

4.1.29 **To receive and consider the Trust’s clinical governance and risk management reports and review recommendations on actions for improvement.**

The Committee received reports from the Clinical Governance Group on a monthly basis.

4.1.30 **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.**

Key issues and assurance reports are presented to the Board by the Committee Chair.

4.1.31 **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).**

As above.

4.1.32 **To oversee, through receipt of periodic status reporting, the update of clinical policies.**

The Committee receives updated policies for consultation or approval in line with the Trust’s Document Control Policy.

4.1.33 **To identify key themes from complaints, PALS and patient engagement, good practice and learning and provide oversight on behalf of the Board.**

The Committee received a quarterly report on complaints and patient experience, including key themes and learning from complaints.

4.1.34 **To identify key themes from patient experience, quality indicators and provide oversight of action plans to attain assurance.**

As above.

The Committee has particularly monitored progress against the improvement in 55-day complaint response times.

4.1.35 **To receive, by exception, reports relating to patient experience following review at relevant groups.**

As above.

4.1.36 **To receive and review relevant reports of or relating to the Dorset integrated care system and provider collaborative.**

The Committee received a quarterly update from NHS Dorset, presented by the ICB Chief Nursing Officer and Chief Medical Officer on an alternate basis.

4.2 The Committee approved a new governance cycle in July 2023.

5 CONCLUSION

5.1 The Committee considers that it has discharged its responsibilities as set out in its terms of reference.

Cliff Shearman
Chair, Quality Committee
May 2024

Appendix 1 – Attendance at Quality Committee 2023/24

Quality Committee		18-Apr-23	16-May-23	20-Jun-23	18-Jul-23	15-Aug-23	19-Sep-23	17-Oct-23	21-Nov-23	19-Dec-23	23-Jan-24	27-Feb-24	26-Mar-24
Present	Karen Allman	D	D		D								
	Judy Gillow								A				
	Irene Mardon										D		
	Helena McKeown												
	Mark Mould			D									
	Stephen Mount	A		A									
	Tina Ricketts												D
	Cliff Shearman										A		
	Paula Shobbrook					D							
	Caroline Tapster												
	Peter Wilson												
In attendance	Leanne Aggas												
	Charlotte Baylem												
	Claire Bone												
	Robert Bufton												
	Louise Campbell												
	Sharon Collett												
	Suzanne Cunningham												
	Sue Davies												
	Steve Dickens												
	Yasmin Dossabhoy												
	Ewan Gauvin												
	Judy Gillow												
	Hayley Flavell												
	Karen Hill												
	Matt Hodson												
	Bruce Hopkins												
	Fiona Hoskins												
	Marjorie Houghton												
	Robert Howell												
	Paul Johnson												
	Becky Jupp												
	Deborah Lane												
	Alex Lister												
	Mark Major												
	Irene Mardon												
	Helena McKeown												
	Vicky Melville												
	Laura Northeast												
	Sue Reed												
	Richard Renaut												
	Claire Rogers												
	Madeleine Seeley												
	Debbie Simmons												
	Joanne Sims												
	Diane Smelt												
	Susanne Surman-Lee												
	Kerry Taylor												
	Matt Thomas												
	Lorraine Tonge												
	Kari Trehorn												
	Mathew Trotman												
	Sean Weaver												
	Daniel Webster												
	Nicki Whiller												
	Lisa White												
	Ruth Williamson												
	Michele Whitehurst												
	Hanna Wilkinson												
Was the meeting quorate?		Y	Y	Y	Y	Y	Y	Y	Y	Y	Inquorate for part of meeting	Y	Inquorate for part of meeting

Key

	Not in Attendance
A	Apologies
D	Delegate Sent
	In attendance
	N/A

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

FINANCE & PERFORMANCE COMMITTEE ANNUAL REPORT 2023/24

1 PURPOSE OF THE REPORT

1.1 The Finance & Performance Committee (the "Committee") is presenting this report to the Board of Directors following a review of the Committee's adherence to its terms of reference. The report sets out how the Committee satisfied its terms of reference between 1 April 2023 and 31 March 2024. The Committee seeks to provide the Board with evidence that it has met its responsibilities as set out in its terms of reference during the relevant period.

2 MEETINGS

2.1 Fourteen formal meetings were held during the year, all of which were quorate:

- 17 April 2023
- 15 May 2023
- 19 June 2023
- 28 June 2023 *(joint with Audit Committee)*
- 17 July 2023
- 14 August 2023
- 18 September 2023
- 16 October 2023
- 9 November 2023
- 20 November 2023
- 18 December 2023
- 22 January 2024
- 26 February 2024
- 25 March 2024

2.2 Meeting attendance is detailed in **Appendix 1.**

3 MEMBERSHIP

3.1 Membership of the Committee comprises four Non-Executive Directors (at least one of whom should have recent and relevant financial experience)[1], the Chief Finance Officer, the Chief Strategy & Transformation Officer and the Chief Operating Officer.

Membership of the Committee in 2023/24 comprised of:

- Philip Green, Non-Executive Director and Committee Chair *(until 30 September 2023)*
- Pankaj Davé, Non-Executive Director
- John Lelliott, Non-Executive Director and *(from 1 October 2023)* Committee Chair
- Sharath Ranjan, Non-Executive Director *(from 24 May 2023)*

[1] Pankaj Davé and John Lelliott are all chartered accountants.

- Claire Whitaker, Non-Executive Director *(from 1 October 2023)*
- Mark Mould, Chief Operating Officer
- Pete Papworth, Chief Finance Officer
- Richard Renaut, Chief Strategy & Transformation Officer

4 COMPLIANCE WITH TERMS OF REFERENCE

4.1 A review of the Committee's compliance with its own terms of reference was undertaken (by the Company Secretary Team to support the Committee) in June 2023 by scrutinising the agendas and minutes of the fourteen Committee meetings which took place between 1 April 2023 and 31 March 2024. This evidences how the Committee has discharged each of its responsibilities:

4.1.1 **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.**

During 2023/24, the Committee was the Lead Committee for:

- **Board Assurance Framework Risk 1:** Risk of not meeting the patient national constitutional standards for planned care (no patients waiting more than 65 weeks on RTT pathway by March 2024).
- **Board Assurance Framework Risk 2:** Risk of not meeting the patient national constitutional standards for emergency care.
- **Board Assurance Framework Risk 7:** Risk of not returning to recurrent financial surplus from 2026/27.
- **Board Assurance Framework Risk 9:** Risk of not integrating teams and services and then reconfiguring to create the planned and emergency hospitals.
- **Board Assurance Framework Risk 9:** Risk that the Trust's Electronic Patient Record (EPR) not fit for purpose for UHD and this contributes to

4.1.2 **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.**

The Committee received the Board Assurance Framework risks at the majority of its meetings and monitored progress.

4.1.3 **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.**

The Committee reviewed the annual report and accounts in conjunction with the Audit Committee and recommended approval to the Board.

4.1.4 **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.**

The draft operational budget was presented to the Committee in February 2024, with a subsequent update presented in March 2024, taking into account the ICS planning process. The Committee also reviewed the annual plan in March 2024.

4.1.5 **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.**

The Committee reviewed on a quarterly basis the capital programme report and received periodic updates from the ICB's Chief Finance Officer.

4.1.6 **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.**

The Committee reviewed the draft operational budget as in 4.1.4, in addition to approving (where within delegated limits) and made recommendations for approval of tenders, contracts and business cases to the Board.

4.1.7 **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.**

The Committee received various reports including, financial performance report, operational performance report, cost/efficiency improvement report, consultancy commitments, patient level information and costing report, and national costs submission assurance.

4.1.8 **To review and examine monthly and year to date financial management variances both revenue and capital and report to the Board.**

This was achieved through monthly review of a financial performance report and quarterly review of a capital programme report.

4.1.9 **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.**

The Chair of the Committee raises issues to the Board through their key issues and assurance report. Efficiency improvement continues to be a key area of focus.

4.1.10 **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.**

The Committee considers and makes recommendations to the Board on major capital projects (such as the New Hospitals Programme).

The Committee received, for example, a report in December 2023 post-approval in relation to certain variances.

4.1.11 **To review and make comment to the Board on borrowing against Prudential Borrowing Code and other ratios.**

As noted above, the Committee receives a monthly finance performance report; and reviews and makes comment to the Board on certain business cases.

4.1.12 **To monitor and recommend improvements to Treasury and Financial Systems, meeting the objectives of strengthening the use of financial resources.**

This is to be met through Financial Systems Development update exception reports presented by the Chief Finance Officer; no Financial Systems Development update exception reports were presented to the Committee during the period.

4.1.13 **To review and recommend individual investments of cash balances/cash advances.**

The Committee received a monthly financial performance report.

4.1.14 **To monitor banking arrangements, including approving tenders of banking services.**

Where applicable, this would be presented to the Committee through review of the regular financial performance report (and relevant recommendation report).

4.1.15 **To support the Trust in fulfilling the requirements of its licence and commissioner contracts in relation to key performance indicators.**

The Committee reviewed the operational performance report at each meeting. (The Committee is also sighted upon the Integrated Performance Report on a monthly basis).

4.1.16 **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.**

During the period, in addition to the Committee Chair's report to the Board, Board agendas included provision for escalations from Committee Chairs to the Board.

4.1.17 **To consider the impact of accounting policies for external reporting, taking into account the requirements of NHS England and other appropriate bodies.**

Where applicable, this would be provided through exception reporting by the Chief Finance Officer to the Committee and to the Board.

4.1.18 **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.**

Estates improvement was previously reported to the Quality Committee on a quarterly basis. During the period and following the remit of the Committee being expanded, monthly estates compliance reports were initially presented to and monitored by the Committee, with it subsequently being agreed that these again be presented quarterly.

4.1.19 **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.**

Prior to January 2023, review of the Private Patients Strategy was the responsibility of the Private Patients Strategy Committee, and the Quality Improvement Strategy and Benefits Realisation that of the Transformation Committee.

From January 2023, the Committee's remit was expanded to include these additional items. Private Patients Strategy and Transformation matters are considered monthly on an exception basis and every 3 or 4 months with a more substantive report.

4.1.20 **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.**

The Committee received updates in relation to the private patients strategy (please see above), with input provided to the Board.

4.1.21 **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.**

The Committee approved the procurement strategy in February 2023 (prior to the current financial year).

4.1.22 **To review the Digital Strategy and provide input and recommendations to the Board for approval.**

The Committee has received updates on the refresh of the Digital Strategy, with a revised draft to be considered by the Committee in the 2024/25 financial year.

4.1.23 **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.**

This was a new responsibility from January 2023, prior to which the Audit Committee reviewed an information governance report on a quarterly basis. The Committee received the information governance report during the period.

Further work is in progress in relation to reporting to the Committee related to key information management, technology and digital implementations.

4.1.24 **To receive reporting in relation to cyber security including regular maintenance of critical systems and equipment and minimising impact on clinical services during downtime.**

The Committee received a cyber security report bi-annually.

4.1.25 **To review the Sustainability Strategy (Green Plan) and provide input and recommendations to the Board for approval.**

The Committee reviewed the Trust's Sustainability Strategy prior to presentation to the Board in March 2024.

4.1.26 **To monitor the implementation of the Trust's sustainability plans, receiving regular progress reports to scrutinise delivery and the meeting of key milestones.**

The Committee received exception reports on a monthly basis, with quarterly deep-dives scheduled.

4.1.27 **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**

The Committee received the Trust's draft annual report, which included sustainability, climate adaptation and carbon reduction and related areas of corporate social responsibility.

4.1.28 **To receive and review financial and other relevant reports of or relating to the Dorset ICS and provider collaborative.**

The Committee was periodically attended by the Chief Finance Officer of the Integrated Care Board, with updates related to the Dorset ICS also provided by the Trust's Chief Finance Officer.

4.1.29 **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**

Please see paragraph 4.1.1 above.

4.1.30 **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.**

The majority of the Committee's monthly agenda items included new and current risks rated 12-25 applicable to the Committee's scope.

5 CONCLUSION

5.1 The Committee considers that it has substantially discharged its responsibilities as set out in its terms of reference.

John Lelliott
Chair, Finance & Performance Committee
June 2024

Appendix 1 – Attendance at Finance & Performance Committee 2023/24

Appendix
Attendance at Finance and Performance Committee 2023-2024

		17-Apr-23	15-May-23	19-Jun-23	17-Jul-23	14-Aug-23	18-Sep-23	16-Oct-23	09-Nov-23	20-Nov-23	18-Dec-23	22-Jan-24	26-Feb-24	25-Mar-24
Present	Philip Green						A							
	Pankaj Dave													
	John Lelliott													
	Mark Mould			D										
	Pete Papworth					D								
	Sharath Ranjan													
	Richard Renaut					D								
	Claire Whitaker													
	Camilla Axtell													
	Mandi Barron													
	Jeff Belk													
	Alan Betts													
	Colin Blebta													
	Clare Bones													
	Robert Bufton													
	Sharon Collett													
	Yasmin Dossabhoy													
	Richard Ferris													
	Peter Gill							D						
	Judy Gillow													
	Andrew Goodwin													
	Stephen Harding													
In Attendance	Siobhan Harrington													
	Marjorie Houghton													
	Stephen Killen													
	Alex Lister													
	Sarah Locke													
	Mark Major													
	Judith May													
	Rob Morgan													
	Sharath Ranjan													
	Helen Rushforth													
	Patricia Scott													
	Carrie Stone													
	Matt Trotman													
	Andrew Ward													
	Rob Whiteman													
	Claire Whitaker													
Was the meeting quorate?		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

Key

	Not in Attendance
A	Apologies
D	Delegate Sent
	In attendance
	N/A

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

PEOPLE & CULTURE COMMITTEE ANNUAL REPORT 2023/24

1 PURPOSE OF THE REPORT

1.1 The People & Culture Committee (the "Committee") has prepared this report for the Board of Directors. It sets out how the Committee satisfied its terms of between 1 April 2023 and 31 March 2024. The Committee seeks to provide the Board with evidence that it has met its responsibilities as set out in its terms of reference.

2 MEETINGS

2.1 Four formal meetings were held during the year, all of which were quorate:

- Wednesday 10 May 2023
- Wednesday 9 August 2023
- Wednesday 8 November 2023
- Wednesday 14 February 2024

2.2 Meeting attendance is detailed in **Appendix 1.**

3 MEMBERSHIP

3.1 Membership of the Committee comprised three Non-Executive Directors, the Chief People Officer, the Chief Medical Officer, the Chief Nursing Officer and the Chief Operating Officer.

Membership of the Committee in 2023/24 comprised of:

- Pankaj Davé, Non-Executive Director and Chair
- Karen Allman, Chief People Officer *(until 30 November 2023)*
- Judy Gillow, Non-Executive Director *(from 1 October 2023)*
- Philip Green, Non-Executive Director *(until 30 September 2023)*
- Irene Mardon, Acting Chief People Officer *(from 1 December 2023 to 25 February 2024)*
- Mark Mould, Chief Operating Officer
- Sharath Ranjan, Non-Executive Director *(from 24 May 2023)*
- Tina Ricketts, Chief People Officer *(from 26 February 2024)*
- Paula Shobbrook, Chief Nursing Officer
- Caroline Tapster, Non-Executive Director *(until 31 December 2023)*
- Peter Wilson, Chief Medical Officer

4 COMPLIANCE WITH TERMS OF REFERENCE

4.1 A review of the Committee's compliance with its own terms of reference was undertaken (by the Company Secretary Team to support the Committee) in June 2024 by scrutinising the agendas and minutes of the four Committee meetings which took

place between 1 April 2023 and 31 March 2024. This evidences how the Committee has discharged each of its responsibilities:

4.1.1 **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.**

During 2023/24, the Committee was the Lead Committee for:

- **Board Assurance Framework Risk 3:** Risk of not significantly improving staff experience and retention over the next 3 years (and not being in the NHS staff survey results top 20% of comparator trusts).

4.1.2 **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.**

Following the development of the Board Assurance Framework, the Committee reviewed the risk for which it was the lead Committee at each meeting, monitoring progress, controls/gaps in controls and associated risks.

4.1.3 **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.**

As above.

4.1.4 **To review the Trust's significant risks report and receive updates on directorate workforce risk issues, action plans or unresolved matters/concerns for escalation.**

The Committee reviewed at each meeting risks rated 12+ relating to workforce and organisational development. At each meeting the Committee received updates from the Care Groups, including risks and escalations to the Committee.

4.1.5 **To review reports from the Guardian of Safe Working and Freedom to Speak Up Guardian as well as Safe Staffing reviews**

The Committee received:

- Quarterly Guardian of Safe Working Hours Report;
- Quarterly Freedom to Speak Up Report;
- Bi-annual safe staffing reports for nursing and midwifery.

4.1.6 **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.**

The Committee received a report on the 2022 staff survey in May 2023 and resulting actions. During this meeting, the Care Group reports also contained an update on their local results and actions.

Updates on the GMC survey results were received at the August and November 2023 meetings of the Committee.

4.1.7 **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.**

The Committee received a quarterly report from the Freedom to Speak Up Guardian.

4.1.8 **To oversee and monitor the implementation of the Equality, Diversity and Inclusion strategy.**

The Committee received a quarterly report on Equality, Diversity & Inclusion, including progress against the strategy.

4.1.9 **To obtain assurance in relation to the Trust's security management - violence prevention and reduction strategy.**

The annual security report was reviewed by the Committee in August 2023.

4.1.10 **To oversee the development by the Trust of an effective staff structure and workforce operating model across the organisation.**

The Committee received the Nursing Establishment Review in August 2024, and were provided with updates on medical job planning as part of the Chief Medical Officer's Report.

It reviewed a further nursing safe staffing report in February 2024, along with midwifery staffing reports in August 2023 and February 2024.

4.1.11 **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.**

Fulfilment of this responsibility will be strengthened in 2024-25 with the introduction of staff engagement report.

4.1.12 **To monitor organisational integration and cultural development and the implementation of action plans as necessary.**

The Committee reviewed a report on the integration assessment in November 2023, with updates on cultural development provided throughout the year, for example as part of reporting on Freedom to Speak Up.

4.1.13 **To receive reporting relating to changes in Professional Education and Essential Core Skills training to ensure compliance and continued provision of high-quality care.**

The Committee received a quarterly report on Education & Training which included compliance. These metrics were also referenced in the Chief Officer's reports.

4.1.14 **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.**

The Committee received a quarterly report on Education & Training. The Committee also commissioned a report on Talent Management which would be presented in April 2024 (outside the scope of this report). This would include a focus on developing a more representative leadership and succession planning.

4.1.15 **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.**

Appraisal performance was reported to the Committee through the Chief Officers' and Care Group reports.

4.1.16 **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.**

In November 2023, the Committee received a report on the integration assessment, with a subsequent update on the Transforming Care Together programme provided in February 2024.

4.1.17 **To receive and monitor workforce indicators including recruitment, retention/turnover, sickness, appraisals and training.**

These indicators were monitored at each meeting through the Chief People Officer's Report.

4.1.18 **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).**

The Committee reviewed the annual WRES and WDES reports in August 2023.

4.1.19 **To review the Trust's Equality and Diversity Monitoring Report.**

The Committee received and reviewed a quarterly report on Equality, Diversity & Inclusion.

4.1.20 **To review the Gender Pay Gap Report.**

The Gender Pay Gap Report was reviewed by the Committee in May 2023.

4.1.21 **To review the annual consultant revalidation report.**

The Committee reviewed the annual revalidation report in August 2023.

4.1.22 **To receive and review relevant reports of or relating to the Dorset integrated care system and provider collaborative.**

The governance cycle approved by the Committee in November 2023 accounts for a bi-annual update from the Integrated Care Board.

4.2 The Committee approved a new governance cycle in November 2023.

5 CONCLUSION

5.1 The Committee considers that it has discharged its responsibilities as set out in its terms of reference, save as noted above in 4.1.11 and 4.1.22.

Pankaj Davé
Chair, People & Culture Committee
July 2024

Appendix 1 – Attendance at People & Culture Committee 2023/24

People & Culture Committee		10-May-23	09-Aug-23	08-Nov-23	14-Feb-24
Present	Karen Allman				
	Pankaj Davé				
	Judy Gillow				
	Philip Green				
	Irene Mardon				
	Mark Mould		A		
	Sharath Ranjan				
	Paula Shobbrook				
	Caroline Tapster			A	
	Peter Wilson				A
In attendance	Alan Betts				
	Sharon Collett				
	Abigail Daughters				
	James Donald				
	Yasmin Dossabhoy				
	Richard Ferns				
	Rob Flux				
	Paul Froggatt				
	Ewan Gauvin				
	Judy Gillow				
	Jonathan Harding				
	Andrea Holloway				
	Fiona Hoskins				
	Darren Jose				
	Deborah Lane				
	Sarah Macklin				
	Irene Mardon				
	Helen Martin				
	Deborah Matthews				
	Lisa McManus				
	Keith Mitchell				
	Sharath Ranjan				
	Leanna Rathbone				
	Richard Renaut				
	Tina Ricketts				
	Lorraine Tonge				
	Kani Trehorn				
	Lisa White				
	Stuart Willes				
	Sandy Wilson				
Was the meeting quorate? Y/N		Y	Y	Y	Y

Key

	Not in Attendance
A	Apologies
D	Delegate Sent
	In attendance
	N/A

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

AUDIT COMMITTEE ANNUAL REPORT 2023/24

1 PURPOSE OF THE REPORT

1.1 The Audit Committee (the "Committee") is presenting this report to the Board of Directors following a review of the Committee's adherence to its terms of reference. The report sets out how the Committee satisfied its terms of reference between 1 April 2023 and 31 March 2024 (the "review period"), particularly to provide the Board with evidence relevant to its responsibilities for the Annual Governance Statement. The Committee's terms of reference are next due to be reviewed in July 2024.

1.2 The existence of an independent audit committee is a central means by which the Board of Directors ensures that there are effective internal control arrangements in place. The Committee independently reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities, both clinical and non-clinical.

1.3 The Committee receives and considers reports from both internal and external auditors, counter fraud specialists and scrutinises the Trust's annual report and financial statements.

1.4 The Committee has a governance cycle detailing which papers are expected to be presented at each meeting of the Audit Committee. This is reviewed annually and updated as necessary during the year.

2 MEETINGS

2.1 Five formal meetings were held during the year, all of which were quorate:

- Thursday 18 May 2023
- Thursday 13 July 2023
- Monday 9 October 2023
- Thursday 18 January 2024

In addition to the Joint Audit and Finance & Performance Committee meeting held on Wednesday 28 June 2023.

2.2 Meeting attendance is detailed in **Appendix 1.**

2.3 It is usual for the External and Internal Auditors and the Counter Fraud Specialist to attend all formal meetings of the Committee. During the period, a representative from external audit, internal audit and the counter fraud specialists was present at each meeting.

2.4 The Trust Chair is not a member of the Committee but may attend meetings at the invitation of the Audit Committee Chair.

2.5 Although the Senior Independant Director should ideally not chair the Audit Committee *(Code of Governance for NHS Provider Trusts B2.5),* this is provided for in the Committee's terms of reference and was approved by the Board.

3 MEMBERSHIP

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.

Membership of the Committee in 2023-24 comprised of:

- Stephen Mount, Non-Executive Director and Chair *(until 30 September 2023)*
- Judy Gillow, Non-Executive Director and Chair *(from 1 October 2023)*
- John Lelliott, Non-Executive Director
- Cliff Shearman, Non-Executive Director
- Claire Whitaker, Non-Executive Director *(from 1 October 2023)*

During his tenure, Stephen Mount was - and John Lelliott is - a qualified accountant. Cliff Shearman and Judy Gillow were members of the Quality Committee during the period.

4 COMPLIANCE WITH TERMS OF REFERENCE

4.1 A review of the Committee's compliance with its own terms of reference was undertaken (by the Company Secretary Team, for review and consideration, by and to support the Committee) in May 2024 by scrutinising the agendas and minutes of the Committee meetings which took place between 1 April 2023 and 31 March 2024. This evidences how the Committee has discharged each of its responsibilities:

4.2 **Governance, risk management and internal control**

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.[1] In particular, the Committee will review the adequacy and effectiveness of:

4.2.1 **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 Committee (or joint Audit and Finance & Performance Committee) reviewed these items prior to submission to the Board:

[1] The Quality Committee has primary responsibility for the oversight of clinical risk management.

- Annual governance statement – May 2023 *(for 2022-23)* and March 2024 *(for 2023-24)*;
- Annual report – June 2023;
- Annual financial statements, including external audit opinion – June 2023;
- Annual draft licence compliance, including assurance – March 2024;
- Annual draft code of governance compliance – March 2024;

In 2023-24, the Quality Account was reviewed by the Quality Committee prior to submission to the Board.

4.2.2 **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 Committee reviewed the risk register at each meeting, in addition to the Board Assurance Framework (BAF) on a quarterly basis.

Progress reports were received from internal audit in relation to audits undertaken aligned to the BAF and provided an assessment of design effectiveness, areas of strength and improvement including recommendations.

In 2023-24, the Committee commissioned a risk management action plan aimed at strengthening the Trust's approach to risk management, particularly risk appetite and tolerance. It reviewed the action plan in January 2024 and will continue to monitor progress throughout 2024-25.

4.2.3 **The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications.**

During 2023-24 the Committee reviewed and recommended to the Board the Anti-Fraud, Bribery and Corruption Policy and the Managing Conflicts of Interest Policy.

As a consultation group, it also received an update on the development of a new Fit & Proper Persons Policy.

The Committee received an update on ongoing quality improvement work for the Trust's policies and procedures; it received a formal report at the meeting held in April 2024 (outside the scope of this report).

In March 2024, the Committee reviewed the Trust's compliance with the Code of Governance for NHS Provider Trusts and the Provider Licence.

It also recommended approval of the annual certificates (Continuity of Services 7 and Training of Governors) in March 2024.

4.2.4 **The wording in the annual governance statement and other disclosures relevant to the Terms of Reference of the Committee.**

The Committee reviewed and recommended approval of the draft annual governance statement in May 2023 (for 2022-23) and March 2024 (for 2023-24).

4.2.5 **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[2].

The clinical audit plan for 2023-24 was presented to the Committee in May 2023, with a subsequent progress report received in January 2024.

4.3 **Counter Fraud**

4.3.1 **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;**

The Committee received the counter fraud progress report at each meeting, including updates on investigations.

It also reviewed and recommended approval to the Board of the Anti-Fraud, Bribery and Corruption Policy and Managing Conflicts of Interest Policy in July 2023 and January 2024 respectively.

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

The annual review of the effectiveness of the Local Counter Fraud Specialist was presented to and approved by the Committee in October 2023.

The regular reports from the LCFS included updates on their activities within the Trust, including engagement with staff.

4.3.3 **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.**

The Committee reviewed and approved the counter fraud programme for 2024-25 in January 2024.

The LCFS' reports to the Committee contained findings from investigations and management responses.

4.4 **Internal Audit**

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:

4.4.1 **Considering the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal.**

The Committee received progress reports from internal audit at each meeting.

[2] In conjunction with the Quality Committee

The annual review of the effectiveness of the internal audit service was presented to and approved by the Committee in October 2023.

4.4.2 **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.**

The annual internal audit plan was considered at the meeting held in April 2024 (outside the scope of this report).

4.4.3 **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;**

The Committee reviewed the major findings and management action plans as part of the internal audit progress report presented to each meeting.

Representatives of both internal and external audit received each other's progress reports and plans as part of the Committee's meeting materials (consequently supporting coordination).

4.4.4 **Ensuring the internal audit function is adequately resourced and has appropriate standing within the Trust.**

The annual review of the effectiveness of the internal audit service was presented to and approved by the Committee in October 2023.

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

As above.

4.5 **External Audit**

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:

4.5.1 **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.**

The annual review of the effectiveness of the external audit service was presented to the Committee in October 2023 and recommended for approval by the Council of Governors.

4.5.2 **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.**

The annual external audit plan was considered at the meeting held in April 2024 (outside the scope of this report).

4.5.3 **Discussing with the external auditors their evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.**

The Committee received an external progress report at each meeting and technical update.

4.5.4 **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.**

The Committee reviewed external audit reports at each meeting.

4.5.5 **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.**

A policy is in place on the use of external auditors for non-audit work in place which is due for review by the Committee in October 2024.

4.6 **Financial Reporting**

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

The integrity of the financial statements is monitored through regular external audit reports.

4.6.2 **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.**

As above.
In addition, the Committee received an internal audit report on Key Financial Systems (Cash Office).

4.6.3 **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.**

The Committee reviewed the draft annual governance statement in May 2023 (for 2022-23) and March 2024 (for 2023-24). The annual report and accounts, alongside the external audit report on the financial statements was reviewed by the Joint Audit and Finance & Performance Committee in June 2023.

4.7 **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.**

The effectiveness of the LCFS was reviewed in October 2023.

During 2023-24, regular reporting on Freedom to Speak Up was presented to the People & Culture Committee. Reporting on this has since been included in the Committee's governance cycle for 2024-25.

4.8 **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.**

The Committee reviewed reports on Emergency Preparedness, Resilience and Response in May 2023 and October 2023.

5 CONCLUSION

5.1 The Committee considers that it has discharged its responsibilities as noted above.

Judy Gillow
Chair, Audit Committee
May 2024

Appendix 1 – Attendance at Audit Committee 2023/24

Attendance at Audit Committee

Audit Committee		18 May 2023	13 July 2023	09 October 2023	18 January 2024
Present	Stephen Mount				
	Judy Gillow				
	John Lelliott				
	Cliff Shearman			A	A
	Claire Whitaker			A	
In attendance	Melanie Alflatt				
	Mandi Barron				
	Jonathan Brown				
	Yasmin Dossabhoy				
	Ewan Gauvin				
	Judy Gillow				
	Tony Hall				
	Kim Hampson				
	Siobhan Harrington				
	Matt Hodson				
	Duncan Laird				
	Mark Mould				
	Pete Papworth				
	Richard Renaut				
	Paula Shobbrook				
	Joanne Sims				
	Adam Spires				
	Mark Stabb				
	Carrie Stone				
	Kani Trehorn				
	Peter Wilson				
Was the meeting quorate?		Y	Y	Y	Y

Key

	Not in Attendance
A	Apologies
D	Delegate Sent

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

POPULATION HEALTH & SYSTEM COMMITTEE ANNUAL REPORT 2023/24

1 PURPOSE OF THE REPORT

1.1 The Population Health & System Committee (the "Committee") has prepared this report for the Board of Directors. It sets out how the Committee satisfied its terms of between 1 April 2023 and 31 March 2024. The Committee seeks to provide the Board with evidence that it has met its responsibilities as set out in its terms of reference during the relevant period. This was the Committee's first year of operation.

2 MEETINGS

2.1 Five formal meetings were held during the year, all of which were quorate:

- Friday 28 April 2023
- Wednesday 14 June 2023
- Tuesday 10 October 2023
- Wednesday 24 January 2024[1]
- Monday 25 March 2024

2.2 Meeting attendance is detailed in **Appendix 1.**

3 MEMBERSHIP

3.1 In 2023-24, membership of the Committee comprised of three Non-Executive Directors, the Chief Medical Officer and the Chief Informatics & IT Officer.

Membership of the Committee in 2023-24 comprised of:

- Caroline Tapster, Non-Executive Director and Committee Chair *(until 31 December 2023)*
- Helena McKeown, Non-Executive Director and Committee Chair *(from 1 January 2024)*
- Peter Gill, Chief Informatics & IT Officer *(until 31 December 2023)*
- Stephen Mount, Non-Executive Director *(until 30 September 2023)*
- Sharath Ranjan, Non-Executive Director *(from 24 May 2023)*
- Peter Wilson, Chief Medical Officer

4 COMPLIANCE WITH TERMS OF REFERENCE

4.1 **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.**

[1] The meeting held on 24 January 2024 was inquorate for part of the meeting. All necessary decisions were taken during the time a quorum was in place.

This was the Committee's first year of operation and there were no Board Assurance Framework risks for which the Committee was assigned as lead Committee.

4.2 **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.**

As above.

4.3 **To develop the architecture to support outcomes-based population health improvement and measurement.**

In October 2023, the Chief Medical Officer presented a proposal for the delivery of population health management at the Trust. Following this, the Committee received updates in January and March 2024 on the alignment of the Trust's Patient First programme with the health inequalities workstream. It will continue to monitor this throughout 2024/25.

4.4 **To consider key population health/pathway issues and commission work from clinical groups within the Trust as appropriate, reviewing re-engineered pathways and outcomes.**

An update on the Trust's activities was reviewed by the Committee at each meeting. Throughout the year, there was particular focus on access and "Did Not Attends" (DNAs) and the "100-day challenge" programme within the Ear, Nose and Throat Department.

Initially, three particular areas would be the Trust's focus going forward: learning disabilities, inequalities in mortality and access to healthcare.

4.5 **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**

The Committee reviewed the Dorset Integrated Care Partnership Strategy in April 2023. As part of the alignment of the Patient First programme and population health management was outlined the Trust's contributions to the Joint Forward Plan and its objectives. An operational update on the Trust's activities was received at each meeting.

4.6 **To obtain assurance that the Trust has efficient processes to identify variation in outcomes, incorporating those with protected characteristics and other vulnerable groups.**

The Committee obtained assurance on the inequalities data available to the Trust through the Dorset Intelligence and Insight Service (DiiS), particularly for those metrics required as part of the NHS England statement on information on health inequalities.

4.7 **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.**

In 2024-25 the Committee will have a greater role in the oversight of the Trust's progress in becoming an anchor institution.

4.8 **To receive and review relevant reports of or relating to the Dorset integrated care system and provider collaborative.**

The Committee received and reviewed:

- The Dorset Integrated Care Partnership Strategy (April 2023)
- An update from the ICB Chief Medical Officer (June 2023)
- An ICB health inequalities update (January 2024)

4.9 **To consider and review, as appropriate, available good practices and learning from other organisations.**

The Committee reviewed and took learning from the Royal Free London NHS FT's Population Health Annual Report. In particular its programme for staff "Flourish@TheFree".
It also received an update from NHS England on the transformation programme for Core20PLUS5 for children and young people.

5 CONCLUSION

5.1 The Committee considers that it has discharged its responsibilities as noted above, subject to paragraphs 4.3 and 4.7.

Helena McKeown
Chair, Population Health & System Committee
June 2024

Appendix 1 – Attendance at Population Health & System Committee 2023/24

Population Health & System Committee		28-Apr-23	14-Jun-23	10-Oct-23	24-Jan-24	25-Mar-24
Present	Peter Gill		A			
	Helena McKeown					
	Stephen Mount	A				
	Sharath Ranjan				A	
	Caroline Tapster					
	Peter Wilson					
In attendance	David Broadley					
	Sharon Collett					
	Yasmin Dossabhoy					
	Ewan Gauvin					
	Judy Gillow					
	Siobhan Harrington					
	Charlotte Ives					
	Paul Johnson					
	Deborah Lane					
	Judith May					
	Helena McKeown					
	Richard Renaut					
	Kani Trehorn					
	Michele Whitehurst					
	Rob Whiteman					
	Ruth Williamson					
	Sandy Wilson					
Was the meeting quorate?		Y	Y	Y	Inquorate for part of meeting	Y

Key

	Not in Attendance
A	Apologies
D	Delegate Sent
	In attendance
	N/A

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

CHARITABLE FUNDS COMMITTEE ANNUAL REPORT 2023/24

1 PURPOSE OF THE REPORT

1.1 The Charitable Funds Committee (the "Committee") has prepared this report for the Board of Directors. It sets out how the Committee satisfied its terms of reference – which relate to the operation of the University Hospitals Dorset NHS Foundation Trust Charitable Funds (Charity Registration Number 1057366) (the "Charity") - between 1 April 2023 and 31 March 2024. The Committee seeks to provide the Board with evidence that it has met its responsibilities as set out in its terms of reference during the relevant period.

1.2 The Committee exists as a committee of the Trust (in its capacity as Corporate Trustee of the Charity), with the Board of Directors acting as the Board of the Trustee.

2 MEETINGS

2.1 Four formal meetings were held during the year, all of which were quorate:

- Thursday, 4 May 2023
- Monday, 7 August 2023
- Monday, 13 November 2023
- Monday, 5 February 2024

2.2 Meeting attendance is detailed in **Appendix 1.** All members attended at least 75% of the meetings for which they were eligible.

3 MEMBERSHIP

3.1 Membership of the Committee comprises three Non-Executive Directors, the Chief Finance Officer, the Chief People Officer.

Membership of the Committee in 2023/24 comprised of:

- John Lelliott, Non-Executive Director and Committee Chair *(until 30 September 2023)*
- Claire Whitaker, Non-Executive Director and Committee Chair *(from 1 October 2024)*
- Pankaj Davé, Non-Executive Director
- Philip Green, Non-Executive Director *(until 30 September 2023)*
- Irene Mardon, Acting Chief People Officer *(from 1 December 2023 to 25 February 2024)*
- Helena McKeown *(from 1 October 2024)*
- Pete Papworth, Chief Finance Officer
- Tina Ricketts *(from 26 February 2024)*

4 COMPLIANCE WITH TERMS OF REFERENCE

4.1 A review of the Committee's compliance with its own terms of reference was undertaken (by the Company Secretary Team to support the Committee) in April 2024 by scrutinising the agendas and minutes of the four Committee meetings which took place between 1 April 2023 and 31 March 2024. This evidences how the Committee has discharged each of its responsibilities:

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

The Committee monitored the application of charitable funds through the quarterly finance report.

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

The Committee made decisions in respect of the investment portfolio, considering advice from the investment manager (Quilter Cheviot). In relation to legislation, policy and guidance from the Charity Commission, recommendations of the Chief Finance Officer were taken into account. Under the Trust's Standing Financial Instructions (section 16.5), the Chief Finance Officer is responsible for all aspects of the management of the investment of charitable funds.

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

Section 16 of the Standing Financial Instructions predominantly sets out responsibilities of the Chief Finance Officer.

The Committee reviewed and approved business cases between £25,000 and £250,000 in line with the Scheme of Delegation. Where presented to the Committee, approval of expenditure from charitable funds exceeding £250,000 was recommended to the Board.

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

Performance of the investment portfolio was presented at each meeting by the investment manager (Quilter Cheviot) and monitored by the Committee. The Committee also conducted a review of the ethical positioning of the investment portfolio in August 2023. Balances of individual funds were reviewed through the standing finance report.

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

The Committee reviewed the draft annual report narrative in May 2023, followed by the full annual report and accounts in August 2023 which were recommended to the Board for approval.

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

The Committee received and reviewed the quarterly finance report. It also reviewed and approved charity recharges and the financial forecast and compliance with reserves policy in August 2023.

4.1.7 **To ensure that expenditure is controlled and utilised on suitable projects.**

The Committee reviewed expenditure and charitable funds applications through the quarterly finance report. It also considered and, if thought suitable, approved applications presented to it between £25,000 and £250,000.

4.1.8 **To establish policies and procedures to ensure the effective day to day management of the charitable funds and to ensure that these procedures are followed.**

The Committee reviewed and approved the fundraising policies in February 2024. It also approved the reserves policy in August 2023. Assurance of the effective day-to-day management of the charitable funds was provided through the quarterly fundraising and finance reports.

4.1.9 **To review detailed business cases relating to major investment decisions and to recommend investment or otherwise.**

The Committee reviewed and, if suitable, approved business cases between £25,000 and £250,000. Business cases above £250,000 were recommended to the Board for approval.

4.1.10 **To ensure legacies are realised in a timely and complete manner.**

Legacy performance was reported to the Committee through the quarterly fundraising report.

4.1.11 **To safeguard donated money.**

At each meeting of the Committee, the following were received:

- a fundraising report;
- a finance report.
- an investment portfolio update.

and the risk register reviewed and discussed.

4.1.12 **To review annually the overall fundraising strategy and fundraising projects and recommend schemes to the Board for approval.**

The fundraising strategy for 2024/25 was approved by the Committee in February 2024. Business cases were recommended to the Board where the value exceeded the Committee's delegated limit of £250,000.

4.1.13 **To enact the overall strategy, as set by the Board, on the use of the Charitable Fund.**

Progress against the fundraising strategy was regularly monitored through the Committee's quarterly fundraising and finance reports.

4.2 A governance cycle detailing which reports are to be expected at each meeting was formally reviewed and approved in February 2024. The governance cycle is attached as **Appendix 2.**

5 CONCLUSION

5.1 The Committee considers that it has effectively discharged its responsibilities as set out in its terms of reference.

Claire Whitaker CBE
Chair, Charitable Funds Committee
May 2024

Appendix 1 – Attendance at Charitable Funds Committee 2023/24

Charitable Funds Committee		4 May 2023	7 Aug 2023	13 Nov 2023	5 February 2024
Present	Claire Whitaker				
	John Lelliott				
	Pankaj Davé				A
	Philip Green				
	Irene Mardon				
	Helena McKeown				
	Pete Papworth				
	Karen Allman				
Attendees	Debbie Anderson				
	Matthew Benbow				
	Robert Bufton				
	James Creasey				
	James Donald				
	Yasmin Dossabhoy				
	Rob Flux				
	Ewan Gauvin				
	Jonathan Harding				
	Chris Hickson				
	Marjorie Houghton				
	Alex Lister				
	Helena McKeown				
	Marie Miller				
	Louise Pennington				
	Nik Ramsay				
	Isabel Smith				
	Mandy Tanner				
	Andrew Ward				
	Claire Whitaker				
	Julia Yeates				
Was the meeting quorate?		Y	Y	Y	Y

Key

	Not in Attendance
A	Apologies
D	Delegate Sent
	In attendance
	N/A

Appendix 2 – Charitable Funds Committee Governance Cycle (version February 2024)

Agenda Item	Feb	May	Aug	Nov	Goes to
Quarterly Reports					
Chartiable Funds Committee Minutes	X	X	X	X	N/A
Matters Arising - Action List	X	X	X	X	N/A
Investment Report	X	X	X	X	N/A
Risk Register	X	X	X	X	N/A
Fundraising Quarterly Report	X	X	X	X	N/A
Finance Quarterly Report	X	X	X	X	N/A
Business Cases / Charitable Funds Applications	X	X	X	X	Board Part 2 (if over £250k)
Annual Reports					
Fundraising Strategy	X				N/A
Fundraising Policies	X				N/A
Charitable Funds Committee Governance Cycle	X				N/A
Charitable Funds Committee Terms of Reference		X			Board Part 1
Chartiable Funds Committee Annual Report		X			Board Part 1
Draft Annual Report Narrative		X			N/A
Seasonal Staff Benefits		X			N/A
Annual Report & Accounts			X		Board Part 2
Charity Recharges			X		N/A
Financial Forecast and Compliance with Reserves Policy			X		N/A
Review of Investment Policy			X		N/A

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 03 July 2024

Agenda item: 9.2

Subject:	Annual Operating Plan 2024/2025
Prepared by:	Alan Betts, Director of Integration
Presented by:	Richard Renaut, Chief Strategy & Transformation 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:	All BAF Risks
Purpose of paper:	To seek **Board approval** for the annual plan 2024/5 which was approved at Trust Management Group (TMG) on 18 June 2024. Please note the draft plan was presented to Board (Part 2) on 3 April 2024. Certain sections of the plan have now been updated following receipt of the national planning guidance and completion of finance, activity, and workforce discussions with the ICB.
Executive Summary:	**National/System Update** The final submission of the Dorset ICB plan (including finance, activity, performance, and workforce) was made to the NHS Regional Team on 12 June 2024. **UHD Annual Plan 2024/25** The plan is aligned with our Patient First approach, and strategic objectives. The plan will inform all staff objectives based around the five priorities:

The following sections have been updated following the draft being presented to TMG in March 2024 :-

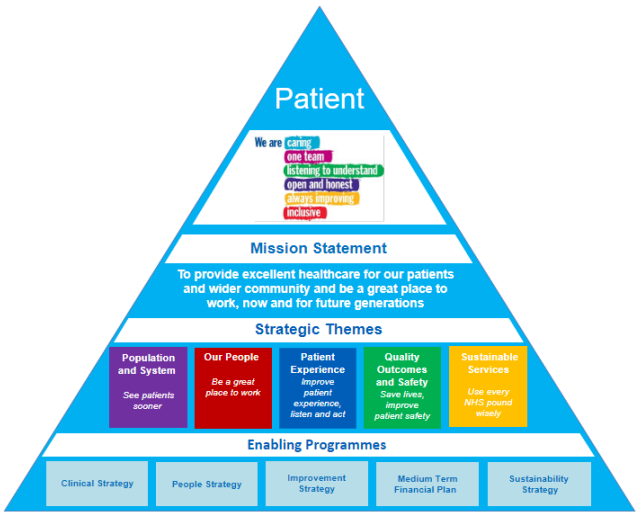
- Section 2.1(CQC) – Section updated to reflect plan for 2024/25 rather than review of 2023/24
- Section 5 (Population & Systems) – Updated to reflect targets following receipt of 2024/25 planning guidance and latest activity assumptions.
- Section 5.3 (Health Inequalities) – Updated to reflect recent system discussions
- Section 6 (Sustainable Services) – Financial Strategy section now completed following budget setting with ICB.

2024/25 Specialty Plans

The final versions are available to Board members. No plans have changed since the draft submission to TMG/Board in March & April 2024 respectively.

Background:

The Annual Plan summarises the UHD plans for a range of priorities organized under our strategic themes, and within the patient first triangle.



Key Recommendations:	(1) To note the final update on the national/system planning position (2) To note the changes to the draft plan submitted to the Board in April 2024. (3) To approve the final version of the plan.
Implications associated with this item:	Council of Governors ☒ Equality, Equity, Diversity & Inclusion ☐ 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	19 March 2024	Draft plan presented and feedback provided
Board of Directors	3 April 2024	Draft plan with outstanding sections
Trust Management Group	18 June 2024	TMG approval for plan

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 ☐

Appendix 1 – BOARD VERSION 03.07.24 : 2024/15 UHD Operational Plan (Master Version) V1.0

University Hospitals Dorset
NHS Foundation Trust

2024/25 Operational Plan: University Hospitals Dorset NHS Foundation Trust

BOARD VERSION 03.07.2024

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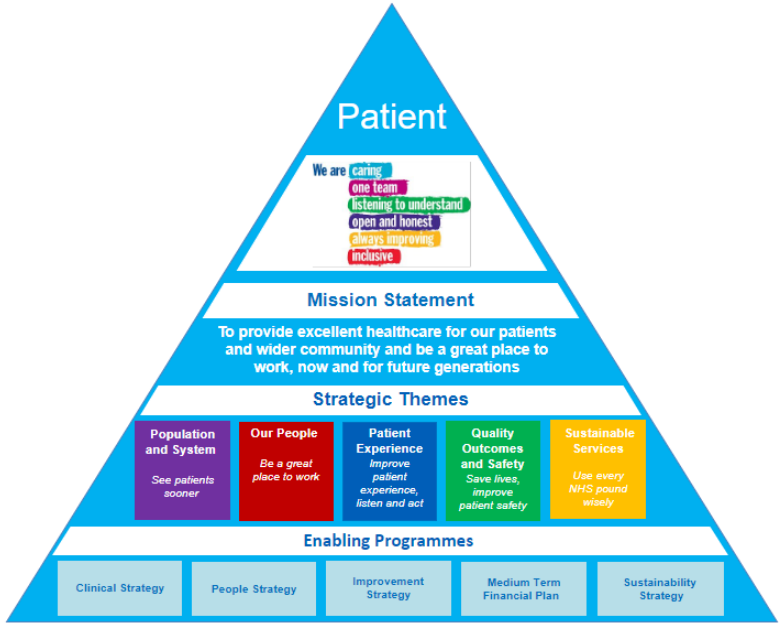
1. Foreword – A Year of Transition Ahead

As we look forward to 2024/2025 as a team, dedicated to our patients and public, there are mixed emotions. There is hope, for the exciting future we are creating, trepidation at the scale and range of challenges, and pride at the awesome staff, partners and volunteers who deliver amazing things 24 hours a day, 7 days a week.

What this plan sets out to do is provide the framework guiding our efforts to achieve our vision. This is summarised in our triangle.

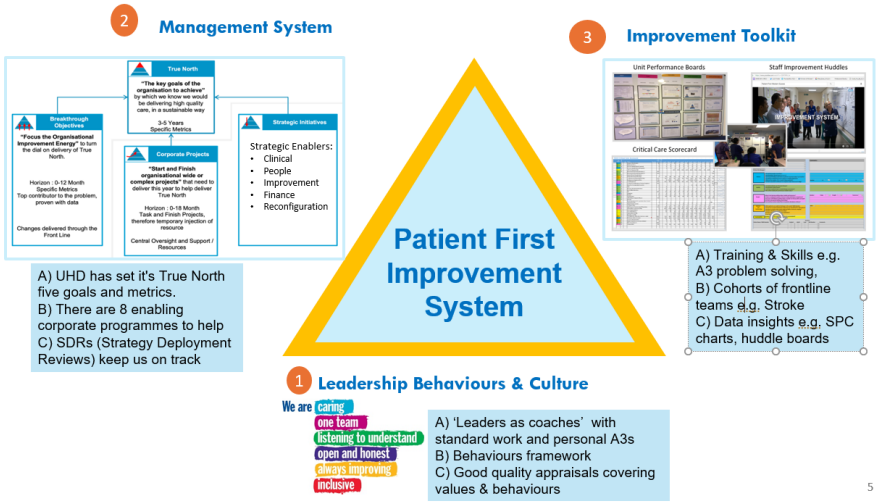


For 2024/2025 we have five objectives that every member of staff should be contributing to. These are:

It is my role as Chief Executive to ensure we create the conditions for all our staff to thrive. That way we can make real, tangible progress in all five areas. How we do that, and all the supporting plans required, are summarised in the Patient First Improvement System (PFIS) below, and in the pages that follow. As we start this year, we need a sense of curiosity. To enquire, to listen, to understand, go and see. The solutions lay with our staff and patients – where the magic happens, that makes great healthcare and a great place to work.

PFIS has three parts:

1. Living our values, and the behaviours that reinforce our Patient First approach, will be more and more about how we succeed in the future. This fits within our revamped management system.
2. Providing greater alignment and better ways of delivering major changes. Key to these are our 8 corporate projects and 10 breakthrough measures.
3. Having the tools and training for continuous improvement being deployed at scale in services.



This is a journey that will take many years, to embed our Patient First way of working. It is also accepting "better never stops". Learning from other NHS Trusts that started their similar journeys eight or nine years ago, shows we need to have perseverance and a willingness to change, along with the self-discipline and psychological safety for staff and services to thrive. With our values and twelve positive behaviours, we are set for the first full year of our exciting Patient First journey.

UHD's Values and 12 Positive Behaviors

With very best wishes
Siobhan Harrington

1.1 Background – enabling future success

University Hospitals Dorset NHS Foundation Trust (UHD) has an exciting future ahead, built upon many years of progress across a broad range of areas. These include:

- Creation of the largest planned care hospital in England by 2026.
- Creation of the major emergency care hospital, starting with the opening of the BEACH building in 2025.
- Integrated community neighbourhoods, as part of our NHS Dorset vision of Dorset becoming the healthiest place to live in the UK.
- A digital future, including an integrated electronic health record across Dorset and Somerset by 2026.
- A green and sustainable future, including 80% decarbonisation by 2030 and other targets set out in our Green UHD Strategy, including significant energy reduction investment in 2024.
- A workforce strategy, which has seen significant achievements already, including cutting our vacancies from 9% to 6%, and improvements across the board in our staff survey.
- A patient experience strategy agreed in 2024 which maps out improving our partnership with patients and listening to improve.
- Our clinical strategy, based upon the Clinical Services Review and creation of planned / emergency separation. This will be updated in 2024/2025 as part of our work to set our ambitions, by service, for the next ten years.

These form our enabling strategies to help us achieve our "True North" mission of excellent care, and a great place to work. They each have a background, based on many years of effort, and a forward looking, optimistic and ambitious approach.

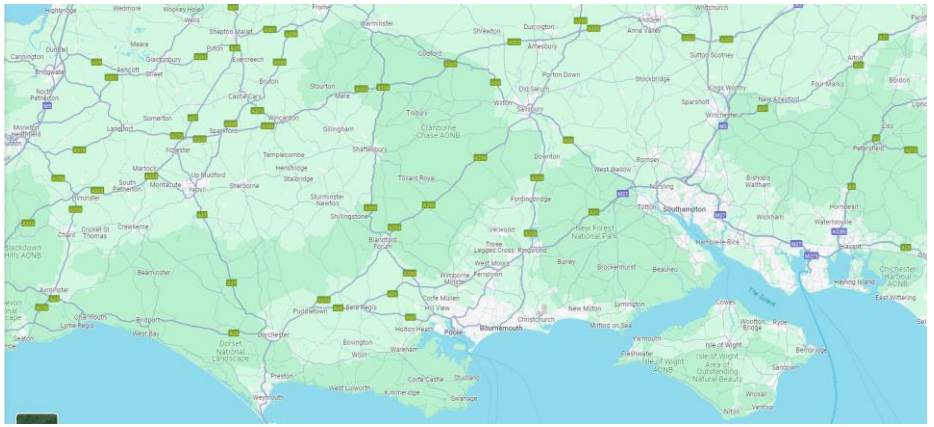
For an organisation formed by merger in October 2020, that has navigated Covid, industrial action and major construction programmes, this shows how we are both responsive to todays issues whilst also laying strong foundations for our future.

1.2 Our Trust and our communities

UHD serves Bournemouth, Poole and Christchurch, East Dorset and Purbeck, and parts of the New Forest for most hospital services. This is a population of around 750,000 with one of the most elderly populations in the UK. Significant health inequalities exist. For more information see the Director of Public Health report: (Annual report 2022-23)

Our specialist services also serve the whole of Dorset, South Wiltshire and parts of Hampshire, for a population of around 1 million. These services include Oncology, Neurology, Vascular, Cardiac and Interventional Radiology, along with specialist areas in services like Surgery.

Our three main sites are Poole, Royal Bournemouth and Christchurch hospitals. We also have services in many community setting including patient's homes. Our Outpatient Assessment Centre at the Dolphin Shopping Centre (Poole) is also popular. We then have many staff working offsite at Yeomans Way, Discovery Court and Alderney Sterile Services.



UHD employs around 10,000 staff including via our staff bank. We are blessed with hundreds of volunteers and strong partners, and have a thriving charity and allied independent charities.

All this stands us in good stead for what are significant challenges to meet the health needs of our population, which is ageing and growing, by about 1% per year. In addition the local area remains popular for 30,000+ students and over one million visitors a year.

More detail at service level is set out in the annexe.

1.3 Vision, Values and Strategic Themes

Our Vision

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

We are part of an integrated system of health and care, working towards making Dorset the healthiest place to live in England. That requires us to not just change, but transform in many ways. All our enabling strategies have this vision and a transformative ambition. Whilst this is an Annual Plan, it is a stepping stone to those positive transformations.

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

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

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

Patient First is the overarching strategy for University Hospitals Dorset. It's our guiding principle at the heart of everything that we do. It's also the long term approach we take to transforming health services. It sets out that our True North is the 'patient first and foremost'. This is supported by the values of compassion, teamwork, communication, respect, continuous improvement, and inclusion.

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

This is a journey that will take many years and includes delivery of our key strategic enabling programmes that will set us up for success. Taken together this is an ambitious plan, that will require our upmost ability and resilience to see through but is

the right thing for us to ensure we achieve putting our patients first.

Our strategic themes will support the delivery of our vision and shape our 'breakthrough' annual objectives and enabling programmes. The five strategic themes are:

Strategic Theme	Vision LONG TERM
POPULATION AND SYSTEM *Mark Mould*	Consistently delivering timely, appropriate, accessible care as part of a wider integrated care system for our patients.
OUR PEOPLE *Tina Ricketts*	To be a great place to work, attracting and retaining the best talent.
PATIENT EXPERIENCE *Chief Nursing Officer*	All patients at UHD receive quality care which results in a positive experience for them, their families and carers. Every team is empowered to make continuous improvement by engaging with patients in a meaningful way, using their feedback to make change.
QUALITY OUTCOMES AND SAFETY *Peter Wilson*	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 – HSMR) and patient safety (Patient Safety Incidents - PSIs).
SUSTAINABLE SERVICES *Pete Papworth*	To maximise value for money enabling further investment and sustainability in our services to improve the timeliness and quality of care for our patients, and the working lives of our staff.

Within the next 12-18 months we aim to achieve the following which are known as our breakthrough objectives:

Strategic Theme	Breakthrough Objective SHORT TERM: 12 – 18 MONTHS
POPULATION AND SYSTEM *Mark Mould*	• **Planned Care** - to achieve 109% weighted value elective activity against a 2019/20 baseline, including specialist advice and guidance • **Emergency/Urgent Care:** >78% of patients treated within 4 hours through the emergency care pathway
OUR PEOPLE *Tina Ricketts*	To deliver improvements in the NHS Staff Survey Results for: • "I would recommend my organisation as a place to work" > 65% • Staff Engagement Score > 7.1 / 10
PATIENT EXPERIENCE *Sarah Herbert*	• A 5% improvement in employees who see patient care as a top priority for UHD • To increase the Friends & Family Test (FFT) and Have Your Say (HYS) feedback rates by 30%
QUALITY OUTCOMES AND SAFETY *Peter Wilson*	• HSMR <100 • Improve Staff Survey safety culture questions by 5% • Implement UHD PSaF
SUSTAINABLE SERVICES *Pete Papworth*	• To fully deliver the budgeted Efficiency Improvement Programme target with at least 80% achieved recurrently

Progress has been made in 2023/2024 in these areas, but there is a long way to go. To help us get from here to there we have the following eight organisational wide and/or complex projects. They all need to deliver within 1 to 2 years to enable us to deliver our strategy. They are, each in their own right, a “blockbuster” programme with their own governance and projects. All are overseen by the Trust Management Group (TMG) the most senior operational group in the Trust.

These are covered in more detail in the specific sections within this document. Whilst the colour coding links to the primary strategic theme, all projects support multiple areas. They are therefore reinforcing each other and our transformation efforts.

Corporate Projects

1.4 Patient First and our Improvement Strategy

We are developing a culture of continuous improvement to support the delivery of our refreshed strategy and strategic priorities.

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

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

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

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

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

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

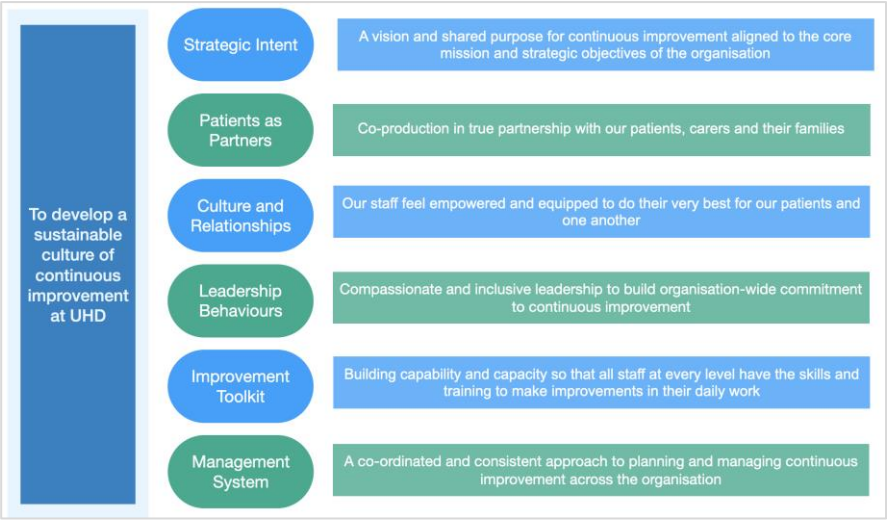
The first clinical services using this approach are Stroke, Critical Care and Christchurch Day Hospital. The next group starting in 2024 are Maternity, Paediatrics and Acute Medicine. Further cohorts of services will be selected over 2024/2025.

Patient First is the UHD Improvement Method

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

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

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



2. Patient Experience

True North Goal - Improve patient experience, listen and act	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.
Breakthrough Objectives	A 5% improvement in employees who see patient care as a top priority for UHD To increase the Friends & Family Test (FFT) and Have Your Say (HYS) feedback rates by 30%
Corporate Projects	***CQC Getting to Outstanding*** – One plan with one purpose to coordinate delivery of improvements in order that: • Staff feel they work in an outstanding organisation committed to delivery of great care. • There is structure, capacity and resilience to excel going forward • We are confident that we will be able to demonstrate we are well led.

The UHD Patient Experience and Engagement Strategy 2023-2025 sets out how the Trust will deliver the patient first objectives and guide how we will continue to meaningfully engage with patients during the continued transformation of our services.

As part of the Patient First journey, our patient experience **CARE** Priorities further expand on the trust priority of 'improving patient experience' by acting on feedback. The **CARE** priorities for the organisation are the following;

Continuous Feedback- increasing the opportunity for patients to give their views on their care and increase accessibility by using different methods to enable patients to tell us about their experiences.

Areas for Improvement- teams use this feedback to recognise and drive changes, ensuring any improvements that are made deliver the intended improvement.

Recognising People- ensuring all patients who use our services are heard, by actively seeking out their opinion through engagement with the community.

Excellent Partnerships- working with health, social and voluntary partners to understand the views of the public and work together to solve problems.

The **CARE** Priorities link to our trust values. The strategy describes what activities and measures will be taken to achieve these Priorities. During 2024-2025 it is expected that the **CARE**

priorities, set out in the strategy will be realised in full, with the outcome being outstanding care for our patients.

Clear and transparent communication with the public about the transformation of our services has been vital and will continue into 2024-2025, where plans for moving of services across UHD will be realised. The public and patients of the hospitals have been extensively involved in decision making through the Clinical Services Review engagement, but this was several years ago. Therefore, this next phase will include being informed of the changes and provided with educational materials and workshops to understand what the transformation will mean to them. Involvement includes co-designed workshops for the transformation of services e.g. stroke services. Similar involvement of our patients is planned into future transformation, which will include larger scale workshops and smaller group work for particular changes.

2.1 Care Quality Commission (CQC)

During 2023/24 the CQC undertook short notice announced focused inspections to urgent and emergency care services (Emergency Departments at Poole Hospital and Royal Bournemouth Hospital) as well as Outpatients at Poole Hospital and the Outpatients Assessment Clinic at Dorset Health Village on 27 and 28 June 2023.

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.

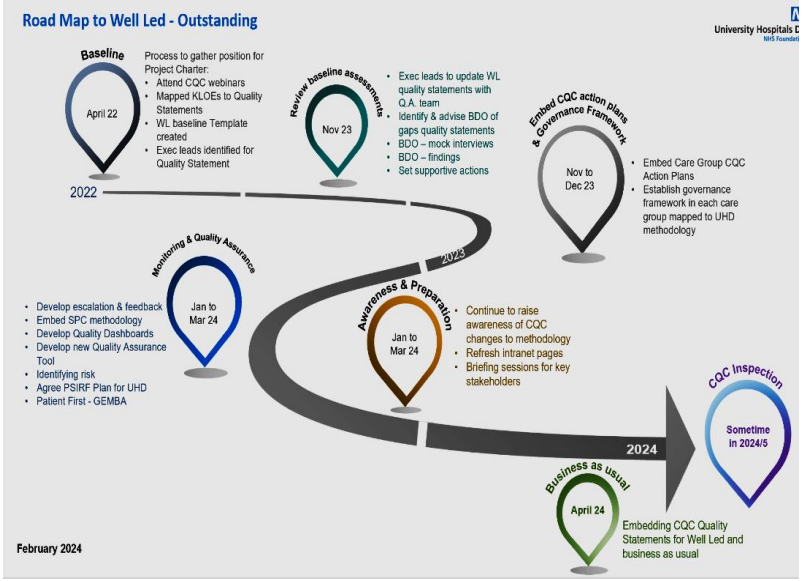
Poole Hospital remains rated 'Requires Improvement and Royal Bournemouth Hospital remains rated 'Good' overall. However, we aspire to be "Outstanding" and have established a corporate project and roadmap for success.

The project plan includes:

- Completion of a baseline assessment against the new Care Quality Commission Quality Statements for Well led
- Creation of well led action plan from the completed baseline assessments
- Provision of briefing sessions to staff to raise awareness about the new Care Quality Commission single assessment framework. Ensuring staff are aware of the new quality statements, evidence sources and assessment methodology that will be used for future inspections.
- Provision of resource materials to help teams discuss the new Care Quality Commission methodology and help teams prepare for the new style inspections.
- Utilise our Patient First work to support best practice, innovation and quality improvement
- Ensure ongoing monitoring of CQC action plans to address the issues highlighted in previous reports. The Trust Management Group and Quality Committee will

ensure oversight of effectiveness of the actions identified.

- Horizon scan reports published by external bodies such as the Care Quality Commission, NHS England and Health Services Investigations Body, to learn from others and aim for continuous improvement. External reports and reviews on our services, and the services of others, are an important part of the quality approach at UHD, and we will continue to use these to understand where further improvements to our services can be made.
- Develop and implement peer review and ward accreditation processes to support assurance against quality statements



3. Quality Outcomes and Safety

***True North Goal* – Save lives, Improve patient safety**	To be rated the safest Trust in the country and be seen by our staff, as an outstanding organisation for effectiveness (Hospitalised Standardised Mortality Ratios – SMR) and patient safety (Patient Safety Incidents – PSIs)
Breakthrough Objectives	• Reduce HSMR <100 • Improve staff survey safety culture questions by 5% • Implement UHD PSaF
Corporate Projects	***Building a UHD Safety Culture (PSIRF) –*** Developing a culture and programme plan of safety that will deliver: • PSIRF – e-learning from deaths, formal investigator and compassionate engagement training. Patient Safety syllabus • LfPSE – Learning from Patient Safety Events • Safety skills and leadership training • Business Intelligence for quality and safety ***Implementing a new electronic health record (EHR)*** - To sign a contract with an EPR vendor by 31.3.2024 that enables UHD to begin its migration off the current EPR (which is expected to take at least 2 years).

3.1 Clinical Strategy

At a high level our Clinical Strategy is to deliver the Clinical Services Review from 2019. For UHD this is the creation of the planned and emergency hospitals by 2026, supported by £500m capital investment. The programme is a once in a generation change unlocking huge benefits. Implementation is already well underway (see Transforming Care Together, section 6.3). In 2014/15 key service changes include Pathology, Haematology, Stroke and Maternity and preparations for virtually every other service affected in 2025/2026.

Looking beyond that change, the need for a clinical strategy for the next 10 years, now needs to be developed. The critical phase of work in 2024/2025 will provide the framework. Alignment with clinical strategy development across Dorset and Hampshire will be required both through and with the Dorset Provider Collaborative. This will need to start with how best to meet our populations needs and to navigate the limited resources available. Exploiting opportunities, especially in technology, research and innovation will be important.

Workforce trends and developing staff, including with education providers, will assess opportunities for Dorset, including more Allied Health Professionals and a Medical School.

The clinical strategy will need to be meaningful and owned at specialty level for it to truly shape our future. This will mean significant time, and numerous iterative stages of work before completion, expected in 2025/2026.

3.2 Building a UHD Safety Culture

The corporate projects for 2024/2025 includes ***Building a UHD Safety Culture***

- Development of a patient safety strategy for UHD which focuses on using the experiences of staff and patients to identify opportunities for learning and improvement.
- Development of an implementation and transitional plan for the new Patient Safety Incident Response Framework (PSIRF)
- Development of an integrated framework for patient safety, quality improvement, transformation and innovation that maximises resources and reduces duplication
- Development of the UHD Patient Safety Culture Assessment Tool.

The Patient Safety Incident Response Framework (PSIRF) is a fundamental cultural safety change in the way we think, report and investigate incidents. Our Patient Safety Incident Response Plan, based on the NHS framework, focuses on **learning and improvement.** It is built on a culture in which people feel **safe**

to talk, and we will be working **in partnership with patients** to improve.

With compassionate engagement, we want to:

- Improve the experience for patients and families whenever a patient safety incident occurs.
- Reduce harm from patient safety incidents through learning and improvement.
- Support compassionate leadership, just culture and learning for improvement.
- Work with system partners to undertake thematic reviews of patient safety across care pathways.
- Improve the safety and care we provide to our patients.
- Maximise our resources to support quality and safety.
- Train staff in improvement methodologies.

We will be looking for themes and interconnected causal factors. This way, we aim to reduce repeat patient safety risks and focus on the quality, rather than the quantity, of patient safety investigations. Investigations will be viewed as improvement projects with clear plans.

Our Patient Safety Incident Response Plan (approved in December 2023) set out our Patient safety priorities for Team UHD for the next 12-18 months. We will focus on**:**

- Patient falls
- Medication safety
- Hospital Acquired Pressure ulcers
- Diagnostics processes, specifically the follow up of radiology and laboratory investigations
- Deteriorating patient management
- Mental health (management and reducing restrictive interventions)
- Post-partum haemorrhage
- Unexpected term admission to neonatal intensive care (NICU)
- Still births

We aim to engage with patients, carers, relatives and Patient Safety Partners in our improvement and learning responses to patient safety incidents and we will provide training for our staff in investigation skills, report writing and compassionate engagement. We will also look to improve how we support staff involved in a patient safety incident and create safe spaces for open and honest reporting and learning. We will develop additional feedback mechanisms to share learning and improvement across the Trust and within the wider community.

Measuring and improving safety culture within teams and across the trust is a key component of our Patient First strategy and Patient First objectives.

We have adapted some of the language used in the original 2006 Manchester Patient Safety Framework tool to create a bespoke UHD Patient Safety Assessment Culture Toolkit. The UHD PSaF Tool links to the UHD Trust values and Patient First objectives and will support staff to look think about the strengths and weaknesses of the patient safety culture in their teams and consider what a more mature safety culture might look. Teams will then use patient first improvement methodology to look at areas for improvement and also to share good practice. We aim to roll out UHD PSaF across the Trust over the next 12 months.

3.3 Implementing a new PAS/EHR

The UHD Board of Directors supported a decision in December 2023 for Dorset to collaborate with Somerset Foundation Trust in order to address the affordability of achieving an Electronic Health Record Solution (EHR) for each ICS. The collaboration will bring some savings in terms of the overall costs, e.g. a single instance across the regions, staffing costs associated with the configuration effort and third party systems costs. Following National and Regional advice it has been agreed to develop a single Outline Business Case (OBC) covering both Somerset and Dorset.

The OBC will be prepared for submission to NHS England by May. There is a five-month process for approval. This should lead to the procurement commencing in Autumn 2024. Contract award should be April 2025 with implementation from October 2026.

The scope of the EHR is all the patient related IT Systems in the Acute Trusts excluding the scanned records, PACS system and Pathology system. The increased scope includes Mental Health and Community being in the same solution, with future aspirations for Primary care and Social Care to move onto the same single system.

The joint EHR Programme will deliver transformational change to digitise and modernise our technology landscape to support higher quality care. It will also be a sustainable solution. By creating a joined-up electronic heath record and harmonising our care pathways, this delivers many benefits:

- eliminate unwarranted variation and waste,
- unlock efficiencies and financial savings,
- retain, and attract the best workforce,
- deliver the best care across our services.

All these achieve better patient outcomes.

The current plans for UHD are to continue to ensure that the existing systems in the Trust are kept up to date and supported, until the new system is implemented. The following programmes of work therefore are required:

- An upgrade to the order communications system along with looking at an interim solution for closed loop result management to reduce the risk of Serious Incidents associated with pathology and radiology results.
- Expansion from the proof of concept to the next stage of deployment of the Strategic Integrated Image Solution (SIIS) as part of the south-east three diagnostics network
- A systematic rolling stock replacement of all layers of our technical infrastructure and end-user devices
- Work to achieve a fully compliant Data Security and Protection Toolkit submission will also be continued.

4. Our People

True North Goal - Be a great place to work	To be a great place to work, attracting and retaining the best talent
Breakthrough Objectives	To deliver improvements in the NHS Staff Survey Results for: • "I would recommend my organisation as a great place to work" > 65% • Staff Engagement Score >7.1/10
Corporate Projects	***Safer Staffing*** – **There is a need to establish baseline workforce data in order to improve confidence in workforce deployment, utilisation and planning** Agreed staff establishment is aligned financially and professionally Agreed process for identifying and changing future workforce and staff in post maintains currency and accuracy Systems use, Rostering process and quality assurance processes in place ensuring optimum use - including staff satisfaction Provision of management analytics to inform workforce deployment decisions and Board assurance

4.1 People Strategy

National guidance sets out the requirement to accelerate plans to grow the substantive workforce and work differently as we keep our focus on the health, wellbeing, and safety of our staff. It sets out the need to invest in our workforce, with more people tackling substantive gaps in acute care. It emphasises new ways of working and strengthening the compassionate and inclusive culture needed to deliver outstanding care. Our people have remained under increasing pressure and have also been impacted by the cost-of-living crisis, workforce capacity issues and a need to focus on the large-scale integration and transformation plans that UHD have in place.

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

Our overarching ambition and True North goal is to be within the top 20% of acute Trusts for the National staff engagement score along with increasing the number of staff who would recommend the organisation as a place to work. This will support us to improve our people's experience and ensure the Trust is a great place to work, attracting, developing and retaining the best talent.

We know there remains a shortfall of trained people to meet the rising demands for healthcare. We will need to be more flexible, creative and innovative in how we attract, retain and develop our people. This then enables us to fulfil our core purpose and achieve our vision. A key focus on workforce planning. Our work continues to be underpinned by the principles of the NHS Long Term Plan, the CQC Well Led domain and the NHS People Plan.

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

Key Actions for 2024/25:

Compassionate and Inclusive Leadership

We will continue to place health and wellbeing at the heart of our line manager's duties, encouraging them to have meaningful conversations, giving feedback and communicate clearly and consistently about expectations and objectives. Ensuring the strong voice of staff is essential to ensure their involvement and innovation. We recognise colleagues that most need help are the most unlikely to speak up. We will also continue to face the inequalities agenda head-on, with a particular focus in 2024/25 on improving key Workforce Race

Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) indicators.

Key actions:

- Continue focussed work on the Trust's cultural development programme to embed organisational values and ensure the voice of our staff continues to be heard.
- Launch our new online *Thank You* tool, and a new annual staff award event to show staff how proud we are of everything they do for UHD.
- Continue focus on supporting our managers to have valued based appraisal conversations with a focus on individual development and aligning objectives to the Trust's True North.
- Further integrate our leadership and lifelong learning offers for staff including apprenticeship and accreditation opportunities in partnership with Bournemouth University and further developing a modular programme to support basic people management skills and competencies.
- Develop a Talent Management strategy aligned to *Patient First* and the needs of our workforce – a co-ordinated approach to attracting, developing and retaining our staff and harnessing their potential
- Review the 2023 staff survey results at team, directorate and care group level and design improvement interventions, including:
    - increase in % BAME composition target to improve leadership diversity by 2025
    - improvements in our Black, Asian and minority ethnic disparity ratio
    - continue to implement priorities within our *Leading for Equality, Diversity and Inclusion* plan and health inequalities within our staff groups.
- Continue to enhance staff network engagement and intersectionality to strengthen contribution to organisational decision-making process.

Systemic Wellbeing Offer

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

Key actions:

- Further develop our Mental Health First Aid (MHFA) and Wellbeing Ambassador programmes.
- Embed a range of targeted resources, education and support for line-managers.

- Increase proactive health and wellbeing initiatives enabling staff to remain well at work.
- Review “hotspots” of MSK injury-reviewing processes and working patterns and continue to work closely with the ICS MSK team.
- Embed a speaking up culture and remove any barriers staff may face, through the support of our Freedom to Speak Up Guardians and ambassadors. To help support our leaders build working environments that are psychologically safe and based on respect and civility.

4.2 Workforce Planning and Data

Workforce Planning, Recruitment and Retention

During 2024/25 we will continue to focus on Workforce Planning by generating information, analysing it to inform future requirements of staff and skills and translating that into a set of actions that will develop and build on the existing workforce to meet UHD’s future resource requirements. Planning will also reflect patient pathways and care of the future.

Corporate Project – Workforce Baseline Data

We will ensure:-

- Agreed staff establishment is aligned financially and professionally
- Agreed processes for identifying and changing future workforce maintains currency and accuracy
- There is a provision of management analytics to inform workforce deployment decisions and Board assurance

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

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

5. Population and Systems

True North Goal - See patients sooner	Consistently delivering timely appropriate, accessible care as part of a wider integrated care system for our patients.
Breakthrough Objectives	**Planned Care** - To achieve a minimum of 109% weighted value elective activity against a 2019/20 baseline, including specialist advice and guidance. **Emergency/Urgent Care:** >78% of patients treated within 4 hours through the emergency care pathway. Stretch target: • To have no patients waiting in excess of 52 weeks on an RTT pathway to be seen or treated by March 2025.
Corporate Projects	***Planned Care Improvement Programme*** To coordinate delivery of improvements in planned care in order that we meet patients' expectations and national constitutional standards for planned care and reduce inequalities in outcomes and access for patients whilst improving productivity and value. ***Hospital Flow Programme*** Single plan to coordinate delivery of improvements in Urgent and Emergency Care that will meet the constitutional standards for Urgent and Emergency Care and reduce inequalities in outcomes and access for patients whilst improving productivity and value.

Overarching aim:

Our True North goal for our Systems and Partnerships is to consistently deliver timely appropriate, accessible care as part of a wider integrated care system for our patients. For planned care our 2024/25 breakthrough is to achieve a 109% weighted value elective activity against a 2019/20 baseline, including specialist advice and guidance, and for emergency care that 78% of patients are consistently treated within 4 hours in Emergency Care Services.

How to achieve this:

We will plan to increase the amount of elective activity we undertake compared to 2019/20. Our Planned Care Improvement Corporate Project is helping us focus our efforts to achieve this.

In the challenging context of recovering services following the COVID-19 pandemic and continuing high demand for hospital services, we are working to achieve these targets by first ensuring that no patients wait in excess of 65 weeks on an open RTT pathway by September 2024 and in excess of 52 weeks by March 2025. Our breakthrough objective for Emergency/Urgent Care relates to reducing the number of patients waiting in our emergency departments in excess of 4 hours to be treated and either admitted or discharged. Our Hospital Flow Programme supports the work needed to achieve this.

Our population and system goals are also supported by our Transforming Care Together programme. This is a £501million capital investment programme that includes the establishment of the Bournemouth Emergency Hospital and Poole Planned Care Hospital in December 2025.

5.1 Planned Care

Our Planned Care Improvement Programme focuses on knowing what our population needs and delivering the best care and support to our population within the facilities, budget and workforce available. This covers patients requiring cancer treatment, outpatient care, patients needing surgery, diagnostic and therapy services. To see or treat people in a timely way we need to fully understand the demand for services through a fully validated waiting list and referral data, and what productive capacity we will need to meet this demand.

The planned care programme is closely aligned to the Hospital Flow programme ambitions to reduce the average length of stay, bed occupancy and the number of patients in hospital with no criteria to reside. It is also aligned to the ICP three strategic priorities: prevention and early help, thriving communities and working better together.

Planned care - Activity

Guidance issued by NHS England in 2023/24 asked the Trust to seek to increase activity levels to above those we delivered in 2019-20 levels, to increase the amount of day case activity, improve our use of theatre capacity, and to free up slots for outpatient treatment by reducing unnecessary follow-up treatment. This remains the ask in 2024/25. This table summarises how the Trust performed against this ask and the level of activity we are committed to delivering in 2024-25.

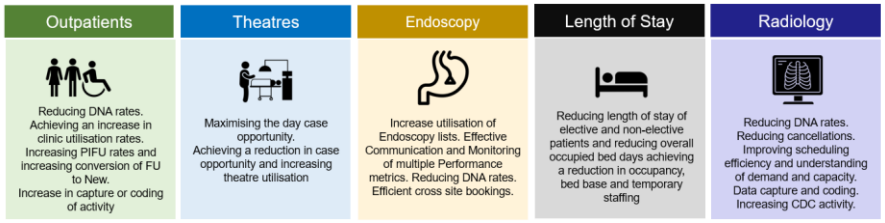
Activity Type	2019-20 Baseline	2023-24 Forecast outturn	2023-24 % Increase	Planned % Increase 2024/25
Ordinary spells	12,837	13,202	13,587	105.8%
Day cases	84,630	77,771	90,382	106.8%
Outpatient procedures	71,743	71,753	73,853	102.9%
Outpatient first attendances without a procedure	198,425	209,940	212,685	107.2%
Outpatient follow up attendances without a procedure	295,290	281,511	305,714	103.5%

How we will achieve it:

The Trust plans to increase its planned care activity by:

- Increasing productivity of services to operate within existing capacity. The Trust has identified five areas of

focus: outpatients, theatres, endoscopy, reducing length of stay in hospital and radiology.



- Increasing the provision of High Volume Low Complexity (HVLC) outpatient clinics and theatre sessions. This will include HVLC pathways for upper limb surgery in trauma and orthopaedics and expansion of HVLC pathways in ENT, Oral Maxillofacial Services and Ophthalmology.
- Continuing to reduce unwarranted variation in clinical standards and outcomes through the adoption of best practice outlined in the Getting It Right First Time (GIRFT) programme. This includes implementing a day case arthroplasty pathway and reducing length of stay for hip and knee replacements. The Trust will also seek to rapidly adopt best practice outlined through the Further Faster programme speciality handbooks where it has not done so already.
- Full implementation of National evidence-based intervention guidance to improve the quality of care being offered to patients by reducing unnecessary interventions and freeing up resources that can be put to use elsewhere.
- Increasing the use of one-stop ambulatory pathways supported by diagnostic teams.
- Enhancing use of the Outpatient Assessment Centre, in Poole and efficient use of theatre capacity including transfer of activity and capacity from Wimborne to UHD Theatres. We will also improve efficiency and utilisation in the Cardiac Cath Labs via scheduling improvements.
- We will continue the work started in 2023-24 to ensure we meet national standards on data quality and that all inpatient, outpatient and day case activity is suitably recorded and reported against.

With the support of the Clinical Acute Networks Dorset (CANDo) programme, we will work with Dorset County Hospital and other relevant partners to improve the resilience and sustainability of services by:

- Implementing a single service across Dorset for Orthodontics and Rheumatology.
- Increase the frequency of HVLC cataract lists and increased Glaucoma follow ups.
- Establish Networks across nine specialities, including Gastroenterology, Ear, Nose and Throat Services, Gynaecology, General Surgery, Urology, Trauma & Orthopaedics, Dermatology, Ophthalmology and Respiratory

- Establish a single Orthopaedic hand service across Dorset.
- Designing and implementing a community-oriented model for Dermatology.
- Optimising treatment in acute care for Respiratory.

Planned Care – Referral to Treatment Times

National planning guidance sets out that patients waiting more than 65 weeks should be seen by September 2024 and one of the stretch ambitions within the Trust is to eliminate waits over 52 weeks by March 2025.

How we will achieve it:

In 2023-24 the Trust improved its referral to treatment times and has significantly reduced the numbers of patients waiting more than 65 weeks for planned care. The number of patients who potentially would wait over 65 weeks if not seen in the year reduced from just over 40,000 to below 330 between April 2023 and March 2024.

The Trust plans to achieve zero patients waiting more than 65 weeks for treatment or outcome by September 2024. Our modelling of our capacity to reduce 52 week waits, including the impact of increased productivity and increasing planned care activity, indicates that the Trust will not reduce these to zero by March 2025 without delivering more activity. The Trust would need to exceed the national activity targets to be able to deliver this, such that Trust plans to deliver 109% of the baseline (2019/20) activity in 2024/25 to bring about a reduction in waits exceeding 52 weeks.

We will achieve this reduction by implementing efficiency and productivity improvements. This will include, ensuring only the patients who need our services are referred, effective management of referrals, outpatient and diagnostic clinic capacity, follow up (including increasing patient initiated follow up pathways) and discharge. We will also work to reduce lost capacity through missed appointments.

In theatres, we aim to reduce our dependency on agency staff and insourcing/outsourcing by encouraging workers back into substantive and bank roles. The Trust aims to deliver an improvement in the time our surgeons spend operating by increasing theatre utilisation rates to be in line with national best practice at 80% by March 2025, moving to 85% in some specialities. The number of theatre sessions run will also increase returning to 93% against the template operating in 2019/20.

We forecast that there will be areas where increased productivity alone will not deliver the reduction planned in the waiting list or the length of time patients wait. In these areas, we will consider ways of investing that delivers the best value for patients.

We will ensure waiting lists are validated achieving 90% validation of pathways greater than 12 weeks, supported by the

expansion of digital first validation. The Trust developed an RTT waiting list management training programme for staff in 2023-24 and will continue to roll this out in 2024-25 to promote evidence based best practice.

Diagnostics and Community Diagnostic Centres

The national planning guidance requires trusts to maximise the roll out of community diagnostic capacity with new community diagnostic centres (CDCs). Trusts are also asked to increase the percentage of patients that receive a diagnostic test within six weeks compared to 2023/24; to 95%.

The Dorset CDC Programme is responsible for rolling out additional diagnostic across Dorset in line with the 2020 Richards' Review and Dorset's strategy for delivery. Over the last 12 months the Trust has made progress in the following areas:

- Ultrasound, Dexa scanning and phlebotomy services have commenced at the Outpatient Assessment Centre, Poole.
- We have increased colposcopy services, delivered additional endoscopy (including Cytosponge and TNE) and increased CT capacity in Poole hospital.
- Mobile MRI services in AECC, Boscombe are in place until end of March 2024.

In 2024/25 the Trust will continue its roll out programme to increase diagnostics capacity by:

- Completion of AECC, Boscombe CT and ultrasound room build in order to deliver an increase in capacity.
- Provision of additional Echocardiograms, MRI and familial health breast surveillance capacity at Poole.
- Provision of additional fibroscan capacity at the Outpatient Assessment Unit, Poole.
- Completion of an endoscopy modular build at Poole by 2025.
- Roll out of tele-dermatology pre and post referral pathways across all CDC sites.

The increased capacity will provide additional diagnostics in a range of locations across Dorset enabling a reduction in wait times for tests and development of one stop clinics.

Two of the CDC sites in Dorset are in known areas of deprivation, thus providing tests closer to home and supporting a reduction in health inequalities.

Transforming Outpatient Care

The planning guidance sets out continuing to further improve outpatient services. Trusts are also asked to increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff. For UHD this target is 49% across 2024/25

How we will achieve it:

The overarching aim is to work towards operating models, capacity and scheduling that deliver clinically effective and efficient outpatient care and reduces waiting times across our sites, optimising opportunities for transformation that includes digital models of care and better space utilisation. The Trust will achieve this by:

- Continuing to deliver safe, high quality patient care for our outpatients and scaling up on actions to reduce health inequalities in patient access and experience of outpatients.
- Providing a sustainable nursing, administrative and Phlebotomy workforce now and into the future.
- Digitally transforming services that will enable improved patient access and experience, and responsive and effective ways of working, increasing productivity and workforce retention. This includes moving to paper free booking methods, expanding the use of DrDoctor patient facing digital capabilities including the coverage of text reminders, video consultations and implementing two-way bookings. The Trust will roll out e-outcomes for capturing the outcomes of clinics and e-assessment pathways.
- Optimising clinic templates and clinic room utilisation, supporting elective recovery plans.
- We will continue to support a reduction in the number of patients waiting a follow up appointment through validation and increased clinic utilisation.
- Providing a more personalised approach to outpatients by expanding the use of patient-initiated follow-up (PIFU) to all major outpatient specialties, moving or discharging 5% of outpatient attendances to PIFU pathways by March 2025.
- Using an approach to understanding where efficiencies in our outpatient processes can be made through deploying process mining and intelligent workflow analysis.
- Increasing the reach of Specialist Advice and Guidance (Vascular, UGI) and reducing response times to ensure General Practitioners receive advice when they need it and to reduce referrals into secondary care.

Timely Access to Cancer Care

The Trust continues to work as an integral part of the Dorset ICS Cancer Programme alongside the Wessex Care Alliance (WCA) to ensure key priorities are met in the national planning guidance.

The national planning guidance specifies for Trusts to recover the 62 Day Standard to 70% by March 25 and for the 28 Day Faster Diagnosis Standard to achieve 77% by March 2025.

We will also maintain the number of people waiting no longer than 62 days (including 104 backstops) below 220 patients (nationally agreed target in 23/24).

How we will achieve it:

In 23/24, UHD signed up to the Cancer Recovery and Improvement Programme that was led by the Dorset ICS Cancer Programme to recover cancer performance to meet the national targets, whilst implementing new and best practice pathways to support rapid diagnosis and treatment.

For 24/25, the programme is moving away from 'recovery' internally at UHD, to a programme of sustainability and improvement across the entire remit of Cancer Services.

The priorities for 24/25 consist of sustaining the performance priorities whilst working to meet the requirements in the planning guidance. The following pillars make up the wider Cancer Improvement Programme at UHD to aspire towards becoming a Centre of Excellence for Cancer:

- Developing a Clinical Strategy for Cancer as the 12th large treating hospital in the UK.
- Articulating and supporting our cancer workforce to be fit for the future.
- Transforming MDT meetings and processes to maximise digital opportunities and to use our clinical resources efficiently.
- Quality, Safety and Patient Experience – driven through the development of the Personalised Care programme.
- Work collaboratively with the ICS to confirm commissioning and financing arrangements for the future.
- Establish the Cancer Improvement Programme at UHD
- Appoint a Clinical Director for Cancer Services
- Implement the Best Practice Timed Pathways, including maintaining priority pathway changes for prostate cancer.
- Fully implement Tele-dermatology
- Develop and embed process to identify and support patients on an open cancer pathway who are impacted by health inequalities.
- Grow links with the VCS to enhance experiences for patients and to support clinical teams.
- Ensure the counting and coding opportunities are maximised for new work such as Personalised Stratified Follow Up (PSFU) pathways.
- Roll out Rhabdomyosarcoma (RMS) treatments to Lung, Thyroid, Renal and Skin if there is agreement for sustainable commissioning of this service.

5.2 Hospital Flow Programme

Key Challenges

Long waiting times in Emergency Departments have a potential to cause harm and a negative impact on patients and staff experience. This increases risk across the organisation of a longer length of stay in hospital, less access to care by our community and Ambulance waits at our front door. Our patients have an expectation and constitutional right to receive Urgent and Emergency care in line with National Standards, and our Trust along with every other hospital, is challenged to deliver these standards consistently. These standards are

agreed by clinical experts who evidenced receiving care in a timely manner improved quality of care and mortality rates and will increase staff morale and experience.

The creation of the emergency hospital in 2025/2026 is a major step towards meeting these challenges. Planning for transition to the new configuration of services is where this programme and Transforming Care Together are joined up.

At any time, more than 20% of UHD beds in 23/24 continued to be occupied by patients that have No Criteria to Reside (NCtR) in hospital but who have an ongoing health or social care need that requires support. UHD has remained one of the most challenged Trusts for the numbers of patients wating to leave that no longer require a hospital bed. This may delay physical rehabilitation or support to undertake daily activities at home. The lack of availability of resources to care for people out of hospital often delays patients' discharge, sometimes for a considerable period. This pressure is felt throughout the Urgent and Emergency Care Pathway, and manifests as increased bed occupancy and increased escalation beds being opened (planned and unplanned surge beds). At its worst it results in crowded Emergency Departments and delayed Ambulances in the departments.

In 2023 UHD returned to reporting the 4-hour standard as the key Emergency Department metric. Previously UHD had been part of a national pilot for a different set of metrics set by NHS England. This change of metrics has embedded through 2023 in to 2024. Achievement of 76% of patients being seen and discharged from the Emergency department within 4 hours is proving challenging to achieve. Work will continue through 24/25 towards achieving and increasing performance against the 4-hour standard.

The challenges faced by UHD are not unique and sites with Emergency Care Pathways throughout England are facing similar issues. The most recent National UEC Delivery Plan for Recovering Urgent and Emergency Care Services was published at the end of January 2023 and links with plans for the NHS with those of the Department of Health and Social Care. Many of the actions in the National UEC Delivery Plan for Recovering Urgent and Emergency Care Services focus on challenges and factors outside of the Acute Hospital. While the Dorset ambition to reduce NCtR by 50% was not achieved in 23/24 UHD remains committed to working as part of the Integrated Care System and with our partners from Local Authorities and other sectors to achieve the benefits for our patients as laid out in the plan.

For the in-hospital actions the previous UHD Hospital Flow Improvement Group became the Urgent and Emergency Care (UEC) programme board in October 2023 and refreshed its Terms of Reference to meet fortnightly to oversee plans to deliver productivity and transformational change to support the

delivery of the 4-hour standard and UEC pathway improvements. The UEC programme board reports to our Executive led Trust Management Group. There are four Key Lines of Enquiry:

- 4-hour Safety Standard,
- efficient hospital pathways,
- discharge, and
- operational flow.

These report to a single steering group. Each workstream is led by a senior team that are accountable for delivering transformational change required to achieve the National UEC Delivery Plan for Recovering Urgent and Emergency Care Services.

Risks and Issues

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

Assumptions

- Dorset system plans to achieve 50% reduction in NCtR is achieved.
- UTCs are funded and are developed to fully integrate into the core Urgent and Emergency Care front door in 2024/25
- Transformation initiatives and funding support for schemes will facilitate deliverables, safe care and progress against key standards.

Patient Flow & Bed Capacity

In 2022/23, investment was made in key areas to improve flow and increase inpatient capacity. Funding for 23/24 was minimal and provided a small element of escalation bed funding. In 2023/24 the teams enhanced and developed services with SDEC services across both sites, introducing highly successful Departure Lounges, and recruitment of Discharge Facilitators. In 2024/25 our teams will continue to develop schemes to improve productivity and efficiency in patient pathways, for both elective and emergency patients. This also puts us on the trajectory for the reconfigured planned / emergency hospitals.

Underpinning the Trust's surge and capacity planning is our bed modelling. The UHD bed modelling tool is being adopted

by the Dorset system in 24/25 to underpin the overall capacity requirements for Dorset and adopt system wide assumptions. UHD used high levels of 'escalation' beds, above core for initial months post winter pressures, at considerable cost. A key assumption in our modelling, as well as our bed gap mitigation plans, is the role of the system-wide community capacity and the Discharge to Assess (D2A) programme. In addition to supporting our system-wide work, internally, our focus is on planning for discharge from admission and Pathway 0 discharges, which form 88% of all discharges daily.

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

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

Discharge to Assess (D2A)

The Dorset system implemented a simplified discharge pathway in 23/24 which continues to embed. This is supported by a Discharge to Assess (D2A) model for those patients who are unable to be discharged to their usual place of residence due to new care needs. The model aims to optimise patient rehabilitation and recovery and complete assessments for their longer term needs outside of the acute hospital. 23/24 has seen challenges as patients have not moved through the D2A pathway as efficiently as planned or required for a successful impact to be felt at UHD. Delivery of this model remains a priority for the Dorset system for 24/25.

Key Benefits once achieved

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

Further system-wide improvement work includes:

- Ensuring flow through the D2A capacity and that it does not become blocked.
- Continuing to expand community capacity.
- Review of pathways and commissioning for complex and specialist patient needs.
- 'Front door' pathways for unnecessary admission avoidance.
- 7-day discharge planning and discharges – UHD now have a 7-day service but this is not in all providers.
- Transport services that support discharge, a new transport provider will be announced in 24/25 for routine transport.
- Planning for the high level and increasing number of frail older patients in Dorset, including over 85s.

Discharge Planning – Planning to leave from point of admission

Our internal work on early planning and reduced discharge delays is being driven by our Urgent and Emergency Care (UEC) programme board. The workstream's next phase of work is focused on:

- Estimated Date of Readiness (EDR) - rollout of our Best Practice Toolkit for early and effective discharge planning and processes, supported by developments to our Health of the Ward bed management system. This aims to optimise the time our patients spend in our hospitals, reduce long lengths of stay, increase P0 discharges and provide early information to our system partners to support discharges and capacity planning.
- Developing pathways and processes on our wards that support the Discharge to Assess (D2A) model.
- 7-day discharges/discharge planning so patients are discharged when they are medically optimised.
- Streamlining assessment and referral pathways including the development of digital solutions that release time to therapy.
- Develop our Health of the Ward bed management system as central conduit for digitally sharing timely information and to support our data driven intelligence and reporting internally, across the system and nationally.

Risks and Issues

- Demand (non-elective and/or elective) exceeds bed modelling scenario assumptions.
- 'Staycations and visitors to Dorset result in surge demand at peak periods.
- Increase in the number of patients ready to leave requiring step down to community services.

- Discharge to Assess capacity and pathways are unable to deliver further reductions in Length of Stay to offset the acute bed capacity gap.
- Workforce gaps, particularly in therapy and care capacity, impacting on service and system delivery.
- Inability of system partners to meet demands on services – health and social care out of hospital.

5.3 Health Inequalities

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

In 2023/24 we sought to strengthen our use of population health management to narrow the gap in health inequalities and improve health outcomes. We built on work to proactively identify the health inequalities of our population to inform service design and policy development. Our Population Health and System Committee of the Trust Board was established to support the Trust in achieving its strategic objective, to transform and improve our services in line with the Dorset ICS Long Term Plan.

In 2024/25 the Committee will continue to do this through:

• Providing oversight of the implementation by the Trust of its responsibilities pursuant to the system Making Dorset the healthiest place to live - Joint Forward Plan: 2023-2028.

• Assisting the Trust's Board of Directors in its oversight of achievement of breakthrough objectives and strategic initiatives relating to population health and health inequalities.

• Receiving and reviewing information and data relating to population health and health inequalities and reporting to the Board.

We will frame our vision for addressing health inequalities around: patients and families, our workforce and our leaders. This will include:

- A focus on reducing variation in access to elective health care and reducing Hospitalised Standardised Mortality Ratios (HSMR). We will take a particular focus on Children and Young People in reducing DNA rates in our ENT services.
- Ensuring accessible information related to care and treatment. Including ensuring our Transforming Care Together programme considers accessibility and signage.
- Building on our patient experience and community networks in co-designing improvements; including capturing the views of our staff living in Dorset.
- Embedding health inequalities in our Patient First methodology for improvement.
- Reviewing our Equality Impact Assessment to ensure it comprehensively considers the impact on health inequalities.
- Expanding opportunities for staff to access training on health inequalities and building an informed workforce that understands their role in reducing health inequalities. We will also work with the ICS to develop a

communications plan to support staff to deliver public health messages.
- Increasing our staff's access and use of data to better understand unwarranted variation.

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

- Against the 24 Domains introduced in NHS England's statement on information on health inequalities published in November 2023, we will make available in our Annual Report an assessment of variation and identify the areas requiring strengthening.
- Working in partnership with the system and its health inequalities delivery programme, we have identified data as a priority, including further rapid development of indicator definitions for the collection above and development of dashboards in relation to the Core20Plus5 national framework for adults and children.
- We will use this data to identify the needs of our communities' experiencing inequalities in access, experience and outcomes in relation to their health, so that we can respond with tailored strategies for addressing inequalities and track the impact of these strategies.

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

Building on the work undertaken in 2023/24 to evaluate the impact of elective recovery plans on addressing pre-pandemic and pandemic-related disparities in waiting lists we will continue to spread the learning to date to other prioritised cohorts. Including a focus on reducing DNA rates and increasing health literacy.

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

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

6. Sustainable Services

True North Goal - Use every NHS pound wisely	To maximise value for money enabling further investment and sustainability in our services to improve the timeliness and quality of care for our patients, and the working lives of our staff.
Breakthrough Objective	To fully deliver the budgeted Efficiency Improvement Programme target with at least 80% achieved recurrently.
Corporate Projects	***Efficiency Improvement Programme (including One Dorset Procurement***) – Full delivery of planned CIP targets, with at least 80% achieved recurrently ***Transforming Care Together Programme (Build Ready and Service Ready Programmes) -*** **Build ready:** • Completion of BEACH building • Completion of NHP funded Wards and Theatres • Completion of associated enabling works • Completion of Poole's new Endoscopy Unit **Service Ready:** • Teams Integrated, new clinical models in place. • Move plans implemented and services safely moved. **Staff Ready:** • Engagement • Workforce planning

6.1 Financial Strategy

Locally, the Dorset Integrated Care System continues to operate under significant pressure, with high demand for urgent and emergency care services, and a significant number of patients in acute hospitals who are medically ready for discharge. At the same time, there is a continued focus on recovering the backlog of elective patients who are waiting too long for their operations. Within the Trust, both Emergency departments continue to operate under extreme pressures; and we continue to care for over 200 patients who no longer require acute care but are unable to be safely discharged due to a lack of available step-down care. As a result, we continue to operate at Operational Pressures Escalation Level (OPEL) 3 with bed occupancy frequently exceeding 100%.

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

Revenue

Considerable financial planning and detailed financial modelling has been undertaken within the Trust. This reflects the national planning guidance together with the agreements reached within the Integrated Care System in relation to the distribution of funding across partner NHS organisations.

Whilst the plan reflects a financial break-even position, a number of financial risks remain which could, if unmitigated, drive an in-year deficit. The most significant risks are:

- An efficiency requirement of 5% has been included within the Trusts budget, equating to £42m. Good progress has been made in identifying and developing plans to achieve this, however, there remains a shortfall of £10m representing a risk to the achievement of the plan overall.
- Recovering elective services to the required and budgeted 109% threshold may cost more than the funding available, or funding may be clawed back for failing to achieve this threshold. This could present a risk of circa £7.5m.
- The plan assumes that the Trust will operate within 20 funded escalation beds. During the last 12 months an average of 65 have been required peaking at 115 in January. Improving the timely discharge of patients who

no longer require acute care will be vital in mitigating this risk.

- Pay costs have been budgeted based on the substantive cost, with only a small amount budgeted for the premium cost of agency cover. If the current agency expenditure run rate continues there is an additional risk of up to £5 million.

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

Capital

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

This very significant and ambitious programme totals almost £0.5 billion with budgeted spend of £166 million during 2024/25 (assuming final approval of the New Hospitals Programme business case) comprising three key elements:

- Estates Development (section 6.2);
- Digital Transformation; and
- Medical Equipment replacement programme.

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

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

Cash

The trust continues to hold a significant cash balance which has been strategically built up over many years and is fully committed, supporting the medium-term capital programme.

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

2024/25 Financial Priorities

The Trust's absolute priority during 2024/25 is to deliver within its agreed budget. Achieving this will reduce the underlying recurrent revenue deficit and support the vision to return to recurrent financial balance from 2026/27.

6.2 Transforming Care Together Programme

The existing healthcare facilities in east Dorset are insufficient to cater to the rising healthcare demands of our ageing community. To ensure access to timely, high-quality healthcare services for our residents, we need to transform services and separate planned and emergency care per the Clinical Services Review.

This requires the planning and construction of the £201m BEACH (Births, Emergency care, And, Critical care and child Health) building and £262m NHP funded wards and buildings on the Bournemouth Hospital Site to create the Emergency Hospital. On the Poole Hospital site, new theatres, wards and a new Endoscopy building will create the Planned Care Hospital. This modern, fit for purpose estate will have advanced construction, adequate bed capacity, and the capability to offer comprehensive healthcare services.

These changes will help to meet the needs of our population and deliver the overarching benefits of improved outcomes due to centralised emergency and specialised services, shorter waiting times, reduced cancellations and clinical/financial sustainability.

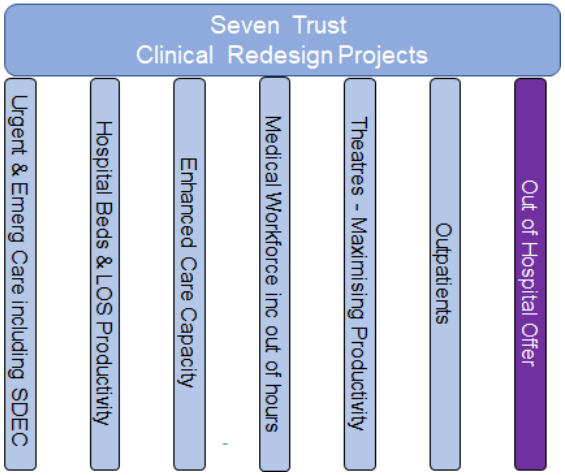
Our Transforming Care Together Programme will be delivered by our Service Ready and Build Ready projects.

Service Ready

Establishing the Planned and Emergency Hospitals means changes to the majority of our clinical services. Our scope is made up of:

- 7 clinical redesign projects
- 23 specialties going from two teams to one
- 31 specialties moving site
- 3 teams going from single site working to split site planned / emergency

Our clinical redesign projects are outlined below:



This will necessitate the development of new clinical and operational models and the integration of teams where the same service is currently supplied over different sites.

Our headline dates for the movement of services are outlined below:

- Phase 1 - Q4 2023/4 & Q1 2024-5: TIU, Haem, Surgical moves, Pathology hub opens
- Phase 2 – Q1 2025/6 – BEACH opens, Maternity, RBH-CC and RBH-ED move
- Phase 3 – Q3-Q4 2025/6 – Planned and Emergency separation
- Phase 4 – Q3-Q4 2026/7 – Final moves and completion

The Transforming Care Together programme will deliver:

1) Clinical excellence delivered from fit for purpose estate
2) Improved patient safety and infection control
3) Shorter waiting times and reduced cancellations
4) Clinically and financially sustainable services

This is a huge programme of change for all our staff and patients and as such there are several risks to manage:

a) Build ready delays (funding and/or construction) – successful management of the construction critical path will help to mitigate these risks

b) Service ready delays (Integration of teams, clinical/operational models, possible workforce shortages) – successful critical path management, staff engagement, workforce and OD support will help to mitigate these risks.

The completion of the Transforming Care Together Programme will deliver:

- Clinical, Financial and Societal benefits as determined in the STP and NHP business cases.
- STP (BEACH) - £21.6m cost savings, 5 specialties with quantified benefits, 6 speciality benefits for up to 150,000 patients per year from planned and emergency separation, societal benefits of £11.4m
- NHP funded Schemes - £6.1m of cash releasing benefits, £8.0m of non-cash releasing benefits and £12.2m societal benefits

Together these benefits will deliver the vision and ensure clinically and financially sustainable services for the UHD service users.

Build Ready

As in previous years, the creation of the planned care hospital at Poole and the emergency hospital on the Royal Bournemouth site remains the centre piece of the Clinical Services Review (CSR) agreed by the Secretary of State for

Health in 2019, following three years of public, staff and partner engagement.

The benefits and reconfiguration changes are set out in our Future Hospitals Website: Investing in our hospitals (uhd.nhs.uk). The links on the website layout the changes across all the UHD sites, with funding coming from a range of sources including the New Hospitals Programme, Sustainability & Transformation Programme as well as other capital investment schemes.

The Estates masterplan provides visuals and the timeline for the major changes that complete in 2026/27:

- The first clinical changes commenced in 2023/24 covering Stoke, Cardiology and the opening of the Pathology Hub.
- The next significant changes are planned for the start of 2024/25 when the new catering block will come online.
- The BEACH building will be handed over to the Trust for commissioning in Oct 2024.
- The initial clinical opening of the BEACH building will be in April 2025 providing Births (Maternity), Emergency Care (Bournemouth ED will move into the new facility; however Poole ED will remain the designated Trauma unit), Antenatal, Bournemouth Critical Care will also move into the new facility.
- All other changes will move as part of the Major Reconfiguration in Q3 2025/26.

There are other extensive changes across both Poole & Bournemouth including the work related to the New Hospitals Programme, the Wessex Fields Access Road and the commencement of the Clinical Diagnostic Hub (CDC) for Endoscopy in Poole.

In 2024/25, there are six strategic changes:

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

2. **BEACH Building completes** in November 2024, with Trust commissioning finishing by the end of March 2025. The first services will move into the BEACH in April 2025

3. **Wessex Fields Access Road completes** in September 2024, at which UHD staff will be able to enter and exit the site directly from the South Bound Wessex Way carriageway

4. **CDC in Poole commences** in Spring 2024 with plans to complete in early 25/26

5. **New Hospitals Programme (New Ward Block and Catering commences)** is due to complete in November 2025 with commissioning running into December 2025.

6. **Catering.** The Central Production Kitchen (CPK) will be fully open, allowing a totally new, improved catering offer. This will offer more choice, be more sustainable, provide greater resilience and provide future opportunities for revenue growth by providing catering to partners.

These six significant service changes will happen in 2024/25 but across all our sites, small and medium sized building works in preparation for major reconfiguration in 2025/26 will continue and step up. The enabling works for the New Hospital Programme will continue, and the Full Business Case for the New Hospitals Programme is expected to be approved in the summer of 2024. Other capital projects will also be progressed, including back log estates works across the Trust.

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

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

6.3 Environmental Sustainability

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

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

The Sustainability Strategy, or Green UHD Plan, sets out our:

- **Vision** - to provide excellent healthcare to our patients and wider community and be a great place to work, now *and for future generations*
- **Green objectives** – to deliver healthy lives, a healthy community and a healthy environment.
- **Cornerstone targets** –
    - To reduce UHD’s core carbon footprint to 80% by 2030 (against 1990 baseline) and to net zero by 2040.
    - Carbon footprint plus to be net zero by 2045.
    - To become an excellent rated clean air hospital by 2026, reduce single use plastics, generate zero waste to landfill and consume 100% renewable energy.
    - The trust also uses a sustainable development assessment toolkit with circa 500 criteria and aims to score 100% by 2030.

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

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

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

- Carbon
- Social value / anchor institution

Our Green Plan aligns the Trust with NHS net zero targets. Given the unprecedented nature of the challenges being addressed, the measures taken to achieve the Green Plan and the Green Plan itself will require regular review and revision along this journey.

In 2024/25, we will build on work through 23/24 and continue to give particular focus to three areas:

- **Decarbonisation of the energy consumed by our estate.** This includes major investment to increase the electrical supply capacity, increase renewable generation on site and detailed planning for heat decarbonisation.

- **Green travel.** The delivery of a detailed sustainable travel plan in 2023/24 was a significant milestone. 2024/25 will see the implementation of several projects needed to deliver against this plan. This includes the introduction of Mobilityways which will provide staff with personalised travel plans and provide the trust with a powerful modelling tool to better assess staff travel needs and support them with sustainable travel solutions. Our aim to ensure staff travel is both easier and more enjoyable (as well as cheaper, healthier and greener).

- **Sustainable quality improvement.** During 2023/24, UHD started on our transformational journey to embrace the “Patient First” quality improvement approach, with the first cohort of staff including 200 managers beginning their training. Through 2024/25 we will ensure environmental sustainability is integrated with Patient First and reconciled with our target to mainstream sustainable quality improvement throughout the trust. Progress is already starting with our Green Theatres work.

The Green Plan is aligned with our work across Dorset ICS, the SW region and fits with our ambitious, bet essential, vision for future generations to benefit from our work today.

7. Corporate Governance

7.1 System partnerships

Integrated Care System (ICS)

The ambition for Dorset to be the healthiest place to live in the UK fits UHD's ambition for our population, and our place as a team player within our ICS. NHS Dorset Integrated Care Board as the key organisation, is leading this work, and their plans on behalf of the system align within ours. In turn these fit within wider national strategies.

For more detail on the Dorset ICS strategy see website (link). UHD's contributions are summarised with the driver diagram overleaf.

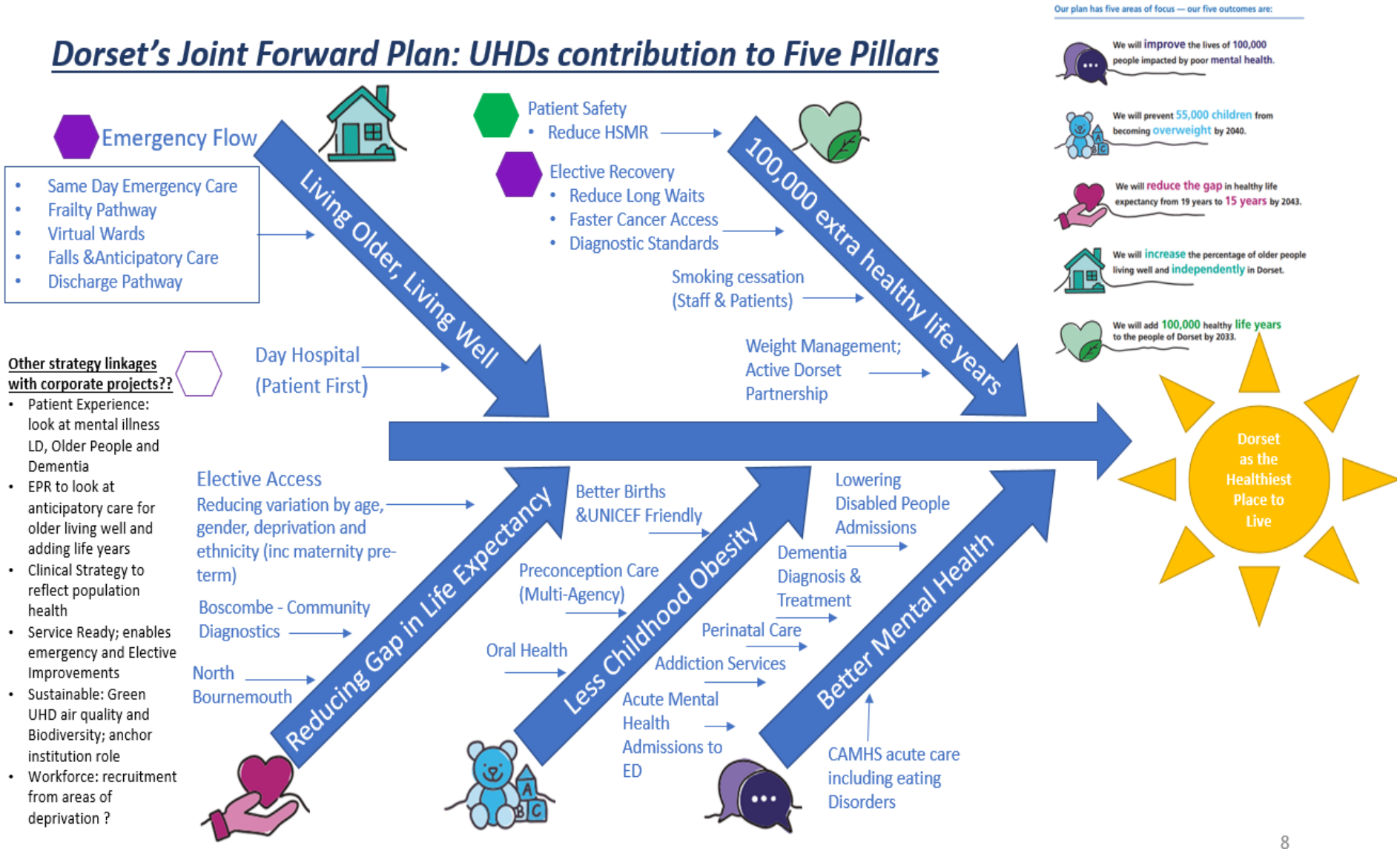
Wider determinants of health

This plan is set within the context that a predominately hospital based healthcare provider is only a small part of an individuals', and populations health and happiness. Therefore our work as an "anchor institution", as an employer, landowner, purchaser of goods and services, and focal point for a community are also important. The progress against what good looks like as an anchor institution, is tracked via our Green UHD plan. In addition we are active members of numerous networks, and partnerships both as a Trust and through the ICS, including for example with the voluntary sector.

University Partnership

A key formal partnership is with Bournemouth University, a highly ranked institution. Over the last three years our partnership has supported education, research, joint appointments and a range of projects, including in leadership development. The strategy will be updated in 2024. One area to explore will be development of a medical school for Dorset, alongside expanding existing programmes including physicians' assistants.

Dorset's Joint Forward Plan: UHDs contribution to Five Pillars



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7.2 Membership and Governors

Member Engagement

The Trust currently has over 14,000 public members, with staff and volunteer members being in the region of 10,000. All individuals in our staff constituency automatically become members unless they choose to opt out. In 2024/25, Governors will further develop upon successful events, communication and outreach, supporting their role of representing the interests of members and the public.

The vision set out in the Trust's Membership Engagement Strategy is to build on the engagement with Trust members to create an active and vibrant membership community, representative of the diverse population the Trust serves and of the staff who work here, that has a real voice in shaping the future of the Trust and the services it provides. To achieve this, the Membership Engagement Strategy sets out three overarching aims:

1. To build representative membership that reflects our whole population of Dorset and West Hampshire;
2. To improve the quality of mutual engagement and communication so that our members are well informed, motivated and engaged;
3. To ensure our staff members have opportunities to be become more actively engaged as members.

Council of Governors (CoG)

In the absence of vacancies, the Council of Governors currently comprises the following:

- 6 Public Governors from the Bournemouth Constituency;
- 6 Public Governors from the Poole & Rest of Dorset Constituency;
- 5 Public Governors from the Christchurch, East Dorset & Rest of England Constituency;
- 5 Staff Governors, each representing a staff class:
    - Medical and Dental;
    - Nursing, Midwifery & Healthcare Assistants;
    - Allied Health Professions, Scientific & Technical;
    - Administrative, Clerical and Management;
    - Estates and Ancillary Services
- 4 Appointed Governors, each representing a partnership organisation:
    - Bournemouth, Christchurch & Poole Council;
    - Dorset Council;
    - Bournemouth University;
    - University Hospitals Dorset Volunteers

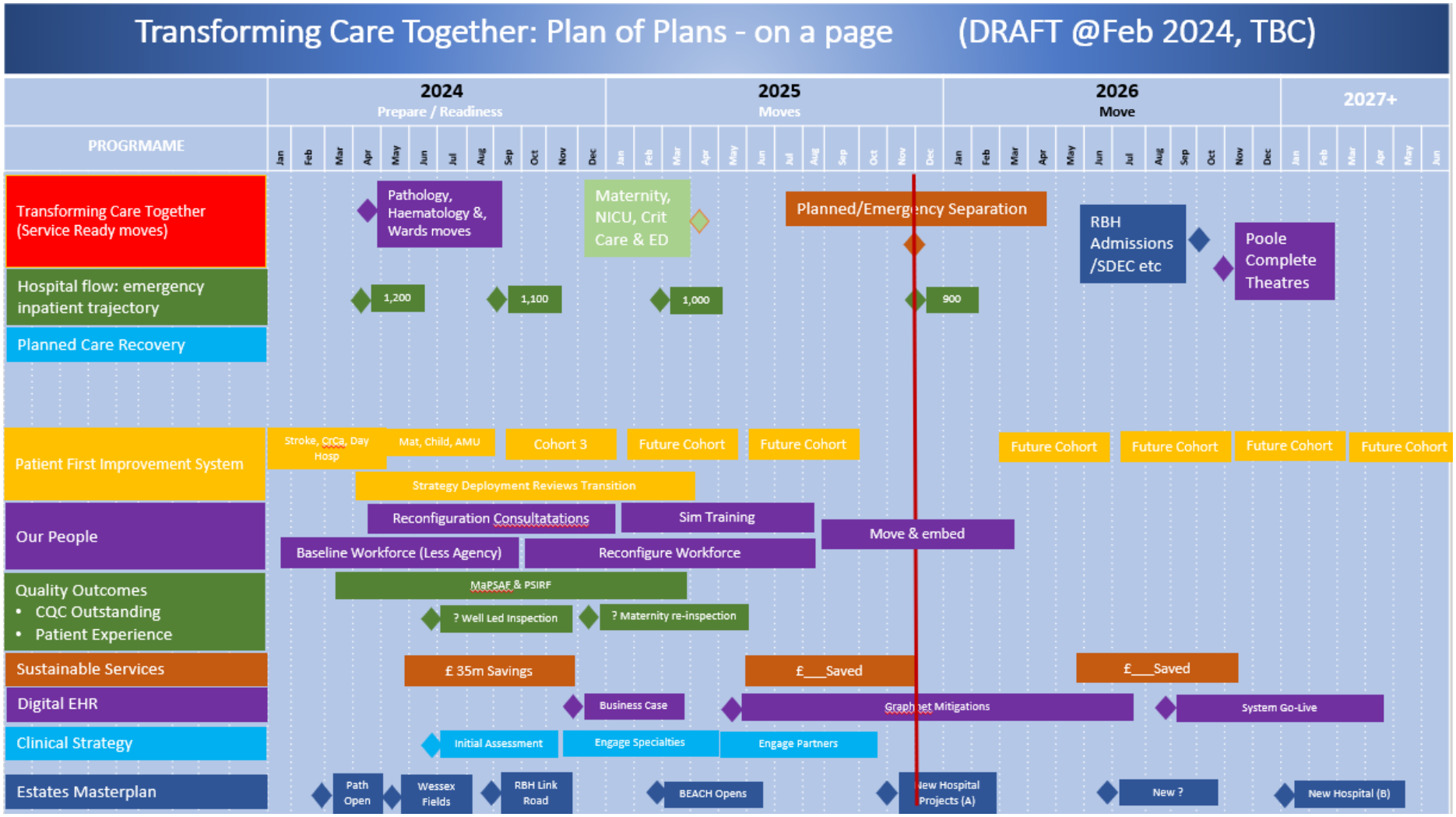
More information about our Council of Governors can be found here

Informal Groups

The Council of Governors has established four informal groups:

- **Membership & Engagement Group** – a forum for discussion on membership, engagement, development and recruitment of members;
- **Effectiveness Group –** a forum for discussion on the effectiveness of the Council of Governors and to informally oversee the development and implementation of plans to enhance this;
- **Quality Group –** a forum for discussion on matters relating to quality and the Quality Account;
- **Constitution Review Group:** a forum for discussion on matters relating to the review and updating of the Trust's constitution triennially. The process for the constitution review is underway and will conclude in 2024/25.

Appendix A – Overarching Transformation Plan



Appendix B – Speciality Level Plans

Appendix - Attendance at Part 1 Board Meetings

Part 1		01 May 2024
	Pankaj Dave	
	Judy Gillow	
	Siobhan Harrington	
	Fiona Hoskins	
	John Lelliott	
	Helena McKeown	A
	Mark Mould	
	Pete Papworth	
	Sharath Ranjan	
	Richard Renaut	
	Cliff Shearman	
	Claire Whitaker	
	Rob Whiteman	
	Peter Wilson	
In Attendance (excl Governors, members of public and non-Standing Invitees)	David Broadley	
	James Donald	
	Yasmin Dossabhoy	
	Ewan Gauvin	
	John Vinney	A
Was the meeting quorate?		Y

Key

	Not in Attendance	
A	Apologies	
D	Delegate Sent	