University Hospitals Dorset NHS Foundation Trust

Council of Governors Meeting - Part 1

Thursday 27 July 2023

16:30 – 18:00

Via Microsoft Teams

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

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

The next meeting of the University Hospitals Dorset NHS Foundation Trust Council of Governors will be held at 16:30 on Thursday 27 July 2023 via Microsoft Teams.

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

Rob Whiteman
Trust Chair

AGENDA – PART 1

16:30 on Thursday 27 July 2023

Time	Item		Method	Purpose	Lead
16:30	**1**	Welcome, Introductions, Apologies & Quorum	**Verbal**		**Chair**
	2	Declaration of Interests	**Verbal**		**Chair**
16:35	**3**	**MINUTES**			
	3.1	For Accuracy and to Agree: Minutes of the Council of Governors Meeting held on 27 April 2023	**Paper**	**Approval**	**Chair**
	3.2	Matters Arising – Action List	**Paper**	**Review**	**Chair**
16:40	**4**	**TRUST CHAIR AND CHIEF EXECUTIVE UPDATES**			
	4.1	Chair's Update	**Verbal**	**Information**	**Chair**
	4.2	Chief Executive's Update	**Verbal**	**Information**	**CEO**
16:50	**5**	**INTEGRATED PERFORMANCE REPORT AND RISK**			
	5.1	Integrated Quality, Performance, Workforce, Finance and Informatics Report	**Paper**	**Information**	**Chief Officers**
17:05	**6**	**GOVERNANCE**			
	6.1	Trust's Annual Report and Accounts	**Paper**	**Information**	**CEO/CFO**
	6.2	External Auditors Annual Report on the Annual Report and Accounts	**Paper**	**Information**	**KPMG**
	6.3	Summary of Operational Plan	**Paper**	**Information**	**CSTO**
	6.4	Board Assurance Framework Annual Report (past year)	**Paper**	**Information**	**CNO**
	6.5	Board Assurance Framework (new year)	**Paper**	**Information**	**CNO**
	6.6	Appointment of the Vice Chair	**Paper**	**Approval**	**Chair**
	6.7	Consultation in relation to Senior Independent Director (SID)	**Paper**	**Approval**	**Chair**

	6.8	Annual Audit Committee Report and Terms of Reference	**Paper**	**Information**	**Audit Committee Chair**
	6.9	Quality Account	**Paper**	**Approval**	**CNO**
	6.10	Membership and Engagement Strategy Review	**Paper**	**Approval**	**MEG Chair**
	6.11	Terms of Reference: • Nominations, Remuneration and Evaluations Committee • Membership Engagement Group • Quality Group • Effectiveness Group • Constitution Group	**Paper**	**Approval**	**Chair**
17:30	**7**	**COMMITTEES AND GOVERNOR GROUPS UPDATE**			
	7.1	Feedback from Nominations, Remuneration and Evaluation Committee (NREC)	**Verbal**	**Information**	**Chair**
	7.2	Feedback from Council of Governor Groups • Membership and Engagement Group • Quality Group	**Verbal**	**Information**	**Group Chairs**
	7.3	Feedback from Governor Observers	**Verbal**	**Information**	**Governor Observers**
	7.4	Feedback from Governwell Conference	**Verbal**	**Information**	**R Bufton/ K Mitchell**
17:45	**8**	Urgent Motions or Questions	**Verbal**		**Chair**
	9	Any Other Business	**Verbal**		**Chair**
18:00	**10**	**Date of Next Council of Governors Meeting:** Thursday 26 October 2023 at 16:30 in the Boardrooms at Poole Hospital			

* late paper

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

Items for Next Council of Governors Part 1 Agenda

Standing Reports

- Feedback from the Nominations, Remuneration and Evaluation Committee
- Integrated Performance Report
- Update from Council of Governor Groups

Annual Reports

- Quality Account (six months review)
- Annual Patient Experience Report
- Report on the Annual Members' Meeting

Reading Room Materials

Integrated Performance Report *(Agenda Item 5.1)*
Trust's Annual Report and Accounts *(Agenda Item 6.1)*
Summary of Operational Plan *(Agenda Item 6.3)*
Board Assurance Framework Annual Report (past year) *(Agenda Item 6.4)*

List of abbreviations:

CEO – Chief Executive Officer
CFO –Chief Finance Officer
CNO – Chief Nursing Officer
CSTO – Chief Strategy and Transformation Officer
KPMG – External Auditors

Other abbreviations

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

AGENDA – PART 2 PRIVATE MEETING

18:15 on Thursday 27 July 2023

Time	Item		Method	Purpose	Lead
18:15	**11**	Welcome, Introduction, Apologies & Quorum	**Verbal**		**Chair**
	12	Declaration of Interests	**Verbal**		**Chair**
18:20	**13**	**MINUTES**			
	13.1	For Accuracy and to Agree: Minutes of Council of Governors Meeting held on 27 April 2023	**Paper**	**Approval**	**Chair**
	13.2	Matters Arising – Action List	**Paper**	**Review**	**Chair**
18:30	**14**	**GOVERNANCE**			
	14.1	Update from the Part 2 meeting of the Board of Directors held on 26 July 2023	**Verbal**	**Information**	**Chair**
	14.2	Feedback from meeting of the Nominations, Remuneration and Evaluations Committee (NREC)	**Verbal**	**Information**	**Chair**
	14.3	Outcome of the Chairman's and Non-Executive Directors' annual performance evaluation	**Paper**	**Approval**	**Chair/SID**
18:50	**15**	Any Other Business	**Verbal**		**Chair**
	16	Reflections on the Meeting	**Verbal**		**Chair**
19:00	**17**	**Date of Next Council of Governors Meeting:** Thursday 26 October 2023 at 18:15 in the Boardrooms at Poole Hospital Future Meetings: Thursday 11 January 2024 at 16:30			

* late paper

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Items for Next Council of Governors Part 2 Agenda:

Standing Items

- Feedback from the Nominations, Remuneration and Evaluation Committee
- Update from the Part 2 meeting of the Board of Directors

Annual Item

- Annual Effectiveness of External Audit Process
- Approve recommendations from Nominations, Remuneration and Evaluation Committee on Chairman's and Non-Executive Directors' remuneration/allowances/terms and conditions

Reading Room Materials

List of abbreviations:

SID – Senior Independent Director

Other abbreviations
CDEL – Capital Delegated Expenditure Limit
CIP – Cost Improvement Programme
ED – Emergency Department
HSMR – Hospital Standardised Mortality Ratio
ICB – Integrated Care Board
ICS – Integrated Care System
ITU – Intensive Therapy Unit
MSG – Mortality Surveillance Group
NHSE/I – NHS England/Improvement
#NOF – Fractured neck of femur
OPEL – Operational Pressures Escalation Levels
SDEC – Same Day Emergency Care
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UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

MEETING OF THE COUNCIL OF GOVERNORS PART 1

Minutes of the meeting of the Council of Governors held on Thursday 27 April 2023 at 16:15 in the Boardroom at Poole Hospital and via Microsoft Teams

Present:	Rob Whiteman	Trust Chair *(Chair)*
	Mandi Barron	Appointed Governor: Bournemouth University
	Robert Bufton	Public Governor: Poole and Rest of Dorset
	Sharon Collett	Public Governor: Bournemouth, Lead Governor
	Steve Dickens	Public Governor: Christchurch, East Dorset and Rest of England
	Beryl Ezzard	Appointed Governor: Dorset Council
	Rob Flux	Staff Governor: Staff, Admin and Management
	Paul Hilliard	Appointed Governor: BCP Council
	Marjorie Houghton	Public Governor: Bournemouth
	Dimitri Ilic	Appointed Governor: Volunteers Service
	Susanne Lee	Public Governor: Christchurch, East Dorset and Rest of England
	Keith Mitchell	Public Governor: Bournemouth
	Markus Pettit	Staff Governor: Estates and Facilities
	Patricia Scott	Public Governor: Poole and Rest of Dorset
	Jeremy Scrivens	Public Governor: Christchurch, East Dorset and Rest of England
	Diane Smelt	Public Governor: Bournemouth
	Carrie Stone	Public Governor: Poole and Rest of Dorset
	Michele Whitehurst	Public Governor: Poole and Rest of Dorset, Deputy Lead Governor
	Sandra Wilson	Public Governor: Christchurch, East Dorset and Rest of England
In attendance:	Judith Gillow	Non-Executive Director
	Siobhan Harrington	Chief Executive Officer
	Sarah Locke	Deputy Company Secretary *(minutes)*
	Irene Mardon	Deputy Chief People Officer
	Mark Mould	Chief Operations Officer
	Pete Papworth	Chief Finance Officer
	Sharath Ranjan	Non-Executive Director
	Paula Shobbrook	Chief Nursing Officer
	Caroline Tapster	Non-Executive Director
	Peter Wilson	Chief Medical Officer
	Klaudia Zwolinska	Corporate Governance Assistant

CoG 039/23	**Welcome, Introductions, Apologies & Quorum** The Chair welcomed everyone to the meeting. Apologies were received from the following members: • Andrew McLeod, Public Governor for Poole and Rest of Dorset The meeting was declared quorate.
CoG 040/23	**Declarations of Interest** Patricia Scott had made a general declaration of interest that she was a volunteer co-ordinator of Speakability Dorset (Stroke Association), aphasia support and a UHD Volunteer. No existing interests in the matters to be considered were declared. In addition, no further interests were declared.
CoG 041/23	**For Accuracy and to Agree: Minutes of the Council of Governors Meeting Part 1 held on 26 January 2023** The minutes of the Council of Governors Meeting Part 1 held on 26 January 2023 were APPROVED as an accurate record. There were no outstanding actions.

CoG 042/23	**Chair's Update** Rob Whiteman expressed that considerable pressure remained in the NHS and across the Trust. The NHS overall had ended with a financial deficit. The national delay in setting the budget had impacted the Trust budget setting, this was subsequently signed off under Board delegation to Siobhan Harrington and Pete Papworth. Rob Whiteman and Siobhan Harrington had attended the Integrated Care Partnership (ICP) on 27 April 2023. Jenni Douglas-Todd, NHS Dorset Chair and Patricia Miller, NHS Dorset Chief Executive had attended and outlined the aspirations of the Integrated Care Board (ICB) at the Board Seminar held on Wednesday 26 April 2023. Two non-executive directors joined the Board of Directors in April 2023, Judy Gillow and Sharath Ranjan. Two further non-executive directors would be starting their handover processes from June 2023 with a formal start date from October 2023. The Board welcomed Peter Wilson, Chief Medical Officer in March 2023.
CoG 043/23	**Chief Executive Update** Siobhan Harrington reflected that her first 11 months had been challenging but rewarding. She summarised the key messages from the national Chief Executive Officers meeting held Wednesday 19 April 2023: • in the latest published public feedback, 70-80% supported the NHS and its principles but acknowledged improvements were required • there had been five waves of Covid nationally followed by industrial actions • focus was on patient care, keeping patients safe, staff and their wellbeing, being optimistic and to do difficult things She also highlighted: • the optional wearing of masks across the Trust (except in high-risk areas) had improved the morale amongst staff • there were less in-patients with Covid than there had been for some time • work on the cancer pathways had resulted in a positive outcome on the cancer performance targets • the system plan for Dorset was balanced but operational and financial challenges were acknowledged • opportunities for savings by reducing waste and duplication were key to addressing the £32m savings programme for the Trust in 2023/24 • planning permission for the development of the road through Wessex Fields had been received • there was a required for a five-year long-term plan and vision for services • eight expressions of interest had been received from local GPs (General Practitioners) to join the executive leadership team • the importance of providing patient feedback, particularly around the changes to catering • 69% of patients had met the 4-hour safety standard at Royal Bournemouth Hospital following the reintroduction of the standard since 2020 • the nurses strike on Sunday 30 April and Monday 1 May 2023 was being planned for, and the risks defined Paula Shobbrook added that an assurance report had been submitted to NHS England and the time that the strike was due to end remained uncertain. A tactical team had been ascertaining the level of detail for all wards and departments. There had been an increase in the numbers of staff that had confirmed their working status for the strike days since the update was provided to the Board of Directors held on Wednesday 26 April 2023. The focus remained on patient safety and staff wellbeing. Siobhan Harrington emphasised the relationship between staff was essential throughout the industrial actions, including through the doctor's strike. Keith Mitchell asked if there were any financial support for catering staff whilst working across sites. Siobhan Harrington advised that there would be a number

	of changes across a number of areas in the Trust over the next two years. It was critical to assist staff with cross site working and ensure clear communication was maintained. Mark Mould added that a consultation process was in progress for three services, including catering staff. The process would look at where the roles would operate from, understanding concerns and looking at options for those staff that are unable to move sites. Beryl Ezzard asked about the numbers of staff striking. Siobhan Harrington confirmed that the upcoming strike was for nurses, but there were up to 380 staff at the previous junior doctor strike, however it was very difficult to ascertain the actual numbers of staff out. Robert Bufton queried if there was a role for Governors in relation to staff retention and motivation. Siobhan Harrington stressed the importance of staff motivation being the responsibility for all. There was executive focus on recruitment and retention and stressed the link to staff engagement and listening to staff. She reinforced the Governor role of supporting the Board in improving the staff morale and motivation. Monthly staff awards and an annual staff award had been introduced. The annual staff awards also included a patient choice award. Diane Smelt shared that the staff morale amongst the domestic staff had significantly improved since the introduction of the staff awards. Patricia Scott questioned whether the catering staff would be brought in house at Poole Hospital and advised that she had witnessed a vast proportion of food on the ward being disposed of during her volunteer role. Mark Mould verified that the catering staff in Poole Hospital were in-house but the cleaning staff at Poole Hospital were under an external contract. He explained that this was being reviewed. Paula Shobbrook added that the food provided at ward level was being changed and had been sampled at the Board/Council of Governors Development Session. Dieticians had been involved with the food choices and portion sizes to ensure suitability for patients with eating difficulties and a reduction in waste. Rob Flux asked about sustainability plans as the Trust size increased. Rob Whiteman explained that productivity across the NHS had declined due to Covid, although there had been an increase in spending. Quality, safety and sustainable budgets were key but the pressure to make savings remained. Siobhan Harrington added that Quality Improvement and Patient First centred around five elements, which included sustainability. The Trust had a 4% cost improvement target with Care Groups having a 2.2% target within that meaning that improvements for patients was needed without it costing money. She also emphasised that the extensive building work would result in changes to the way services operated. Sharon Collett questioned the support available for line managers. Siobhan Harrington praised the resources available for managers to provide support, however further work was required on bringing managers together across the Trust regularly to identify the challenges. All staff would receive Quality Improvement Training which included leadership, coaching and supporting staff. Michele Whitehurst highlighted the geographical challenges with seasonal increases. Siobhan Harrington described the demand and capacity modelling that was taking place across the Dorset system. This would enhance system working.
CoG 044/23	**Integrated Quality, Performance, Workforce, Finance and Informatics Report** Mark Mould presented the operational performance, highlighting: • the elective activity and the elective activity recovery had been impacted by the industrial actions • there had been a reduction of in-patients that were medically ready to leave • Tuesday 25 April 2023 saw the start of the MADE (Multi-Disciplinary Discharge Event) event, which incorporated the Dorset system and focussed on collectively agreeing plans to step down patients to appropriate settings

	• Discharge to Assess started on 1 April 2023 which allowed appropriate assessment outside of the hospital setting • there had been a reduction in the ambulance handovers waiting over 60 minutes and ambulance conveyances, but further work was required • the 4-hour standard had been re-introduced, which ensured that patients were admitted or discharged within four hours of arrival in the emergency department. This had not been reported for the previous three years due to participation of a national pilot • there were zero patients waiting over two years and the numbers of patients waiting over 65 and 78 weeks had also reduced with an ambition to achieve zero patients waiting over 65 weeks by end of March 2024 • achievement of the highest rated Trust in the region for diagnostic wait time standard • the faster diagnostic standard in cancer performance would be achieved for the first time prior to the pandemic Beryl Ezzard asked whether there would be a shortage of staff on the wards with increased beds from 2025. Mark Mould explained the bed numbers would remain similar to the current number of beds. As an emergency and planned care hospital, care needed to be provided faster and with greater value. This would be accomplished through utilising day case surgery, moving procedures to theatres, day cases and outpatients. Paula Shobbrook presented the Quality report, highlighting: • some patients that had sustained a fall or pressure damage often related to their frailty on admission • staffing of wards and the nursing of patients in bays was a key focus • the number of complaints had increased, but there were a vast majority that had been resolved through early resolution • for the previous four months, there had been no mixed sex accommodation breaches • the risk register was being reviewed on a more regular basis Peter Wilson added to the Quality report highlighting: • the HSMR (Hospital Standardised Mortality Rate) was around average when benchmarked against other Trusts nationally. Improvement on HSMR was a focus as part of the Patient First initiative • a new clinical lead for mortality and a new associate medical director for governance and risk had been appointed • achievement of the second lowest Trust in the south-west region for the number of moderate to severe harm patient safety incidents reported. There had been a slight increase in the numbers over the previous two years and were being linked to the LERN reviews Pete Papworth provided the Finance update, highlighting: • the financial year ended with a £188k surplus although this had been achieved through a number of non-recurrent savings • the recurrent underlying deficit was £40m • savings of around £31m had been achieved but again, the majority was non-recurrent • there was a capital expenditure of just under £120m for the full year, this was in line with expectations and the ICS (Integrated Care System) control total • significant cash holding of just over £95m, this was fully committed in relation to the medium-term capital programme • the payment performance of 95% had not been achieved (92%) primarily due to the cyber-attack earlier in the year • 2023/24 would be a challenging year following a submitted balanced budget with a closing £35m deficit Siobhan Harrington added the industrial action had a significant impact on all of the areas that had been discussed as part of the IPR.

	Keith Mitchell asked about the increased waiting list for the most deprived patients. Siobhan Harrington explained that health inequality data was being collated and reviewed at the Population Health Committee which had been established. Mark Mould agreed to look into the data. **ACTION**: To review the increased waiting list for the most deprived patients. **Mark Mould** Michele Whitehurst questioned there was an update on the virtual wards/clinics and whether there was support for manual handling training. Mark Mould responded that ten more clinics had requested to relocate to the Beales outpatient centre which was being scoped. Additional national investment had been received that would enhance the diagnostic capabilities in Beales. Four areas for virtual clinics had been prioritised: children's services, older people's services, end of life support and respiratory. Paula Shobbrook agreed that the mandatory training compliance was below target and explained that there had been difficulties in the availability of trainers and being able to release staff from wards. A tool had been developed to allow for the training to be completed online. Carrie Stone queried if there was a link in the maternity perinatal scorecard with regard to the apgars of less than 7 at 5 minutes and the term admissions to the neonatal unit. Paula Shobbrook advised that this topic had been discussed at the Quality Committee and with the maternity safety champion (Caroline Tapster) and the maternity teams. Reviews had identified inconsistencies on how the scoring had been carried out. Assurance had been provided from the maternity team that the previous scores had been reviewed to ensure accuracy. Learning around consistency and training had been recognised and actions were put in place. The overarching term admissions to the neonatal unit were better than the national and network average. Robert Bufton informed the Council that following a tour of the theatres on the Poole site, it had materialised that should the pumps that provide air to the theatres malfunction, four theatres would have to be closed with a two-hour minimum wait time for the repair. He questioned if the Board considered this an acceptable risk. Siobhan Harrington was thankful for the risk to be raised and agreed to review this. **ACTION**: To review the acceptable level of risk should there be a malfunction in the pump room of the new theatre block on the Poole site. **Siobhan Harrington** The Council of Governors noted the Integrated Performance Report.
CoG 045/23	**Feedback from the Nominations, Remuneration and Evaluation Committee** Rob Whiteman updated the Council of the feedback from NREC, highlighting that the annual statement on the work of NREC was endorsed at the Committee and recommended to the Council for approval. Sharon Collett noted that it had been a busy year for the Committee. The Council of Governors approved the Annual Statement on the work of the Nominations, Remuneration and Evaluation Committee.
CoG 046/23	**Annual Review of the Register of Interests** Sarah Locke reminded Governors that their signed annual declarations of interest were due to be received by 2 May 2023. The outstanding responses were included within the papers. One Governor had declared that sat on various Integrated Care Board and Bournemouth University Groups as a patient representative. This was being reviewed by Yasmin Dossabhoy and Ewan Gauvin. The Council were informed that following approval, the register of interests would be published on the Trust public internet site. The Council of Governors APPROVED the Annual Review of the Register of Interests for publishing on the Trust website.

CoG 047/23	**Annual Review of the Governance Cycle** Sarah Locke highlighted that there were no material changes made to the Governance Cycle for 2023/24 but that it would be reviewed following the establishment of the Council of Governor Groups. The Council of Governors APPROVED the Annual Review of the Governance Cycle.
CoG 048/23	**Schedule of Meetings for 2023/2024** Sarah Locke highlighted from the paper: • at the NREC meeting held on 27 April 2023 it had been requested that the meetings of the Council of Governors and NREC be on the same day • previous Governors had requested that the meetings be held on different days • it would not be possible to include any changes to documents/agenda items between NREC and the Council of Governors • the separation of meeting dates for NREC and Council of Governors would be line with the Board Committees and the Board of Director meetings • dates would be updated to include the Governor Groups as they were developed • It was agreed that the scheduling of NREC and the Council of Governor meetings would be reviewed The Council of Governors APPROVED the schedule of meeting dates for 2023/24.
CoG 049/23	**Annual Members' Meeting** Sarah Locke requested that the Council call the Annual Members' Meeting for Saturday 9 September 2023. Governors were asked for suggestions, based on public feedback, of a topic for the Understanding Health Talk for 2023. Sharon Collett asked if previous topics could be shared to avoid duplication. Sarah Locke agreed to distribute to Governors. Stands would be available at the event, which would include a stand for Governors and a plan to request a Transformation stand to provide an update on as this had been the topic for the Understanding Health Talk in 2022. There was a suggestion of a topic to attract a younger demographic to attend the AMM which included: children's services, buildings process/progress and sports injuries. **ACTION**: To distribute the previous Understanding Health Talk topics that have been held at the AMM to Governors. **Sarah Locke** **ACTION**: To send any suggestions of Understanding Health Talk topics for the AMM to the Company Secretary Team. **Council of Governors** The Annual Members' Meeting will be convened by the Company Secretary Team by ORDER of the Council of Governors for Saturday 9 September 2023.
CoG 050/23	**Rotation of Governor Observers Update** Rob Whiteman outlined that the changes to the Board Committees allowing Governors to rotate as observers through their choice of Committees and asked for approval for the remaining Committee observer vacancies to be redistributed. Sarah Locke informed the Council that there were some Governors that had not yet responded to the request for attending Board Committees as observers. Governors were asked to ensure that they had selected three Committees for the year. The Committee schedule would be reviewed to determine the number of observer spaces remaining and would be distributed back round to the Council. **ACTION**: To redistribute the Committee schedule to all Governors advising how many further Committees they could elect to observe. **Sarah Locke and Klaudia Zwolinska** The Council of Governors APPROVED the redistribution of the Governor Observer Rotation list.

CoG 051/23	**Feedback from Council of Governor Groups** Sandy Wilson provided the feedback from the Membership and Engagement Group highlighting: • monthly meetings with the Communications Team continued • the MEG terms of reference were reviewed and approved. The next review date would be in 2026 • the Membership Strategy was reviewed and agreed to change the name to the Membership and Engagement Strategy • areas of change in the strategy included the removal of reference to the merger, the previous joint Governor activity, the levels of membership and any duplication; the importance of the members voice to be reinforced; support for staff Governors • the strategy was approved with a commitment to complete the three-year action plan • a successful end of life talk and a talk at Corfe Castle had been held • constituencies outlined their planned future events • the annual membership report was in construction • three vacancies were on MEG and it was agreed for those to be filled • a short process was being developed for events to be arranged in between MEG meetings Keith Mitchell asked about the progress on support for staff Governors. Rob Whiteman confirmed that this was being reviewed with Siobhan Harrington and Karen Allman, but this had been delayed due to unforeseen staff absences. The Council of Governors NOTED the feedback from the Council of Governor Groups.
CoG 052/23	**Feedback from Governor Observers** Rob Whiteman invited any of the Committee observers to provide feedback. Diane Smelt provided feedback following her attendance at the Quality Committee. She said that the Committee was well run, was informative and found the exception reports helped to focus the attention on the relevant items. Her suggestion was that it would be really beneficial for more Governors to be able to attend Committees as observers. Rob Whiteman advised that the original plan was to allow Governors to rotate around the Committees and to receive feedback on the Committees throughout the year. He had also requested that Committee Chairs consider resuming meetings in a face-to-face setting. A full review would take place at year end and any changes would be communicated with the Council. The Council of Governors NOTED the Feedback from Governor Observers.
CoG 053/23	**Any Other Business** There being no further business the meeting was closed.
	The date and time of the next meeting of the Council of Governors was announced as Thursday 27 July 2023 at 16:30 at Royal Bournemouth Hospital and via Microsoft Teams.

Council of Governors Part 1 Action List - July 2023						
Minute Ref.	**Meeting Date**		**Lead**	**Due Date**	**Progress**	**Status**
CoG 044/23	27/04/2023	To review the acceptable level of risk should there be a malfunction in the pump room of the new theatre block on the Poole site.	Siobhan Harrington	Jul-23	The Capital Projects Manager has advised of the following: "This is the same scenario as all our Theatres. If a fan were to fail at any time the air handling unit would not function. The current operation would be completed and future activity would be moved to another Theatre. There is a stock of spare fans housed in the Plant Room for this eventuality to enable quick swap over to minimise any downtime. HTM calls for 25% spares in terms of fans and we are keeping 50% spares as an extra buffer. I can also confirm that any works would be carried out by our in house Estates team not an external contractor."	Complete
CoG 044/23	27/04/2023	To review the increased waiting list for the most deprived patients.	Mark Mould	Jul-23	The most recent data presented in the IPR for June 2023, demonstrated at aggregate level this variation has closed, with the average weeks waiting being 7 weeks for both groups. We continue to review the data at speciality level to understand any areas of variation. The Trust has also established a Population Health & System Committee, chaired by Caroline Tapster to oversee Health Inequalities and the work in this area.	Complete
CoG 049/23	27/04/2023	To distribute the previous Understanding Health Talk topics that have been held at the AMM to Governors.	Sarah Locke	Jul-23	The email with the previous Understanding Health Talk topic was sent to Governors on 5 June 2023.	Complete

CoG 049/23	27/04/2023	To send any suggestions of Understanding Health Talk topics for the AMM to the Company Secretary Team.	Council of Governors	Jul-23	Members of the Council of Governors sent their proposed topics to the Company Secretary Team between 5 June 2023 and 11 June 2023. The list with the proposed topic was sent to Rob Whiteman and Siobhan Harrington on 12 June 2023.	Complete
CoG 050/23	27/04/2023	To redistribute the Committee schedule to all Governors advising how many further Committees they could elect to observe.	Sarah Locke Klaudia Zwolinska	Jul-23	The email with additional Committee observer slots was sent to Governors on 9 May 2023 advising them that they have one more slot available to book.	Complete

University Hospitals Dorset
NHS Foundation Trust

COUNCIL OF GOVERNORS - PART 1 MEETING

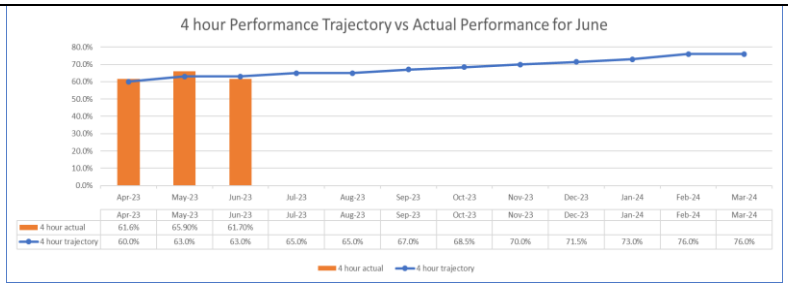
Meeting Date: 27 July 2023

Agenda item: 5.1

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

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

	The cost of the recent industrial action, energy cost inflation and unfunded escalation capacity drive the challenging financial position, with a year-to-date adverse variance of £2.9 million. Consistent with national reporting guidance; elective income is assumed to be received in full, however this has yet to be confirmed. Mitigating actions continue to be identified and progressed to recover this position.
Background:	The integrated performance report (IPR) includes a set of indicators covering the main aspects of the Trust's performance relating to safety, quality, experience, workforce and operational performance. It is a detailed report that gives a range of forums ability if needed to deep dive into a particular area of interest for additional information and scrutiny. As part of our commitment against the CQC Well-Led Framework we continue to develop the format and content of the IPR by: • Extending best practice use of Statistical Process Control (SPC) Charts. • Greater focus on key indicators as part of our Patient First Roll out programme. • Providing SPC training to operational leads who compile the narrative against the data included within the report scheduled in June/July 2023. • Linking the structure of the report to the delivery of our strategic objectives.
Urgent & Emergency Care (1 Advise)	**Strategic goal: To meet the patient national constitutional standards for Planned and Emergency care supporting reducing inequalities in outcome and access and improving productivity and value.** ***Advise (1): The Trust commenced national reporting against the 4-Hour Organisational safety standard in June 2023 at 61.7% against a trajectory of 63%*** • The Trust is planning for further BMA Industrial Action in July 2023 which will continue to impact on access to care for our patients. • The Trust met its trajectory for both April and May 23, however June has proved to be a challenging month. • Attendances have dropped for the first time since January 2023, and there has been a sustained performance improvement for the number of patients in the department longer than 12 hours as well 12 hours from DTA (Decision to Admit). • In terms of Ambulance Handover, there were 599 hours at Poole Hospital (PH) and 540 hours at Royal Bournemouth Hospital (RBH) totalling 1139 hours lost in June vs 1039 in May and 2284 hours reported as lost at UHD sites in April. • Regionally however there was an improvement against handover delays with South West Ambulance Service Trust (SWAST) experiencing 18,180 lost hours vs 20,159 in May across the South-West.

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

Referral to Treatment (RTT) (2 Advise)	**Strategic goal: To meet the patient national constitutional standards for Planned and Emergency care supporting reducing inequalities in outcome and access and improving productivity and value.** **Advise (1): A reduction in 78 weeks waits was achieved at the end of June but the plan to virtually eliminate 78 week waits was not achieved. 65 week breaches are above plan, however the variance to plan has reduced in June.** • Both 78 week waits and 65-week waits were above plan in June but lower than the end of May position. Industrial action (IA) continues to impact on the Trust's capacity for routine elective treatments and appointments. Capacity in the School Age Neurodevelopment Service was also not able to meet the demand for first appointments for patients waiting over 78 weeks in June. The service has experienced an increase in referrals above 40% compared to 2019. • 65 week waits at the end of June 2023 were 30 above plan, however the variance to plan has reduced this month by 63. Consistent progress is being made on reducing the 65 week 'at risk' March 2024 cohort, with this group reducing by 6,311 this month to 22,489. • Additional waiting list initiatives are in place in July for both elective and cancer waits, but these will not fully mitigate against lost capacity due to IA in July.

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

• All efficiency markers for theatre utilisation showed improvement in June and the intended (booked) theatre utilisation rate also increased to 73.4% (plan 87%). Further improvement however is required to achieve this target and an improvement programme is in place. Actions are detailed in the IPR. • Staff vacancies across theatres remains a barrier to providing a full template for all surgical specialties. The workforce pipeline is improving with the trajectory showing a reduction of around 17wte (Whole Time Equivalent) by September 2023 and an

enhanced bank rate for existing theatre staff is expected to increase the number of sessions run in July.

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

- 50% of the monthly activity was admitted during a 6 day period and there was a higher than average presentation of paediatric trauma cases.
- Access to the newly opened Barn theatres nevertheless resulted in a rapid de-escalation of the position and recovery of the backlog of #NOF (fractured neck of femur) cases during the month.
- The ability to flex into the fourth theatre at times of increased demand has provided the ability to manage this patient cohort in a safe and effective way.
- A new pre-hospital #NOF 'pre-alert' from SWAST and admission pathway went live on 6 July 2023.
- Implementation of the e-Trauma tool has commenced with a dedicated T&O (Trauma and Orthopaedic) Lead in post; and technical scoping is complete.

Cancer Standards (1 Assure)

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

Assure (1) Performance against the national Cancer Waiting Times standards in May was below the operational planning trajectories for Cancer 62day and the 28day Faster Diagnosis standard (FDS). The Trust is on track, however, to demonstrate improvement against the FDS standard in June.

- FDS performance in May was below the Trust's operational plan trajectory of 72%.
- Treatment numbers in May were 17.2% lower compared to May 2022 due to an additional bank holiday and industrial action in the month. This negatively impacted on 62-day performance.
- The number of patients on the over 62day PTL increased to above 300 in May but recovery of the increased position has been achieved in June and July to date.

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

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

Looking forward

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

DM01 (Diagnostics report)

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

The DM01 standard has achieved 92.3% of all patients being seen within 6 weeks of referral, 7.7% of diagnostic patients seen >6weeks in June.

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

June	Total Waiting List	< 6weeks	> 6 weeks	Performance
UHD	12,584	11,609	975	**7.7%**

UHD remains the top performing Trust for diagnostics in the south-west region and an area we are very proud of as a team.

Health Inequalities

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

The Dorset Intelligence & Insight Service (DiiS) Health Inequalities dashboard enables analysis waiting times disaggregated by ethnicity, age band and deprivation (Dorset Patients only).
An analysis at Trust level of the average (median) weeks waiting by ethnicity grouping and Index of Multiple Deprivation (IMD) identifies no variation between patients within community minority groups and White British populations, and between the 20% most deprived and the rest of the population treated in Q1. This is an improved position compared to last month.

Variation between age and length of wait on the waiting list is noted within the report with the greatest variation between 0-19yrs and 20+ age bands. However, this variation has reduced in Q1 to date compared to 2022/23. Variation in waits does exist at specialty level and specialties have access to this information.

A health inequalities improvement programme is supporting action on health inequalities in the Trust.

Infection Prevention and Control: (1 Alert , 1 Assure)

Quality, Safety, & Patient Experience Key Points

Strategic goals: To achieve top 20% of Trusts in the country for mortality (HSMR)
To reduce moderate/severe harm patient safety events by 30% through the development of an outstanding learning culture

Alert (1) Cdiff Cases

- In June we have noted a significant increase in the number of C. difficile cases reported, both identified – in the community and trust associated. Infection Prevention Control (IPC) Team working to understand trends.
- This trend has been reported nationally and within the southwest too. IPC teams reviewing.

Advise: Hospital Associated cases trend

	2022/2023														
Organism	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Cdiff	9	10	9	9	11	9	2	4	5	6	4	5	5	8	19
eColi	6	1	7	4	7	9	6	7	5	10	7	14	5	8	17
MRSA	0	0	0	0	0	1	1	0	0	1	0	0	1	0	0
MSSA	4	4	2	3	3	3	7	2	3	3	1	1	4	6	8

- June saw reduction in ward closures as seasonal viral infections declined.
- New guidance for COVID screening appears to be largely adopted across UHD with some local exceptions e.g. Haematology.
- New A-Z pathogens out for consultation, as is IC Principles Policy.
- E. coli increase seen June an but seasonally increased - thought to be due to weather, increase in UTI as source.
- IPC nurse consultant interview process in progress.

Clinical Practice Team

(4 Advise)

Clinical Practice Team

Advise (1) Moving and Handling - Essential Core Skills
The ability to meet the face-to-face level two training requirements for clinical staff continues. The risk register entry remains at 10 (moderate). The development of an eLearning Level 2 package is being developed.

Advise (2) Moving & Handling: Active recruitment into the following posts Associate Practitioner Falls and Moving and Handling and Moving and Handling Risk Advisor successful. Currently we have support from Dorset Healthcare and an external provider to support all new starters with practice and Level 2 face to face training.

Falls prevention & management: The Lead falls and moving and handling lead is currently vacant and after successful recruitment due to start in September 2023.

Advise (3) Six fall incidents reported in month, one moderate harm, and five severe including #NOF and head injury. Scoping and investigation process' are in place for all moderate and above incidents with support from the falls team.

Tissue Viability: The ability of the service to meet the increased demand remains on the risk register entry 1821 and rated as 9 (moderate), an action plan has been completed and is updated.

The number of complex patients being referred to the service remains high.

- The team have successfully recruited an additional band 6 advert for a six-month secondment to support increased activity.

	Advise (4) In month has seen a reduced number of reported incidents with a total of five newly acquired category three ulcers. These were a combination of deterioration of existing, medical devices and newly acquired tissue damage. The appropriate scoping and level of investigation is in place.
Patient Experience (1 Advise, 1 Alert)	**Strategic goal: Every team is empowered to make improvements using patient (or user) feedback, in order that all patients at UHD receive quality care, which results in a positive experience for them, their families and/or carers.** **PALS and Complaints Team** **Advise (1) FFT (Friends and Family Test) Response rates: FFT response rates have returned to levels expected and reported at 91% in June 2023.** In June there were 456 PALS (Patient Advice Liaison Service) concerns raised, 76 new formal complaints and 13 Early Resolution complaints (ERC) processed. The number of complaints that were responded to and closed in June was 75. Regular meetings with the care groups continue to focus on closing of complaints. Key themes from PALS and complaints: • Quality – clinical standards • Safety – errors, incidents and staff competencies • Communication – absent or incorrect • Respect – caring and patient rights **Alert (1) Complaint response times are exceeding the 55-day response time.** The number of complaints that were responded to and closed remains low with a higher number of complaints exceeding 55-day response time, which remains a risk. Additional resource has been sourced and a new corporate complaints process initiated. Despite not seeing a rapid decline in overdue complaint responses the overall average time to respond has reduced meaning that new complaints being processed through the new complaint model is more timely. **Mixed Sex Accommodation Breaches** There were no reported MSA incidents in June 2023.
Nurse Staffing: (3 Advise, 1 Alert)	**Care Hours per Patient Day (CHPPD)** **Advise (1)** June's CHPPD for registered nurses and midwives remained static at 4.8. **Healthcare Support Workers (HCSW)** **Advise (2):** HCSW vacancies remain high; however, June's recruitment event saw high numbers of attendees progressing to job offer. **Alert (1)** The Trust is meeting monthly with the NHS SW Direct support team, to help improve the recruitment and retention of HCSWs.

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

	Assure (3) NHSE Continual Personal Development (CPD) 2023/24 funding confirmed for the Trust of £1,660,000. Nursing and Midwifery Council (NMC) and Health and Care Professions Council (HCPC) registrants are eligible. Additional funding for workforce bid in development.
Resourcing (4 Advise, 3 Alert, 1 Assure)	**Alert (1)** Vacancy rate is being reported at 6.6% as at end of June. **Alert (2)** The Trust is in the top 10 nationally for WTE HCSW vacancies. **Alert (3)** National disruption to the recruitment portal (TRAC) in the last 2 weeks of June. **Medical Recruitment Activity** **Assure (1)** There were 5 new medical starters in June, with 96 medical candidates in the pipeline, over half of whom are international candidates. **General Recruitment Activity** **Assure (2)** Despite national disruption to TRAC, which was not available for use by recruiting managers, applicants or the recruitment team for much of the last two weeks of June, the number of adverts applications and offers in month has remained consistently high. Offers to over 100 newly qualified nurses, and Trainee Nurse Associates (TNA) were sent out. **Advise (1)** The Trust is working in alignment with the NHSE HCSW Direct Support Programme 2023/24 reviewing data and vacancy levels. **Advise (2)** Developing "Support Worker Induction Lite" to increase onboarding places from 32 to 54 per month. Those with previous/current care experience and/or Care Certificate eligible for Induction Lite. **International Recruitment Activity** **Advise (3)** Our first International Radiographers are due to arrive in July from the Philippines, with a further four in the process of being recruited. **Advise (4)** 25 Registered Nursing Degree Apprenticeships (RNDAs) in recruitment pending September start across the Trust.
Occupational Health and Wellbeing	In June OH (Occupational Health) received 183 management referrals, 79% of these were offered an appointment within 10 days of the referral being submitted. 382 pre-placements were received in June, this is a 133% increase from May 2023 and relates to the success of our recruitment activities. The staff physio service and the Psychological Support and Counselling (PSC) service both have a 3-week wait for a new appointment. Initial planning has started for the autumn vaccination program for Trust staff.
Workforce Systems (3 Advise, 2 Alert, 1 Assure)	**Alert (1)** ESR (Electronic Staff Record) Data cleanse - Data from ESR and budgets need to be cleansed to ensure effective, correct and accurate data is presented about the workforce in the Trust. Concerns exist around completion by end of September. **Alert (2)** Lack of rota coordinators in Care Groups is impacting on medical rostering project.

	Advise (1) ESR Data cleanse - The project is 16.5% complete with an expected date of completion as the 30th of September 2023. Progress will be reviewed in mid-July. Lead role may need to be extended post review in July. **Advise (2) Safe Care (safe staffing) -** Aim for the Safecare programme to be fully utilised by April 2024, this will be rolled out in two phases, phase 1 to re-introduce the Safecare sunburst into the daily staffing meetings in September, Phase 2 is based on training around the full abilities of Safecare **Advise (3) Template Reviews -** All 56 templates have been costed, comparisons to the current templates are being undertaken to assess differences.
Temporary Workforce ***(1 Advise, 1 Alert, 2 Assure)***	**Alert (1)** Nursing- demand for bank and agency remain high up 4.4% from previous month. **Advise (1)** Medical Bank and agency requirements indicate a marginal increase in duties requested on Locum Nest Medical Bank with a fill rate of 86%. This is a 5% reduction of fill from previous month. **Assure (1)** The use of high volumes of Registered Mental Health Nurses (RMNs) from off-framework also contributed to the high spend in Q3/Q4 but this trend has been reversed since March. **Assure (2**) A review was undertaken of utilising appropriately skilled untrained Mental Health support has reduced the demand for registered mental health requirements to mainly support staff. A 'Bank Campaign' is now underway to grow the Mental Health Support workforce for the Trust Bank. Hunter Healthcare is currently re-negotiating current agency Mental Health Social Work (MHSW) charge rates to realise further savings. 93 bank applications were received for substantive staff in June – this is a 3.3% increase from May. Overall, 117 new bank workers were added into ESR by Payroll in June.
Organisational Development ***(3 Advise, 2 Assure)***	**Leadership & Talent Advise** • We will shortly be advertising spaces for this year's Coaching Apprenticeship through BPP • Successful closing session for cohort 3 of the Leadership Fundamentals Programme, including Action Learning Sets. Cohort 4 has their final session week commencing 3 July. **Culture & Engagement Advise** • Work has commenced on the 2023 Staff Survey. • The first UHD Staff Awards was held on 15 June. • Quarterly People Pulse is open during July. **EDI Assure** • See Me First campaign launched to visibly acknowledge support required for our staff from an ethnic minority background to eliminate racist and discriminatory behaviour. • A UHD Cultural Awareness Day took place on the 7 July in partnership with the BAME (Black, Asian and minority ethnic) staff network. **Health & wellbeing Assure** • Mental Health First Aider (MHFA) survey circulated. New information and application form created. MHFA Teams channel set up. Online MHFA update training arranged and

	two new cohorts of training organised for September and October • Wellbeing check in conversations developed and rolled out in therapies. Full Trust role out July 2023. **FTSU (Freedom to Speak Up) Advise** • A Deputy FTSU Guardian will be commencing in post from 21 August 2023, for one year.
Trust Finance Position	**Strategic goal: To return to recurrent financial surplus from 2026/27** The Dorset ICS (Integrated Care System) submitted a balanced revenue plan for the year, being the aggregate of individual organisational plans each of which confirmed a break-even revenue plan. However, the Trusts operational revenue budget for the year contains considerable financial risk. A range of mitigation plans have been identified and budgets continue to be actively managed to safeguard the financial performance of the Trust. At the end of June 2023 the Trust reported a deficit of £7.3 million against a planned deficit of £4.4 million representing an adverse variance of £2.9 million. This is mainly due to energy cost inflation £1.379 million, the net cost of the Nursing and Junior Doctors Strike £923,000, unfunded escalation costs of £839,000 together with premium cost pay overspends in the Care Groups. This has been off-set in part by additional bank interest due to a higher cash holding and recent movement in Bank of England base rates and reduced depreciation charges due to the timing of capital expenditure. Cost Improvement Programme savings of £4.1 million have been achieved as at 30 June against a target £3.8 million. This includes non-recurrent savings of £2.5 million. The full year savings requirement is £33.3 million which represents a significant challenge. Current savings plans total £17.9 million representing a shortfall of £15.5 million and a recurrent shortfall of £22 million. Mitigating this shortfall continues to be the key financial focus for the Trust. The Trust has set a full year capital budget of £199.6 million, including £172.7 million of centrally funded schemes including the acute reconfiguration and the New Hospital Programme (NHP). At the end of June 2023 the Trust has committed capital expenditure of £14.6 million against a plan of £51.8 million representing an underspend of £37.2 million. This underspend relates mainly to the New Hospitals Programme and STP (Sustainability and Transformation Plans) Wave 1. The STP Wave 1 full year forecast remains consistent with the plan, however the NHP forecast is dependent on timings of approval and may result in a lower year end spend requiring a re-phasing of the national funding. As at 30 June 2023 the Trust is holding a consolidated cash balance of £101.4 million which is fully committed against the future Capital Programme. The current cash balance is higher than planned due to the successful award of capital funding for multiple schemes alongside a re-phasing of the capital programme spend. The balance attracts Government Banking Services interest of 4.89% at

	current rates, together with a PDC (Public Dividend Capital) benefit of 3.5%. In June there has been a deterioration in the Trusts payment performance due to volume of temporary staffing invoices experienced through the Temporary Staffing Office however recruitment within this team is in progress to further mitigate this risk. Finance continues to work closely in supporting the team in clearing invoices within 30 days.
Key Recommendations:	Members are asked to: • Note the content of the report
Implications associated with this item:	Council of Governors ☐ Equality and Diversity ☒ Financial ☒ Operational Performance ☒ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☒ Regulatory ☒ Strategy/Transformation ☒ System ☒
CQC Reference:	Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well Led ☒ Use of Resources ☒

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Finance & Performance Committee (Operational / Finance Performance)	17 July 2023	Meeting not yet taken place at the time of preparation of the report.
Quality Committee (Quality)	18 July 2023	Meeting not yet taken place at the time of preparation of the report.
Trust Management Board	25 July 2023	Meeting not yet taken place at the time of preparation of the report.
Board of Directors	26 July 2023	Meeting not yet taken place at the time of preparation of the 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

COUNCIL OF GOVERNORS - PART 1 MEETING

Meeting Date: 27 July 2023

Agenda item: 6.1

Subject:	Annual Report and Accounts 2022/23
Prepared by:	Executive Team
Presented by:	Siobhan Harrington, Chief Executive Officer Pete Papworth, Chief Finance Officer

Strategic themes that this item supports/impacts:	Systems working and partnership Our people Patient experience Quality: outcomes and safety Sustainable services Patient First programme One Team: patient ready for reconfiguration	☒ ☒ ☒ ☒ ☒ ☒ ☒
BAF/Corporate Risk Register: (if applicable)	N/A	
Purpose of paper:	Information	
Executive Summary:	The Council of Governors are required to receive the Trust's Annual Report and Accounts for the year ending 31 March 2023.	
Background:	The statutory and regulatory requirements of a Foundation Trust include completion and submission of the Annual Report and Accounts.	
Key Recommendations:	For the Council of Governors to note the contents of the Annual Report and Accounts 2022/23. Hard copies of the documents are available upon request to the Communications Team.	
Implications associated with this item:	Council of Governors Equality and Diversity Financial Operational Performance People (inc Staff, Patients) Public Consultation Quality Regulatory Strategy/Transformation System	☒ ☒ ☒ ☒ ☒ ☐ ☒ ☒ ☒ ☒

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

Report History: Committees/Meetings at which the item has been considered:	Date	Outcome
Trust Management Board	06/06/2023	For information and discussion.
Trust Management Board	27/06/2023	Endorsed.
Joint Audit Committee and Finance and Performance Committee	28/06/2023	Endorsed and recommended to the Board of Directors for approval.
Board of Directors Part 1	28/06/2023	Approved subject to amendments.

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

COUNCIL OF GOVERNORS - PART 1 MEETING

Meeting Date: 27 July 2023

Agenda item: 6.2

Subject:	External Audit Year-End Reports
Prepared by:	Duncan Laird, Senior Manager, KPMG
Presented by:	Jon Brown, Partner, KPMG

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 external audit of the financial statements has been completed. The external auditors annual report summarises the findings and conclusions.
Background:	The Auditor's Annual Report is a public-facing document to be published on the Trust's website and summarises our audit findings and provides our commentary on the arrangements in place for the Value for Money domains of Financial Sustainability, Governance and Economy, Efficiency and Effectiveness.
Key Recommendations:	For the Council of Governors to note the external auditors annual report.
Implications associated with this item:	Council of Governors ☒ Equality and Diversity ☐ Financial ☒ Operational Performance ☐ People (inc Staff, Patients) ☐ Public Consultation ☐ Quality ☐ Regulatory ☐ Strategy/Transformation ☐ System ☐

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

Report History: Committees/Meetings at which the item has been considered:	Date	Outcome
Joint Audit and Finance and Performance Committee	28/06/2023	Endorsed and recommended approval to the Board of Directors.
Board of Directors	28/06/2023	Approved.

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

KPMG

Auditor's Annual Report 2022/23

University Hospitals Dorset NHS Foundation Trust

28 June 2023

Key contacts

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Contents

This report is addressed to University Hospitals Dorset NHS Foundation Trust (the Trust) and has been prepared for the sole use of the Trust. We take no responsibility to any member of staff acting in their individual capacities, or to third parties.

External auditors do not act as a substitute for the audited body's own responsibility for putting in place proper arrangements to ensure that public business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively.

Summary

Introduction

This Auditor's Annual Report provides a summary of the findings and key issues arising from our 2022-23 audit of University Hospitals Dorset NHS Foundation Trust (the 'Trust'). This report has been prepared in line with the requirements set out in the Code of Audit Practice published by the National Audit Office and is required to be published by the Trust alongside the annual report and accounts.

Our responsibilities

The statutory responsibilities and powers of appointed auditors are set out in the Local Audit and Accountability Act 2014. In line with this we provide conclusions on the following matters:

Accounts - We provide an opinion as to whether the accounts give a true and fair view of the financial position of the Trust and of its income and expenditure during the year. We confirm whether the accounts have been prepared in line with the Group Accounting Manual prepared by the Department of Health and Social Care (DHSC).

Annual report - We assess whether the annual report is consistent with our knowledge of the Trust. We perform testing of certain figures labelled in the remuneration report.

Value for money - We assess the arrangements in place for securing economy, efficiency and effectiveness (value for money) in the Trust's use of resources and provide a summary of our findings in the commentary in this report. We are required to report if we have identified any significant weaknesses as a result of this work.

Other reporting - We may issue other reports where we determine that this is necessary in the public interest under the Local Audit and Accountability Act.

Findings

We have set out below a summary of the conclusions that we provided in respect of our responsibilities:

Accounts	We issued an unqualified opinion on the Trust's accounts on 28 June 2023. This means that we believe the accounts give a true and fair view of the financial performance and position of the Trust. We have provided further details of the key risks we identified and our response on page 4.
Annual report	We did not identify any significant inconsistencies between the content of the annual report and our knowledge of the Trust. We confirmed that the Governance Statement had been prepared in line with the DHSC requirements.
Value for money	We are required to report if we identify any significant weaknesses in the arrangements the Trust has in place to achieve value for money. We have nothing to report in this regard.
Other reporting	We did not consider it necessary to issue any other reports in the public interest.

Accounts Audit

The table below summarises the key risks that we identified to our audit opinion as part of our risk assessment and how we responded to these through our audit.

Risk	Findings
Valuation of land and buildings Land and buildings are required to be held at fair value. As hospital buildings are specialised assets and there is not an active market for them they are usually valued on the basis of the cost to replace them with a 'modern equivalent asset'. The Trust engages an expert valuer to provide a valuation of land and buildings at year end.	The Trust engaged Cushman & Wakefield to undertake a desktop valuation of the estate as at 31 March 2023. We did not identify any material misstatements relating to this risk. We considered the estimate to be balanced based on the procedures performed to challenge key assumptions within the valuation, including the use of relevant indices and assumptions of how a modern equivalent asset would be developed.
Fraudulent expenditure recognition Auditing standards suggest for public sector entities a rebuttable assumption that there is a risk expenditure is recognised inappropriately. We recognised this risk over the completeness of non-pay expenditure at year end.	We completed substantive testing including reviewing transactions around the period end to confirm the correct recognition criteria, investigating a sample of variances within the Agreement of Balance exercise and performing sample testing of accruals made at year end to identify potential high risk transactions, which were then agreed to supporting documentation. We did not identify any material misstatements or raise any recommendations relating to this risk.
Management override of controls We are required by auditing standards to recognise the risk that management may use their authority to override the usual control environment.	Our audit methodology incorporates the risk of management override as a default significant risk. We assessed the design and implementation of controls over the posting of journals including post-closing adjustments. We also selected journals that were considered high risk, through applying specific risk based criteria, to test and agreed these journals to supporting documentation. We did not identify any material misstatements or raise any recommendations relating to this risk.

Value for money

Introduction

We consider whether there are sufficient arrangements in place for the Trust for each of the elements that make up value for money. Value for money relates to ensuring that resources are used efficiently in order to maximise the outcomes that can be achieved.

We undertake risk assessment procedures in order to assess whether there are any risks that value for money is not being achieved. This is prepared by considering the findings from other regulators and auditors, records from the organisation and performing procedures to assess the design of key systems at the organisation that give assurance over value for money.

Where a significant risk is identified we perform further procedures in order to consider whether there are significant weaknesses in the processes in place to achieve value for money.

Further details of our value for money responsibilities can be found in the Audit Code of Practice at Code of Audit Practice (nao.org.uk).

Matters that informed our risk assessment

The table below provides a summary of the external sources of evidence that were utilised in forming our risk assessment as to whether there were significant risks that value for money was not being achieved:

Source	Detail
Care Quality Commission rating	The last CQC inspection, published in March 2023, maintained the Trust's overall rating as Good.
Single Oversight Framework rating	The Trust is allocated to segment 3.
Governance statement	There were no significant control deficiencies identified in the governance statement that impacted on our VFM conclusion.
Head of Internal Audit opinion	The Head of Internal Audit opinion gave the Trust moderate assurance that there is a sound system of internal control

Commentary on arrangements

We have set out on the following pages commentary on how the arrangements in place at the Trust compared to the expected systems that would be in place in the sector.

Summary of findings

We have set out in the table below the outcomes from our procedures against each of the domains of value for money:

Domain	Risk assessment	Summary of arrangements
Financial sustainability	**No significant risks identified**	**No significant weaknesses identified**
Governance	**No significant risks identified**	**No significant weaknesses identified**
Improving economy, efficiency and effectiveness	**No significant risks identified**	**No significant weaknesses identified**

Value for money

Financial sustainability	
Description	**Commentary on arrangements**
This relates to ensuring that the Trust has sufficient arrangements in place to be able to continue to provide its services within the resources available to it. We considered the following areas as part of assessing whether sufficient arrangements were in place: ▪ How the Trust sets its financial plans to ensure services can continue to be delivered; ▪ How financial performance is monitored and actions identified where it is behind plan; and ▪ How financial risks are identified and actions to manage risks implemented.	Whilst the Trust was funded to a break even position during covid, the revised arrangements require more robust financial management. The introduction of an Integrated Care system (ICS) break even target also increased the pressure on the Trust to deliver a strong financial performance to contribute to the wider system position. University Hospitals Dorset NHS Foundation Trust (UHD) is a member of the Dorset ICS, and, as a part of the ICS, shares responsibility for any deficit across the system. For 2022/23 UHD delivered a surplus of £0.2m against a planned breakeven position, with the system reporting a £0.5m surplus position overall. The initial financial plans were constructed based on appropriate local and national planning assumptions, with the involvement of budget holders in setting the financial plan and appropriate review and approval from the Finance and Performance Committee (FPC) and Trust Board. Where plans were revised following feedback from the ICS and NHSE, movements from the plan were resubmitted to relevant governance committees for review and discussion. The Trust was given Cost Improvement Plan (CIP) target of £19.1 million for the year alongside a Covid cost reduction target of £13.1 million, with the Covid element to be delivered non-recurrently. At year end, the Trust had achieved the full Covid cost reduction target and £18m of the CIP target, however only £7.2 million of the CIP efficiencies were considered to be recurrent. The reliance on non-recurrent funding creates additional pressures on future years. Whilst we acknowledge the challenges to deliver recurrent savings, the Trust should ensure there remains a focus on these rather than non-recurrent items. A breakeven plan for 2023/24 for the Dorset ICS was submitted in March but this includes significant challenges and savings not yet identified. We found effective arrangements for the alignment of financial, workforce and operational plans. During the financial planning process, medium/long term plans are aligned to the budgets (financial plans) which are approved by budget holders. Budget holders also have joint ownership of workforce and operational plans, which ensures alignment of key planning documents within the Trust. We found that the Trust has an appropriate reporting framework in place. The financial performance of the Trust is reported each month to the Finance and Performance Committee with identification of risks within the position. There was evidence of discussion and challenge by the Committee. A summary report is then provided to Board. The Trust has identified financial sustainability and cost improvement as strategic objectives, which are included on the Board Assurance Framework reported to the Board. The principle risks identified include that the Trust and the ICS will fail to deliver a financial break-even position resulting in regulatory intervention, an unplanned reduction in cash and the inability to afford the agreed 6 year capital programme.

Value for money

Governance	
Description	**Commentary on arrangements**
This relates to the arrangements in place for overseeing the Trust's performance, identifying risks to achievement of its objectives and taking key decisions. We considered the following areas as part of assessing whether sufficient arrangements were in place: ▪ Processes for the identification and management of strategic risks; ▪ Decision making framework for assessing strategic decisions; ▪ Processes for ensuring compliance with laws and regulations; ▪ How controls in key areas are monitored to ensure they are working effectively.	We consider the Trust to have effective processes in place to monitor and assess risk. Strategic risks are recorded and identified using the Board Assurance Framework (BAF), and any identified risks are reported to Board. The BAF is reviewed by the Audit Committee on a quarterly basis and at least bi-annually by the Board. A 5x5 scoring matrix is used by the Trust to score operational risks. All risks rated 12+ are escalated to the Board of Directors and risk status reviewed monthly and are reported to the Audit Committee and risk controls and action plans discussed quarterly. Within the risk register, individual risks are scored, described and assigned an Executive Lead, who are responsible for providing a monthly update on risk status to the Quality Committee and Board of Directors. Our review of the risk register found that this was sufficiently detailed to effectively manage key risks and we identified evidence of review within both the Audit Committee and Board throughout the year. The effectiveness of internal controls is monitored by the Audit Committee, through reporting from Internal Audit and Local Counter Fraud. The programme of work for each organisation is approved at the start of the financial year by the Audit Committee, following input by the lead director. Any recommendations raised by Internal Audit or the Local Counter Fraud teams are reported to the Audit Committee. Our attendance at Audit Committee and review of the Audit Committee papers confirmed that there were appropriate discussions and follow up of recommendations for both Internal Audit and Local Counter Fraud. The Trust has a staff code of conduct and staff handbook in place, as per the standards of conduct and business behaviour policy. Specific guidance is in place for teams and managers via standards of behaviour for these roles. Overall compliance with legislation, laws & regulations is monitored by an annual review of license conditions reported to Board. A register of interests is in place together with a policy for gifts and hospitality. The Trust conducts regular monitoring on new entries to the register with these taken for review to the Audit Committee. Financial plans are approved by the Board, following review and sign off by budget holders, who monitor performance on a monthly basis, with results reported to the Finance and Performance Committee. We found there to be appropriate scrutiny and challenge of the budgets, and appropriate approval through the budget holders and the Finance and Performance Committee for the 2022/23 budget. In order to understand financial performance against budget, budget holders are provided with monthly budget statements which are reviewed by the finance managers. Discussions between finance managers and budget holders enable appropriate challenge and response to adverse variances. The Finance and Performance Committee scrutinise monthly performance, before recommending if any specific actions should be escalated to the Board.

Value for money

Governance (continued)	
Description	**Commentary on arrangements**
This relates to the arrangements in place for overseeing the Trust's performance, identifying risks to achievement of its objectives and taking key decisions. We considered the following areas as part of assessing whether sufficient arrangements were in place: ▪ Processes for the identification and management of strategic risks; ▪ Decision making framework for assessing strategic decisions; ▪ Processes for ensuring compliance with laws and regulations; ▪ How controls in key areas are monitored to ensure they are working effectively.	The CQC undertook inspections of medical care and surgery at Poole Hospital and Royal Bournemouth Hospital in September 2022 and of maternity services at Poole Hospital in November 2022. The reports were published on 10 March 2023 and the CQC rated Poole Hospital's maternity service inadequate and Poole Hospital's surgery as requires improvement. The result is that the overall rating for Poole Hospital has been downgraded to requires improvement, having previously been rated good. No rating was issued for the Royal Bournemouth Hospital, so it remains rated good overall. We have seen evidence of the action plans and responses to the CQC as a result of the inspections and consider the arrangements to be appropriate. Key strategic decisions are made via the Trust's governance process. A scheme of delegation is in place which sets out where different decisions/approvals should take place. Key decisions are made through management and escalation processes for such matters at divisional operational, executive management and Board level. The Standing Financial Instructions and Scheme of Delegation provide guidance for authorisation limits and responsibility for decision making.

Value for money

Improving economy, efficiency and effectiveness	
Description	**Commentary on arrangements**
This relates to how the Trust seeks to improve its systems so that it can deliver more for the resources that are available to it. We considered the following areas as part of assessing whether sufficient arrangements were in place: ▪ The planning and delivery of efficiency plans to achieve savings in how services are delivered; ▪ The use of benchmarking information to identify areas where services could be delivered more effectively; ▪ Monitoring of non-financial performance to assess whether objectives are being achieved; and ▪ Management of partners and subcontractors.	For financial year 2022/23, formal CIP programmes have been re-introduced. At year end, the Trust had achieved the full Covid cost reduction target of £13.1m and £18m of the £19.1 CIP target, however only £7.2 million of the CIP efficiencies were considered to be recurrent. A monthly paper is presented to the Trust's Finance and Performance Committee in order to report on financial performance, allowing the Trust to assess the level of value for money being achieved. Operational Performance is monitored through the weekly Operational Performance Group and monthly through the Finance and Performance Committee, and bi-monthly through the Board. A detailed Integrated Performance Report has been developed to ensure all key metrics are reported through to the Board. Our review of Board minutes and the weekly operating performance group reports found an appropriate level of review and challenge. The Trust forms part of the Dorset ICS and members of the Board and Leadership team are integrated within the governance of the system. This includes the Chief Financial Officer and Chief Operating Officer involvement in system decisions through the Operations and Finance Reference Group and Chief Executive Involvement in the system Leadership Team. This ensures the Trust is integrated into key system decisions and feeds back to the Trust via relevant Board, Committee and operational/clinical meetings. Planning is performed at an ICS level as well as considering the individual entities that make up the ICS, with the aim of achieving financial sustainability at a system level, although there also remains a focus on achieving financial balance at a organisational level. The Trust CEO and Chair provide updates within their reports to Board with the ICS financial performance also being considered in the finance reports. Working within an ICS, the interaction between providers and other stakeholders is essential to ensure the appropriate operational and clinical flows across the system. System working is embedded as business as usual to enact the appropriate actions and change. This is underpinned by the Dorset Health System Collaborative Agreement, which in its agreement principles, states that all providers agree to work within the aggregate of organisational control totals.

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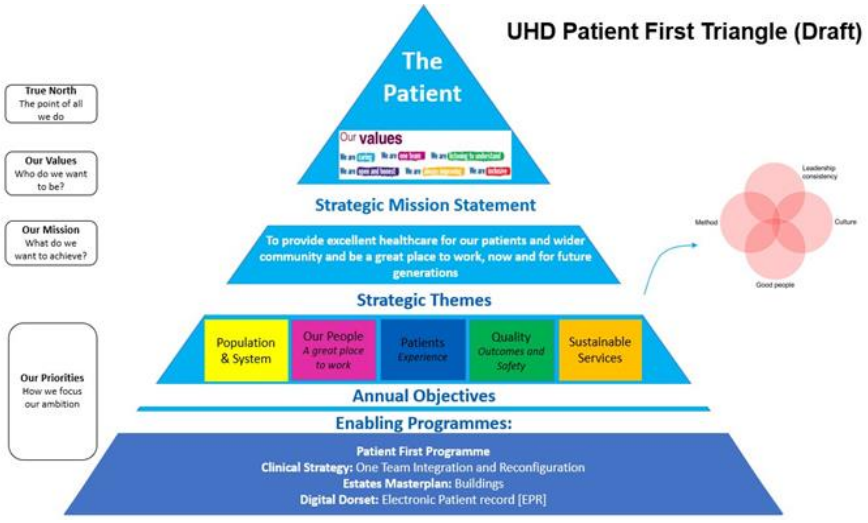
University Hospitals Dorset
NHS Foundation Trust

COUNCIL OF GOVERNORS - PART 1 MEETING

Meeting Date: 27 July 2023

Agenda item: 6.3

Subject:	Summary of Operational Plan
Prepared by:	Alan Betts, Director of Integration and Improvement
Presented by:	Richard Renaut, Chief Strategy and 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: (if applicable)	To be updated with 2023/24 BAF
Purpose of paper:	Information
Executive Summary:	This report provides a summary of key messages from the Annual Plan. Our True North, Strategic Themes and Annual Objectives are being developed as part of our Patient First approach. These are summarised below and will underpin our work in 2023/2024. 

The Annual Plan provides more detail as to the strategic themes and enabling programmes that will underpin our work during 2023/24.

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

Themes	Goal	2023/24 Objectives (SMART wording being developed)
Systems and Partnerships	To meet the patient national constitutional standards for Planned and Emergency care. supporting inequalities in outcome and access and improving productivity and value.	To have no patients waiting in excess of 65 weeks on an RTT pathway to be seen and treated by March 2024 [Stretch target: To have zero non admitted patients above 52 weeks by March 2024]. To achieve 76% of patients treated within 4 hours through the emergency care pathway by March 2024.
Our People	To significantly improve staff experience, engagement and retention over the next 3 years [with NHS Staff Survey results in top 20% of comparator trusts].	All wards / departments taking action to improve their 2022 National Staff Survey results, by March 2024. Overall 2023 NHS Staff Survey results: • Staff Engagement Score > 7/10 • Staff Morale Score > 6/10 • Q23c: I would recommend my organisation as a great place to work > 62% • People Promise 'We are safe and healthy' > 6/10 To achieve a 13% staff turnover rate by March 2024.
Patient Experience	To achieve top 20% in the inpatient survey about the quality of care provided at UHD over the next 3 years.	Family and Friend Test (what our patients say) • Feedback rates increases from baseline in all service over the next year.

	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.	• Is in top 20% rated 'good' over a 3-year period. • Every ward / clinical service has access to monthly Have Your Say survey information and data by March 2024.
Quality (Outcomes and Safety)	To achieve top 20% of trusts in the country for HSMR over the next 3 years. To reduce moderate/severe harm patient safety events by 30% over a 3-year period through the development of an outstanding learning culture	To reduce HSMR over the next 18 months [Sept 2024].
Sustainable Services	To return to recurrent financial surplus from 2026/27.	To reduce the recurrent underlying deficit over a 3-year period [Closing balance of £20m by March 2024].
Patient First Programme	To successfully and sustainably adopt the Patient First approach across UHD.	To deliver Year 1 of transitioning to the Patient First approach including all staff attending a 'Let's have a Conversation' session and encouraged to identify improvements in their ward / department.
One Team *Patient Ready for Reconfiguration*	To integrate teams and services, then to reconfigure, and so create the planned and emergency hospitals	For every service to have an agreed plan to integrate and start delivery so they are "move in" and "patient ready" for the future

UHD Annual Operating Plan process

The Trust's Annual Operating Plan narrative is available on the Trust website https://www.uhd.nhs.uk/uploads/about/docs/our_publications/2023-24_uhd_operational_plan.pdf. This narrative has been drafted by nominated leads throughout the Trust has undergone Executive,

	Trust Management Board (TMB) and Board of Directors review at the time of submission to the Council of Governors. The plan has been accepted at Dorset ICS (Integrated Care System), and south west region level as being compliant and not requiring further revision. Tracking delivery of the plan will be more focused than previous years, with Board committees using the Board Assurance Framework as a main item for their attention and tracking if plans are on track or require escalation. Operational responsibility for delivery will be via TMB and the groups reporting into this. This will require a re-formatting of the TMB and Board committee agendas and time allocated, with a focus on corporate objectives being delivered. Other measures will be 'watched' and managed as business as usual.
Background:	In line with the operational planning guidance and the NHS Dorset Integrated Care Board planning process, annual plans have been developed at specialty Care Group and Trust level that support delivery of quality, financial, workforce and operational objectives alongside the Trust's reconfiguration plans. As this is a transition year to embedding a Patient First approach, some aspects are in development, including adapting a smaller more focused set of strategic themes. The Trust will also align with the ICS Forward Plan and focus on prevention, thriving communities and joined up services.
Key Recommendations :	The Council of Governors are asked to: • **Note** the challenges in delivery of the objectives within the Annual Plan for 2023/24 and the ongoing work required to meet financial, activity, workforce and quality objectives alongside delivery of performance objectives. The risks to achievement will be tracked through the Board Assurance Framework. • **Note** the change in how we work in 2023/24 with greater focus and tracking of progress on a smaller number of higher impact actions, with a 'watch' business as usual approach for the other measures and actions.
Implications associated with this item:	Council of Governors ☐ Equality and Diversity ☐ Financial ☒ Operational Performance ☒ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☒ Regulatory ☒ Strategy/Transformation ☒ System ☒

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

Report History: Committees/Meetings at which the item has been considered:	Date	Outcome
Board of Directors Part 1	24/05/2023	Approval
Board of Directors Part 2	25/04/2023	Draft for approval
Trust Management Board	22/04/2023	Recommendation
Council of Governors	20/03/2023	Information/Update
Trust Management Board	21/02/2023	Information/Update
Trust Management Board	07/01/2023	Information/Update

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

COUNCIL OF GOVERNORS - PART 1 MEETING

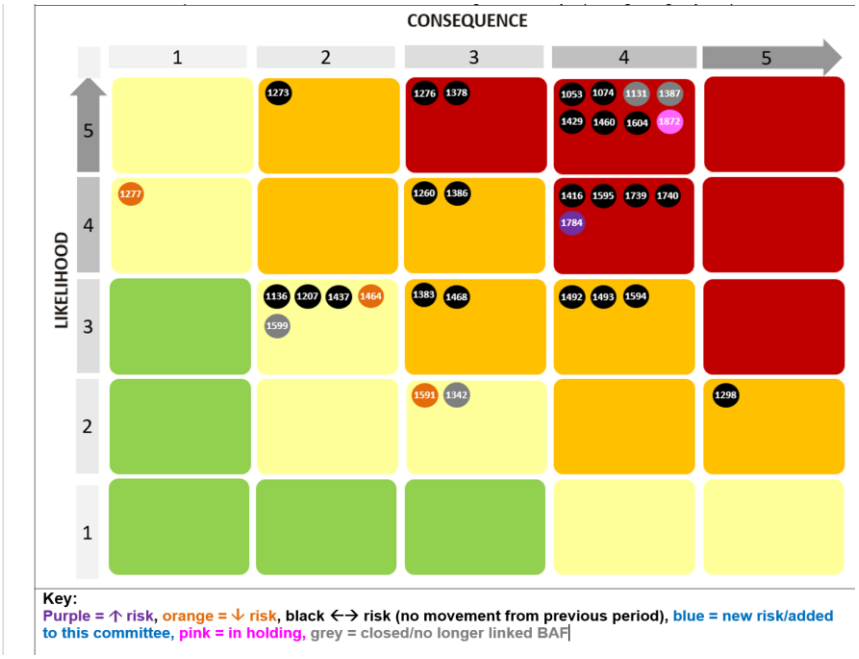
Meeting Date: 27 July 2023

Agenda item: 6.4

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

Strategic themes that this item supports/impacts:	Systems working and partnership ☐ Our people ☐ Patient experience ☐ Quality: outcomes and safety ☒ Sustainable services ☐ Patient First programme ☐ One Team: patient ready for reconfiguration ☐
BAF/Corporate Risk Register: (if applicable)	All
Purpose of paper:	Information
Executive Summary:	The 2022/23 BAF for the Trust is linked to the Board Objectives agreed at the Board of Directors meeting in May 2022. The Q4 report (1 January 23 – 31 March 2023) provides full details of the risks linked to the Board objectives. The table below provides a Q4 summary:

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

	Q4 Heat Map:  The process for agreement and monitoring of the Board objectives, associated KPI and BAF for 2023/24 is provided in a separate paper.
Background:	The Board Assurance Framework is a systematic approach to the identification, assessment and mitigation of the risks that could hinder the Trust achieving its strategic goals. The assurance framework contains information regarding internal and external assurances that organisational goals are being met. Where risks are identified, mitigations and subsequent action plans are mapped against them.
Key Recommendations:	To note for information.
Implications associated with this item:	Council of Governors ☐ Equality and Diversity ☐ Financial ☐ Operational Performance ☒ People (inc Staff, Patients) ☐ Public Consultation ☐ Quality ☒ Regulatory ☐ Strategy/Transformation ☐ System ☐
CQC Reference:	Safe ☐ Effective ☐ Caring ☐ Responsive ☐ Well Led ☒ Use of Resources ☒

Report History: Committees/Meetings at which the item has been considered:	Date	Outcome
Quality Committee	16/05/2023	Received for information
Audit Committee	18/05/2023	Received for information
Board of Directors Part 1	24/05/2023	Received for information

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

COUNCIL OF GOVERNORS - PART 1 MEETING

Meeting Date: 27 July 2023

Agenda item: 6.5

Subject:	Board Assurance Framework (BAF) 2023/24
Prepared by:	Jo Sims, Catherine Hurst
Presented by:	Paula Shobbrook, Chief Nursing Officer

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

Background:	The BAF updated process is developmental and will continue to evolve. Additional BAF risks can also be added, especially for strategic and system risks. The risk register remains active and has both frontline identified risks, and strategy/Board identified risks.
Key Recommendations:	The Boards is asked to review the updated BAF, the controls, and gaps in controls and assurance. Suggestions on improvements to both the content and presentation are invited as part of our always improving approach. The Board is asked to scrutinize the progress being made and the forward looking plans to move towards the target level of risk for each BAF.
Implications associated with this item:	Council of Governors ☒ Equality and Diversity ☒ Financial ☒ Operational Performance ☒ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☒ Regulatory ☒ Strategy/Transformation ☒ System ☒
CQC Reference:	Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well Led ☒ Use of Resources ☒

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Drafts have been shared at Committees and the February and June Board Development sessions.	Various	The agreement of the strategic themes, annual objectives and Annual Operating Plan, has now allowed the BAF to be updated, using the agreed format.
Board of Directors Part 1	26/07/2023	Meeting as not yet taken place.

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

Board Assurance Framework - Plan on a Page 2023/24

NHS
University Hospitals Dorset
NHS Foundation Trust

Team UHD
Our 7 objectives
2023-24

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

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

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

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

PROGRESS

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

Record here any recent risk score changes and why

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

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

PROGRESS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PROGRESS

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

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

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

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

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

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

PROGRESS

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

University Hospitals Dorset
NHS Foundation Trust

COUNCIL OF GOVERNORS - PART 1 MEETING

Meeting Date: 27 July 2023

Agenda item: 6.6

Subject:	Appointment of the Vice Chair
Prepared by:	Sarah Locke, Deputy Company Secretary
Presented by:	Rob Whiteman, Trust Chair

Strategic themes that this item supports/impacts:	Systems working and partnership ☐ Our people ☐ Patient experience ☐ Quality: outcomes and safety ☐ Sustainable services ☐ Patient First programme ☐ One Team: patient ready for reconfiguration ☐
BAF/Corporate Risk Register: (if applicable)	N/A
Purpose of paper:	Decision/Approval
Executive Summary:	As of July 2023, Philip Green is the Vice Chair but will be stepping down from his role of Non-Executive Director as of 30 September 2023. This will require the Council of Governors to appoint a new Vice Chair as of 1 October 2023. The proposal is for this to be Cliff Shearman.
Background:	The Trust Constitution outlines the process for the appointment of the Vice Chair. *Clause 25 Board of Directors – appointment of Vice Chairman* states the following: "The Council of Governors at a general meeting of the Council of Governors shall appoint one of the Non-Executive Directors as a Vice Chairman of the Trust." *Annex 5 Clause 5 Appointment of Vice Chairman of the Board and of the Council of Governors* states the following: "5.1 The Council of Governors shall appoint a Vice Chairman in accordance with Clause 25 of the Constitution." "5.2 Any Non-Executive Director so appointed may at any time resign from the office of Vice- Chairman by giving notice in writing to the Chairman (in Chairman's capacity of Chair of Board and Chair of Council of Governors). The Council of Governors may thereupon appoint another Non-Executive Director as Vice Chairman in accordance with Clause 25 of the Constitution."

	"5.3 The Vice-Chairman may preside at meetings of the Council of Governors."
Key Recommendations:	To approve the appointment of Cliff Shearman as the Vice Chair as of 1 October 2023.
Implications associated with this item:	Council of Governors ☒ Equality and Diversity ☐ Financial ☐ Operational Performance ☐ People (inc Staff, Patients) ☐ Public Consultation ☐ Quality ☐ Regulatory ☐ Strategy/Transformation ☐ System ☐
CQC Reference:	Safe ☐ Effective ☐ Caring ☐ Responsive ☐ Well Led ☒ Use of Resources ☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
N/A	N/A	N/A

Reason for submission to the Board (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

COUNCIL OF GOVERNORS - PART 1 MEETING

Meeting Date: 27 July 2023

Agenda item: 6.7

Subject:	Consultation in relation to Senior Independent Director (SID)
Prepared by:	Sarah Locke, Deputy Company Secretary
Presented by:	Rob Whiteman, Trust Chair

Strategic themes that this item supports/impacts:	Systems working and partnership ☒ Our people ☒ Patient experience ☐ Quality: outcomes and safety ☐ Sustainable services ☐ Patient First programme ☐ One Team: patient ready for reconfiguration ☐
BAF/Corporate Risk Register: (if applicable)	N/A
Purpose of paper:	Decision/Approval
Executive Summary:	Caroline Tapster, Non-Executive Director, currently also holds the role of the Senior Independent Director (SID) of the Trust. Taking into account another role that she now holds, and the time commitment involved, Caroline will be step down as a Non-Executive Director of the Trust in December 2023. It is for the Board of Directors to appoint one of the Non-Executive Directors as the SID, following consultation with the Council of Governors. The proposal upon which the Council of Governors is being consulted is the appointment of Judy Gillow as the SID with effect from 1 October 2023 and for the period of her term of office as Non-Executive Director (unless otherwise determined).
Background:	The Trust Constitution outlines the process for the appointment of the Senior Independent Director. *Annex 7 Clause 3.4 Appointment and Role of the Senior Independent Director* states the following: "3.4.2 The Board shall (following consultation with the Council of Governors) appoint one of the Non-Executive Directors as the SID for such a period not exceeding the

	remainder of the individual's term of office as a Non-Executive Director."
Key Recommendations:	To receive the Council of Governors' feedback upon the consultation on the appointment of Judy Gillow as the Senior Independent Director.
Implications associated with this item:	Council of Governors ☒ Equality and Diversity ☒ Financial ☐ Operational Performance ☐ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☐ Regulatory ☒ Strategy/Transformation ☐ System ☒
CQC Reference:	Safe ☐ Effective ☐ Caring ☐ Responsive ☐ Well Led ☒ Use of Resources ☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
N/A	N/A	N/A

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

COUNCIL OF GOVERNORS - PART 1 MEETING

Meeting Date: 27 July 2023

Agenda item: 6.8

Subject:	Annual Audit Committee Report and Terms of Reference
Prepared by:	Sarah Locke, Deputy Company Secretary
Presented by:	Stephen Mount, Non-Executive Director and Chair of Audit Committee

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:	Information
Executive Summary:	The annual Audit Committee's review of its effectiveness demonstrates to the Council of Governors, how the Audit Committee satisfied its terms of reference during 2022/23. To present to the Council of Governors the terms of reference for the Audit Committee
Background:	The Audit Committee terms of reference specify that the Committee will provide a self-assessment report detailing how the Committee discharged its obligations as set out within its terms of reference. A review of the Audit Committee's compliance with its own terms of reference was undertaken in May 2023 by scrutinising the agendas and minutes of the five Committee meetings which took place between 1 April 2022 and 31 March 2023. The Audit Committee considered that it had discharged its responsibilities as set out in its terms of reference, recognising that new terms of reference were adopted in January 2023.
Key Recommendations:	To note the Audit Committee annual review of its effectiveness and the Committee's terms of reference.

Implications associated with this item:	Council of Governors Equality and Diversity Financial Operational Performance People (inc Staff, Patients) Public Consultation Quality Regulatory Strategy/Transformation System	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☒ ☐ ☐
CQC Reference:	Safe Effective Caring Responsive Well Led Use of Resources	☐ ☐ ☐ ☐ ☒ ☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Audit Committee	13/07/2023	The annual report on the Committeee's review of its own effectiveness was approved. The terms of reference had been in place since January 2023.

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

AUDIT COMMITTEE ANNUAL REPORT 2022/23

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 2022 and 31 March 2023 (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 were reviewed and updated in January 2023[1].

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/or updated as necessary during the year.

2 MEETINGS

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

- Thursday 19 May 2022
- Thursday 21 July 2022
- Thursday 20 October 2022
- Thursday 12 January 2023
- Thursday 9 March 2023

In addition to the Joint Audit and Finance & Performance Committee meeting held on Thursday 16 June 2022.

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

[1] This self-assessment has been prepared against the Committee's terms of reference in effect from 25 January 2023 (notwithstanding that during part of the period under consideration, the previous terms of reference applied).

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. During the review period and with the approval of the Board of Directors in view of the limited duration pending the new Trust Chair joining, Philip Green held the position of Acting Chair of the Trust as well as Chair of the Committee from 1 April 2022 to 31 June 2022 (and therefore attended its meeting held on 19 May 2022).

2.5 Until January 2023 when the Committee's terms of reference were updated to provide for the possibility of two Governors to attend each meeting as observers, it was usual practice for there to be one Governor observer. Since January 2023, two Governors have had the opportunity to attend meetings of the Committee.

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 2022/23 comprised of:

- Philip Green, Non-Executive Director and Chair[2]
- Stephen Mount, Non-Executive Director and Chair[3]
- Pankaj Davé, Non-Executive Director *(until 31 December 2022)*
- John Lelliott, Non-Executive Director
- Cliff Shearman, Non-Executive Director *(from 1 January 2023)*

Stephen Mount, John Lelliott and Pankaj Davé are qualified accountants. Cliff Shearman, Philip Green and Stephen Mount[4] 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 April 2023 by scrutinising the agendas and minutes of the five Committee meetings which took place between 1 April 2022 and 31 March 2023. 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

[2] Philip Green chair until 31 December 2022 and remained a member until after the 12 January 2023 meeting.
[3] Stephen Mount chair from 1 January 2023 and was a member prior.
[4] Philip Green member of the Quality Committee until 31 December 2022. Stephen Mount a member from 1 January 2023.

achievement of the organisations' objectives.[5] 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:

- Annual governance statement – March 2022;
- Annual report – June 2022;
- Quality account – June 2022
- Annual financial statements, including external audit opinion – June 2022;
- Annual draft licence compliance, including assurance – March 2022;
- Annual draft code of governance compliance – March 2022;
- Assurance for corporate governance statement – May 2022.

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 (12+) 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 BAF objectives and provided an assessment of design effectiveness, areas of strength and improvement including recommendations.

For 2023/2024, following discussion by the Board during Board Development Sessions, the BAF document will be enhanced, including to provide clearer presentation of the underlying assurance processes, management of risks (including gaps in controls). These changes will enable the Committee to discharge the above responsibility even more effectively.

4.2.3 **The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications.**

The Trust's Document Control Policy, which outlines the process involved and the procedures to be followed for the creation, approval, publication and review of new or revised Trust-wide clinical and non-clinical policies is due to be reviewed in 2023.

In March 2023, the Committee reviewed the Trust's compliance with the Code of Governance *(also reviewed in May 2022)* and Provider Licence.

4.2.4 **The wording in the annual governance statement and other disclosures relevant to the Terms of Reference of the Committee.**

[5] The Quality Committee has primary responsibility for the oversight of clinical risk management.

The Committee reviewed and recommended approval of the draft annual governance statement in May 2022.

It also recommended approval of the annual certificates (G6 and CoS7) in May 2022.

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[6].**

The clinical audit plan for 2022/23 was presented to the Committee in May 2022.

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 January 2023.

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 endorsed by the Committee in October 2022.

While not one of the specific criteria within the assessment, no concern was raised relating to the standing of the service within the organisation.

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 in May 2022 (2022-23) and March 2023 (2023-24).

The Local Counter Fraud Specialist's reports to the Committee contained findings from investigations.

From April 2023, the Trust's Counter Fraud provider changed from RSM to TIAA.

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:

[6] In conjunction with the Quality Committee

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.

The annual review of the effectiveness of the internal audit service was presented to and endorsed by the Committee in October 2022.

The Committee approved the award of the internal audit contract to BDO in January 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 Committee approved the annual internal audit plan for 2023-24 in March 2023.

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 auditors 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 endorsed by the Committee in October 2022.

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.**

In January 2023, the Committee recommended approval of the award of the external audit contract to the Council of Governors. In October 2022, the Committee reviewed the effectiveness of the external auditors.

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 Committee reviewed the External Audit annual plan in January 2023.

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.**

This was monitored through regular external audit reports.
Previously, in March 2022, the Committee received an internal audit report on key financial systems. This audit was to be repeated in 2023/24.

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.

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 2022. 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 2022.

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.**

During 2022-23, regular reporting on Freedom to Speak Up was presented to the People & Culture Committee.

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 the Emergency Preparedness, Resilience and Response annual report in July 2022, prior to it being presented to the Board.

4.9 The Committee approved its governance cycle in March 2023.

5 CONCLUSION

5.1 The Committee considers that it has discharged its responsibilities as noted above.

Stephen Mount
Chair, Audit Committee
May 2023

Appendix 1 – Attendance at Audit Committee 2022/23

Audit Committee		19 May 2022	21 July 2022	20 October 2022	12 January 2023	09 March 2023
Present	Philip Green					
	Stephen Mount					A
	John Lelliott					
	Pankaj Dave	A				
	Cliff Shearman					
In Attendance	Rob Andrews					
	Melanie Alflatt					
	Leslie Baliga					
	Jonathan Brown					
	Lucy Burgum					
	Jamie Donald					
	Yasmin Dossabhoy					
	David Foley					
	Ewan Gauvin					
	Peter Gill					
	Heather Greenhowe					
	Siobhan Harrington					
	Fiona Hoskins					
	Russell King					
	Sarah Locke					
	Duncan Laird					
	Mark Mould					
	Alyson O'Donnell					
	Pete Papworth					
	Paula Shobbrook					
	Jo Sims					
	Adam Spires					
	Mark Stabb					
	Matt Thomas					
	Kani Trehorn					
	David Triplow					
	Rob Whiteman					
	Paige Willoughby					
	Ruth Williamson					
	Matt Wilson					
Was the meeting quorate?		Y	Y	Y	Y	Y

Key

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

TERMS OF REFERENCE

for the

University Hospitals Dorset NHS Foundation Trust

Audit Committee

January 2023

DOCUMENT DETAILS

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

Approving Body/Committee:	Board of Directors
Chair:	Rob Whiteman
Signed:	
Date Approved:	25 January 2023
Target Audience:	Board of Directors

Document History

Date of Issue	Version No:	Next Review Date:	Date Approved:	Director responsible for Change	Nature of Change
October 2020	1	October 2021	July 2020	Company Secretary	New Document
October 2021	1.1	October 2022		Company Secretary	Deleted 9.1 Requirement for Committee minutes to be reported to the Trust Board Added 9.1 These minutes will be available to the Board fo Directors Remove a phrase at 11.4 i) Amend 11.6,
January 2023	2	January 2024	25 January 2023	Associate Director of Corporate Governance	Alignment of formatting with other Committee ToR; full review and update.

TABLE OF CONTENTS

INDIVIDUAL APPROVAL			
Job Title	N/A	Date	N/A
Print Name	N/A	Signature	
BOARD OF DIRECTORS / COMMITTEE APPROVAL			
If the Board / Committee has approved this document, please sign and date it and forward copies for inclusion on the Intranet.			
Name of approving body	Board of Directors	Date	25 January 2023
Print Name	Rob Whiteman	Signature of Chair	

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

AUDIT COMMITTEE

TERMS OF REFERENCE

1. PURPOSE

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

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

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

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

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

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

2. RESPONSIBILITIES

Governance, risk management and internal control

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

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

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

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

Counter-fraud

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

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

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

Internal Audit

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

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

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

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

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

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

External Audit

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

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

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

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

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

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

Financial reporting

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

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

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

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

2.5.3.2 Areas where judgment has been exercised;

2.5.3.3 Appropriateness and adherence to accounting policies and practices;

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

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

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

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

Freedom to speak up

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

Emergency Preparedness, Resilience and Response (EPRR)

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

3. MEMBERSHIP & ATTENDANCE

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

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

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

and others will attend as invited by the Committee Chair.

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

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

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

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

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

4. AUTHORITY

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

4.2 The Committee is authorised to approve its own governance cycle

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

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

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

5. CONDUCT OF BUSINESS

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

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

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

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

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

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

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

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

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

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

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

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

6. RELATIONSHIPS & REPORTING

6.1 The Committee shall be accountable to the Board.

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

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

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

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

7. MONITORING

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

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

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

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

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

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

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

8. REVIEW

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

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

APPENDIX A

ATTENDANCE AT AUDIT COMMITTEE MEETINGS

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

University Hospitals Dorset
NHS Foundation Trust

COUNCIL OF GOVERNORS - PART 1 MEETING

Meeting Date: 27 July 2023

Agenda item: 6.9

Subject:	Quality Account 2022/23
Prepared by:	Jo Sims, Associate Director Quality Governance and Risk
Presented by:	Paula Shobbrook, Chief Nursing Officer

Strategic themes that this item supports/impacts:	Systems working and partnership ☐ Our people ☐ Patient experience ☒ Quality: outcomes and safety ☒ Sustainable services ☐ Patient First programme ☒ One Team: patient ready for reconfiguration ☐
BAF/Corporate Risk Register: (if applicable)	Not applicable
Purpose of paper:	Review and Discussion
Executive Summary:	This is the second Quality Account for UHD. The Quality Account reports progress against quality priorities set for the financial year 2021/22.
Background:	NHS Trusts are required under the Health Act 2009 and subsequent Health and Social Care Act 2012 to produce Quality Accounts if they deliver services under an NHS Standard Contract, have staff numbers over 50 and NHS income greater than £130k per annum. The Quality Account requirements for 2022/23 are set out in the following publication: https://www.england.nhs.uk/financial-accounting-and-reporting/quality-accounts-requirements The processes for producing Quality Accounts for 2022/23 remain the same as the previous year. • NHS foundation trusts are no longer required to produce a Quality Report as part of their Annual Report. However, NHS foundation trusts are still required to produce a separate Quality Account for 2022/23

	• There is no national requirement for NHS foundation trusts to obtain external auditor assurance on the quality account or quality report, with the latter no longer prepared. • Providers must publish their Quality Accounts on their own websites by 30 June 2023 and forward the link to quality-accounts@nhs.net (NHS providers)
Key Recommendations:	For information at the Council of Governors.
Implications associated with this item:	Council of Governors ☒ Equality and Diversity ☐ Financial ☐ Operational Performance ☐ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☒ Regulatory ☒ Strategy/Transformation ☐ System ☐
CQC Reference:	Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well Led ☒ Use of Resources ☒

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Quality Group	16/06/2023	Review by Council of Governors Sub-group
Quality Committee	20/06/2023	The Committee endorsed the Quality Accounts and recommended to the Board of Directors for approval
Board of Directors	28/06/2023	The Board of Directors approved the Quality Accounts

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 ☐

NHS
University Hospitals Dorset
NHS Foundation Trust

Annual Report 2022/23
Quality Report

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

1 April 2022 - 31 March 2023

Contents

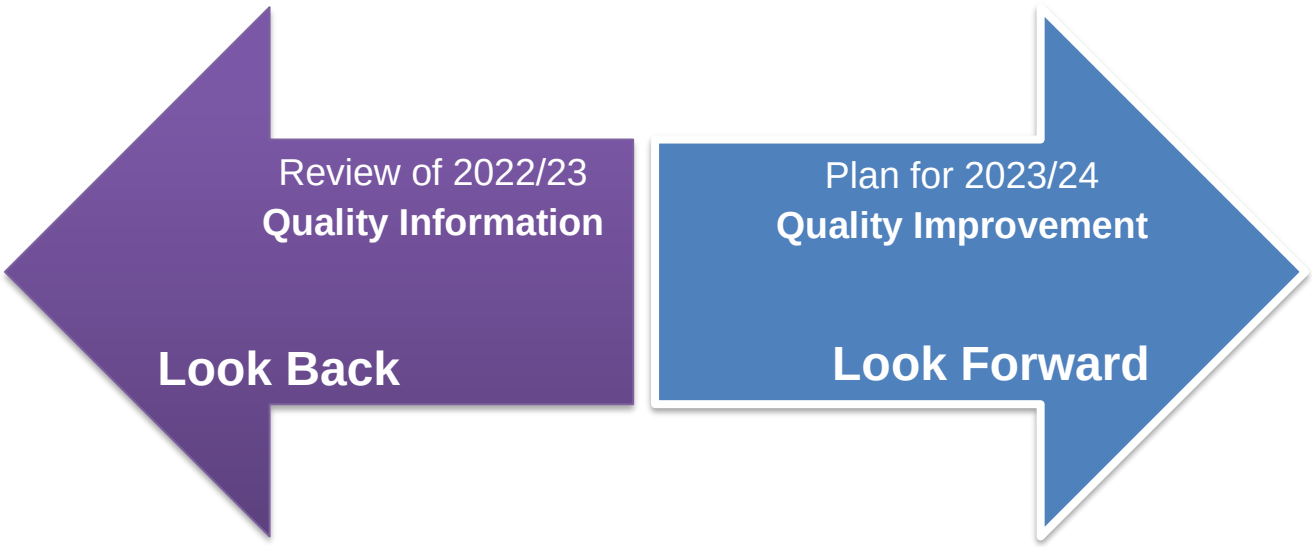
What is a quality account?

All NHS hospitals or trusts have to publish their annual financial accounts. Since 2009, as part of the drive across the NHS to be open and honest about the quality of services provided to the public, all NHS hospitals have had to publish a quality account.

The purpose of this quality account is to:

1. summarise our performance and improvements against the quality priorities and objectives we set ourselves for 2022/23; and

2. set out our quality priorities and objectives for 2023/24.



To begin with, we will give details of how we performed in 2022/23 against the quality priorities and objectives we set ourselves under the categories of:

Patient Safety
Clinical Effectiveness
Patient Experience

Where we have not met the priorities and objectives we set ourselves, we will explain why, and set out the plans we have to make sure improvements are made in the future.

Secondly, we will set out our quality priorities and objectives for 2022/23 under these same categories. We will explain how we decided upon these priorities and objectives, and how we will aim to achieve these and measure performance.

Quality accounts are useful for our board, who are responsible for the quality of our services, as they can use them in their role of assessing and leading the trust. We encourage frontline staff to use quality accounts both to compare their performance with other trusts and also to help improve their own service.

For patients, carers and the public, the quality account should highlight how we are concentrating on improvements we can make to patient care, safety and experience.

It is important to remember that some aspects of this quality account are compulsory. They are about significant areas, and are usually presented as numbers in a table. If there are any areas of the quality account that are difficult to read or understand, or you have any questions, please contact Joanne Sims, Associate Director of Quality Governance and Risk at Joanne.Sims@uhd.nhs.uk

This Quality Account is divided into three sections.

Part 1	Introduction to University Hospitals Dorset NHS Foundation Trust and a statement on quality from the Chief Executive
Part 2	Performance against 2022/23 quality priorities and our quality priorities for 2023/24
	Reviewing progress of the quality improvements in 2022/23 and choosing the new priorities for 2023/24
	Statements of assurance from the Board
Part 3	Other information

Part 1 Statement on quality from the Chief Executive

This Quality Report is the second published by University Hospitals Dorset NHS Foundation Trust.

The Trust quality strategy is supported by wide-ranging quality improvement and patient safety initiatives which cover a large range of specialties and topics. In this report we have outlined some of these activities.

The report outlines some of the main quality governance and patient safety projects that have been progressed this year and celebrates the engagement of our staff to continually improve patient and staff safety, patient experience and clinical outcomes.

The report includes details of inspections by our regulators, the Care Quality Commission (CQC), during 202/23. It has been a busy time with three of our services inspected in September and November last year. These were medicine and surgery across Poole and RBH, and maternity at Poole. The CQC findings were reflective of the challenges across the Trust and across the healthcare system. Some themes in the reports are in common with other trusts across the NHS at the present time, which we are working hard to address.

Staffing has been highlighted in the reports as an issue to be addressed in terms of our both our care and governance, so we are investing to ensure safe staffing and to address some historic issues. Recruitment and retention are a priority. We are seeking all opportunities to find innovative ways to attract staff to our great organisation.

The reports are also clear regarding that the issues we face about getting patients safely discharged from our hospitals when medically ready to leave is affecting our capacity and performance. We know we need system change to make processes simpler and more streamlined. We are working collaboratively through the new Integrated Care Board (ICB) which came into place in July 2022. A new Discharge to Assess pathway is coming into place across Dorset which will have a positive impact and we are working closely with our Dorset partners to help with support in the community and for patients suffering mental health disorders to be cared for in a more appropriate setting.

There are specific issues about UHD that we acknowledge and accept from the reports. We recognise that we need to have clearer and more effective ways of making improvement and learning from ourselves and others. Since I joined the trust last year, these issues have given rise to our plans for a Patient First programme. This will give staff the freedom and tools to make positive and long-lasting changes to work well with each other for the benefit of our patients. We recognise this requires strong visible leadership across the trust, where people feel safe to speak up and where we have a shared vision for the future about our services for patients and our staff.

Working with the trust Board and receiving insights from the Council of Governors, we will continue to strengthen our governance arrangements. We have many experienced managers and staff, and we are pleased to welcome new colleagues for their perspectives. Rob Whiteman joined as our new chair, last summer and Dr Peter Wilson joined us as our new chief medical officer on 3 April 23.

I have had a long career in the NHS in many organisations and from the moment I joined UHD I have been struck by the very special and kind staff here. I know that the values of the trust are important to you all. In light of the CQC's advice we now need to make sure we have everything in place to improve processes, management and leadership across the trust that have been impacted by the disruption of merger, pandemic and industrial action. We have already put improvements in place and fixed issues raised. We recognise though that there is more to do and will ensure we take the actions needed. With the wonderful people we have here I know we can do this.

	**Siobhan Harrington** Chief executive

It is important to note that there are a number of inherent limitations in the preparation of Quality Accounts which may impact the reliability or accuracy of the data reported:

- *data is derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in our internal audit programme of work each year*
- *data is collected by a large number of teams across the Trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflects clinical judgement about individual cases, where another clinician might have reasonably classified a case differently*
- *national data definitions do not necessarily cover all circumstances, and local interpretations may differ*
- *data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to reanalyse historic data.*

To the best of my knowledge, the information contained within this report is accurate.

Part 2 – Priorities for improvement and statements of assurance from the board

Performance against quality priorities set out in the Trust Quality Strategy for 22/23

The Trust identified the following key quality improvement priorities for 2022/2023

IV Fluids	• Continuation of 21/22 priority, ends in Q2 2022/23
Deteriorating Patient	• Continuation of 21/22 priority, likely to continue for all of 22/23
Difficult IV Access	• Continuation of 21/22 priority, ends in Q2 2022
Safety Checklists	• Continuation of 21/22 priority, likely to continue for all of 22/23
Consent	• Standardisation of consent policy across UHD, Q1/Q2 2022/23 • Speciality/Governance leads
VTE risk assessments & prophylaxis	• Complete risk assessments and prescribe prophylaxis if required, Q1/Q2 2022/23 • Working group to be established
AKI/Dialysis management	• Resolve inequalities in service provision and differences in patient pathways, Q1-Q3 22/23
Blood glucose management	• Optimise use of blood glucose systems to improve glucose control
Medical and Pharmacy Communication	• Improve communication of prescribing queries between Medical and Pharmacy teams

Progress has been as follows:

Qi Priorities for 2022/23

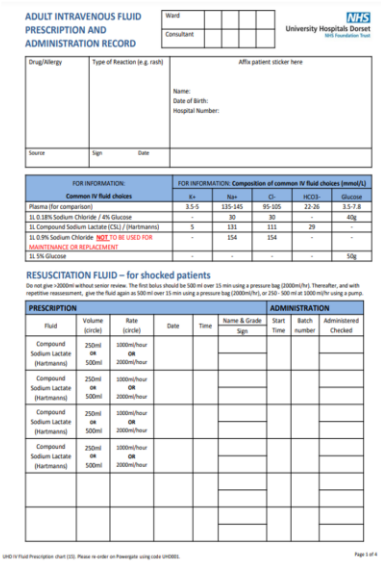
NHS University Hospitals Dorset NHS Foundation Trust

IV Fluids	• IV Prescription chart rolled out, reiterated, and has made a positive difference. Digital fluid balance is ready to deploy, awaiting IT fix	G
Deteriorating Patient Programme	• Complex programme; 4/10 projects already completed successfully; others in progress	A
Difficult IV Access (DIVA)	• New UHD policy agreed, service established, and longer dwell cannulas rolled out	G
Safety Checklists	• Ongoing work across UHD. New National standards introduced February 2023	A
Acute Kidney Injury	• Standardisation of various aspects across UHD has been done, especially intranet and patient information; checklist and education were not achieved. Wider work needed with team and vision / strategy / leadership	A
Blood glucose management	• Project initiated in August 2022 although progress has been inhibited by extended periods of operational pressures	A
Deteriorating patient in ED	• A new 22/23 priority (included within Trust DP Programme). Agreed way forward that now needs to be formalised.	A
Medical and Pharmacy Communication	• Improve communication of prescribing queries between Medical and Pharmacy Teams – 22/23 priority. **REPLACED WITH "THINK STEROIDS" Project.**	A

IV Fluid Management

IV Fluids

- Our new IV Fluid prescription chart for UHD has:
  - a **Reduced rate** fluid prescription for frail patients/renal/ cardiac disease
  - a choice of **Height or weight based** maintenance fluid prescription
  - amalgamated the guidelines for **electrolyte management** into new UHD ones
- We have audited against NICE standards and have
  - succeeded in reducing **"free fluid prescribing"** of 0.9% Sodium Chloride
  - we are at least as good / better on all the standards as we were previously
- Actual prescribed drugs and incidents are lagging indicators and will be reviewed soon, though anecdotal evidence is promising
- We iterated the form based on staff feedback, and the 2nd revision went live in June 2022


ADULT INTRAVENOUS FLUID PRESCRIPTION AND ADMINISTRATION RECORD

Ward

Consultant

NHS University Hospitals Dorset NHS Foundation Trust

Drug/Allergy | Type of Reaction (e.g. rash) | Affix patient sticker here

Name:
Date of Birth:
Hospital Number:

Source | Sign | Date

FOR INFORMATION: Common IV fluid choices

FOR INFORMATION: Composition of common IV fluid choices (mmol/L)

	K+	Na+	Cl-	HCO3-	Glucose
Plasma (for comparison)	3.5-5	135-145	95-105	22-26	3.5-7.8
1L 0.18% Sodium Chloride / 4% Glucose	-	30	30	-	40g
1L Compound Sodium Lactate (CSL) / (Hartmanns)	5	131	111	29	-
1L 0.9% Sodium Chloride NOT TO BE USED FOR MAINTENANCE OR REPLACEMENT	-	154	154	-	-
1L 5% Glucose	-	-	-	-	50g

RESUSCITATION FLUID – for shocked patients

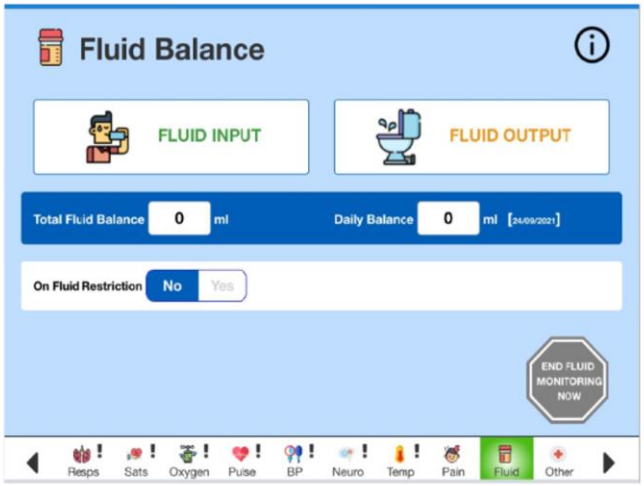
Do not give >2000ml without senior review. The first bolus should be 500 ml over 15 min using a pressure bag (2000ml/hr). Thereafter, and with repetitive reassessment, give the fluid again as 500 ml over 15 min using a pressure bag (2000ml/hr), or 250 - 500 ml at 1000 ml/hr using a pump.

PRESCRIPTION						ADMINISTRATION		
Fluid	Volume (circle)	Rate (circle)	Date	Time	Name & Grade Sign	Start Time	Batch number	Administered Checked
Compound Sodium Lactate (Hartmanns)	250ml OR 500ml	1000ml/hour OR 2000ml/hour						
Compound Sodium Lactate (Hartmanns)	250ml OR 500ml	1000ml/hour OR 2000ml/hour						
Compound Sodium Lactate (Hartmanns)	250ml OR 500ml	1000ml/hour OR 2000ml/hour						
Compound Sodium Lactate (Hartmanns)	250ml OR 500ml	1000ml/hour OR 2000ml/hour						

UHD IV Fluid Prescription chart (11). Please re-order on Powergate using code UHD001. Page 1 of 6

IV Fluids

- A new Digital Fluid Balance was designed and developed on eObs in November 2022.
- The new form will make it easier for nursing staff to automatically plot clear charts for doctors to view.
- Implementation relies on configuration of IT systems across both hospital and this work has been delayed due to operational pressures.
- The plan is to pilot on Ward 1 and A4, then one more ward on each site, then roll out reasonably quickly across UHD.
- Roll out is planned for June / July / August 2023



Managing the deteriorating patient

Deteriorating Patient Programme – Executive Summary

Alignment of 2222 calls	✓	Launched successfully, review held at 6 month stage in May 2023 and deemed a successful change.
Alignment of Resus/CIG Groups	✓	Proposed UHD governance structure identified however existing site based groups remain in place pending overall UHD Governance structure review (Q1 23/24)
Treatment Escalation Planning	✓	Launched successfully in January; Phase II was implemented in March 2023
Sepsis	✓	Single UHD screening tool agreed. Policy ratified and approved. Single UHD Sepsis intranet page launched. UHD E-Learning adapted/launched
Comms between wards / ICU	✓	UHD ICU referral procedure agreed. SOP ratified and approved.
Soft signs / Call 4 Concern	✓	Rolled out across UHD successfully on 1 February 2023. Held 3 month review in May 2023. Working well..
Safe Medical Staffing	✓	The group delivered a standard methodology for safe staffing modelling and for submission for funding where needed.
Training	✓	Deteriorating Patient training content standardised within Induction and across UHD intranet. Training equally accessible across sites.
Useful data / platform integration	✓	Work in progress to standardise the recording of the 2222 calls and Outreach teams across UHD as business as usual.

Deteriorating Patient Programme

- We have aligned all emergency calls for UHD (2222 / 5555 / (9)999) together with the processes behind these calls.
- 6 month review held in May 2023. Noted the change has been successful

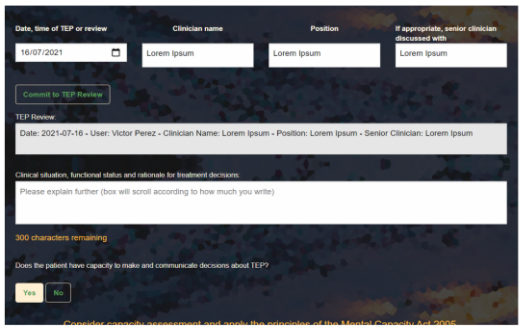
✓

Successful bids for **safe medical staffing** funding 2022/23:

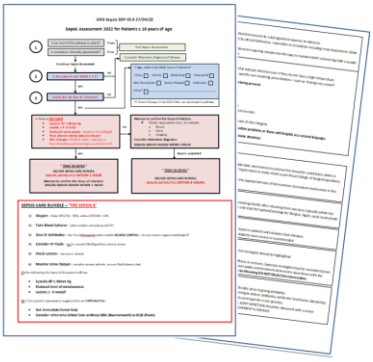
- £450K for Paediatrics
- £670K for Gynaecology
- £240K for Urology
- £1.1M for ED on top of £450K winter funding
- £3M phased for medical staffing in response to HEE

- Standard safe medical staffing modelling and rationale established
- Business Case structuring and content support provided

Deteriorating Patient Programme



- New UHD-wide digital TEP launched in January 2022
- Phase II was implemented March 2023 – enhancements making it easier for clinicians to edit or revise a TEP and flagging when a TEP is out of date



- Aligned **UHD Sepsis policy** created and formally approved
- UHD Sepsis intranet page in place
- Sepsis E-learning adapted and rolled out across UHD

Deteriorating Patient Programme

Previously discussed with ICU and an agreement made that the patient is appropriate for escalation in this admission (depending on the circumstance)	A doctor of registrar level may contact ICU without needing to inform the consultant overseeing that patient's care.
Not previously discussed with ICU but has an up-to-date digital TEP signed off by a consultant in this admission	Consultant to consultant discussion should be the default process. The *Referral to ICU* eForm to be completed at the earliest opportunity.
Not previously discussed with ICU and does not have an up-to-date digital TEP signed off by a consultant in this admission	Consultant to consultant discussion should be the default process. If out of hours, the on-call consultant must be phoned by a doctor of at least registrar level. This should not delay patient care but must be done at the earliest opportunity. The *Referral to ICU* eForm to be completed at the earliest opportunity.

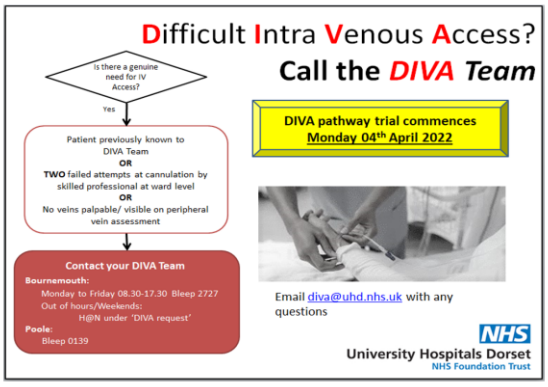
- Aligned UHD Referrals to ICU SOP created and formally approved
- SOP posted to existing Critical Care intranet pages

- Call-4-Concern is an important new safety net - a rapid referral system for patients and their carers to report physical deterioration
- We launched in February 2023 and is being used appropriately. To be reviewed in 6 months.

Managing difficult IV Access

Difficult IV Access (DIVA)

- Aligned UHD DIVA Policy and SOP created and formally approved
- DIVA Team membership and service Poole/Bournemouth established
- Trial of service commenced April 2022 – now Business as Usual
- Roll-out of training of DIVA teams and other key staff



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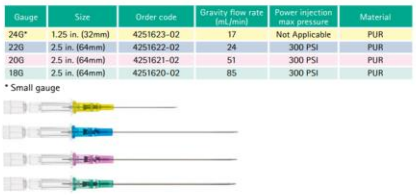
Difficult IV Access (DIVA) (cont'd)

• New intermediate length ultra-sound guided cannula (longer dwell time) introduced to coincide with the DIVA service trial.



• E-form created to automate DIVA Critical Patient Information (CPI) flag to EPR

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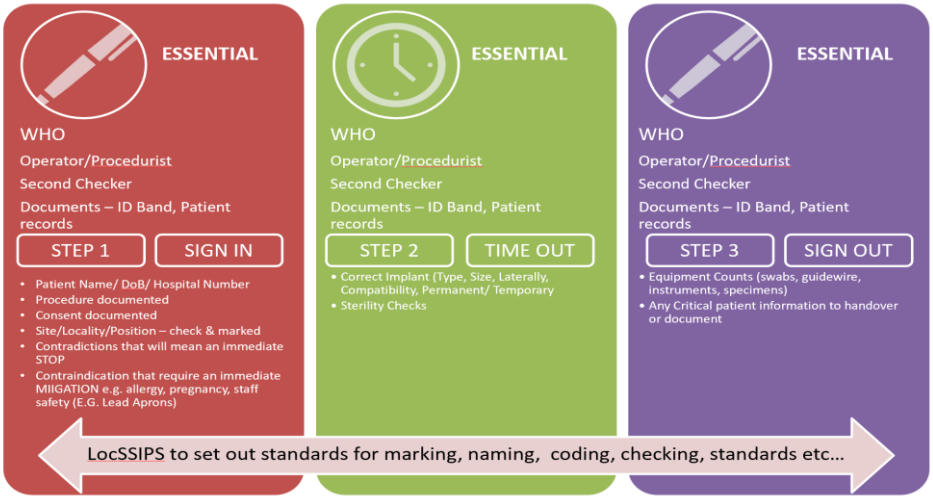
<tr>
<td>Safety Checklists</td>
<td>
Safety Checklists

The Checklist Review Group has been brought together to review the existing checklists at UHD. To compare across sites and specialties and to look at the wider ICS view.

The existing checklists have been grouped into the following categories:
– Dermatology
– Endoscopy
– Theatres
– Day Theatres
– Outpatients

The smaller teams have been tasked with comparing their checklists to the following criteria – this is work in progress



Update: New National Guidance launched February 2023. All teams are currently reviewing impact as likely to change configuration of current checklists and local safety standards for invasive procedures.
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<tr>
<td>Consent</td>
<td>A new UHD Consent Policy was approved in July 2022. The Policy included a template and toolkit for the development of local standard operating procedures for consent.</td>
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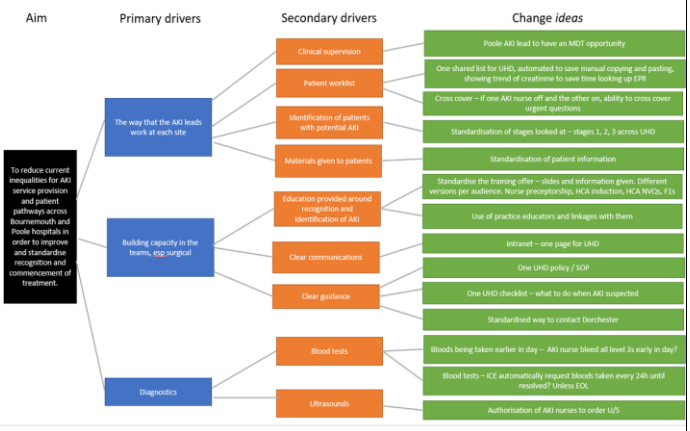
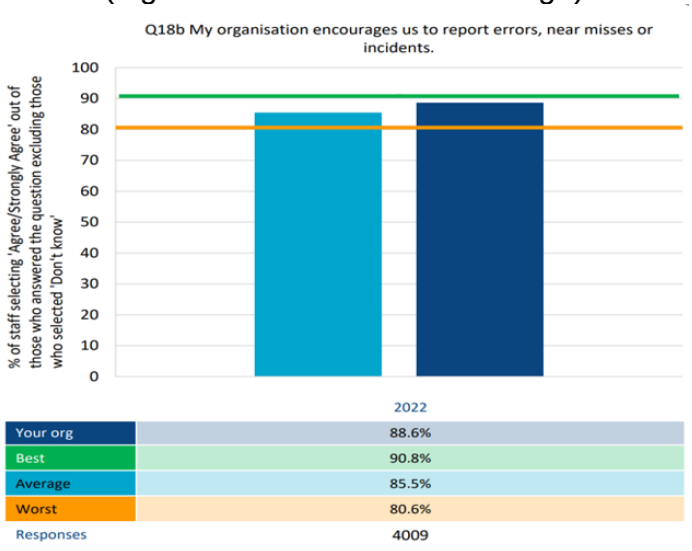
	To support the implementation of the policy a new Level 1 elearning programme for consent was launched and Level 2 training commissioned from an external provider.
Management of Acute Kidney Injury (AKI)	**Acute Kidney Injury** • Standardisation of various aspects across UHD has been done, especially intranet and patient information • UHD AKI checklist was discussed, with the aim of being digital, to provide standardised reminders for clinical actions at commencement of treatment • Education on AKI was discussed and ideas are being worked up. 
Blood glucose management	**Blood glucose management** • Project initiated in August 2022 • Senior involvement/sponsorship provided by Medical CG Director of Nursing and UHD Medical Examiner • Aim is to capitalise on the existing access to AEGISPoC data – to improve/automate bespoke analytical outputs to improve patient safety • A 'grass roots' Blood Glucose Management QI project has been registered by Dr Ammar Hilali – aimed at improving the consistency of recording across all UHD wards. This has since been included within the project to improve the quality of data available within AEGIS PoC  Dr Hilali receiving the prize for *Qi-Project of the Month* (August 2022) from Alan Betts, Director of Improvement
Medical and Pharmacy communication	This project was replaced in year with the 'Think Steroid' project and is about the safe administration and management of steroids. The Medical Care Group are currently leading on this important work in 23/24.

Other Quality Priorities for 2022/23

In addition to the above progress, the UHD Quality Strategy also sets out several other priorities for patient safety, patient experience and clinical effectiveness in 2022/23. These are outlined in the following table with details of action taken in year.

DOMAIN	Priority for 2022/23	Progress made in 2022/23
PATIENT SAFETY	Continuing to participate in the work across the ICS to develop and adopt agreed principles and policies to support a Just Culture.	We have incorporated just culture principles into our HR Policies. A Restorative Just and Learning Culture session was held at our LERN conference on the 3/11/22. The session was multi professional and made the link with patient and staff safety culture. We have reduced our formal disciplinary cases by around 45%.
	Continue to improve the quality of incident reporting across the Trust and (LERN incidents, issues, excellent events and ideas) across all staff groups.	The Trust continues to promote an open culture for reporting and learning from patient safety incidents. The national staff survey results 2022 reported that the Trust had a good reporting culture (higher than the national average). 
	Support transition from the National Reporting and Learning System and STEIS to the new national Learn from Patient Safety Events (LFPSE) service.	The Trust successfully submitted a “test” version of the new reporting form by the deadline of 31/3/23. Although with other Trusts, UHD is now waiting for software updates to the reporting system (Datix) in order to complete the final design work required to go live before the Sept 23 deadline. It is anticipated that Datix will release the required upgrades to users in late July/early August.

	Work with colleagues across the system to plan to implement the new Patient Safety Incident Response Framework (PSIRF) as and when published.	The Trust is working on the development of a PSIRF Plan before the end of Autumn 2023 deadline.
	Work with Workforce leads and colleagues across the system to consider the best approach to implementation of the new national Patient Safety Syllabus as and when training materials become available.	The Trust piloted Level1a and Level 1b training in 22/23. Plans are now in place to include Level 1 and Level 2 training in mandatory essential core skills training in 2023/24. The Trust will also be developing a training plan to support PSIRF implementation.
Patient Experience	The appointment of Patient Safety Partners (PSPs) and development of the role as partners in safety across the system.	Patient Partners are essential part of the UHD Patient Engagement strategy. Patient partners support a wide range of activities across the Trust including patient safety and patient experience.
Clinical Effectiveness	Develop and implement a UHD Clinical Audit plan for 22/23.	A Clinical Audit plan for 22/23 was approved by the Audit Committee and Trust Management Board in May 2022. Details of improvements made following the completion of national and local clinical audits are provided in the statements of assurance section of the report.
	Further develop ward to board reporting and expansion of existing quality metrics.	A new Integrated Performance report has been produced and new Ward to Board quality reporting across UHD has been implemented.

Our quality priorities for 2023/24

UHD is changing and our culture will be changing to focus on improvement and better supporting staff to put our patients at the forefront of everything we do.

This is a journey over 3 to 5 years and starts with setting our ambition high and recognising our current realities. Taking the Patient First approach, we will look to continually improve, and to focus on making a bigger impact on a smaller number of strategic themes. We will continue to uphold our values in how we do this work. We will constantly learn and adapt in how we do this. All of this is summarised in the “UHD pyramid” below.

Our strategic goals at trust level focus on where we most want significant improvements delivered in a sustained way over the next three years. These fit within our Dorset-wide role in the health and care system. This means we are all pulling in the same direction.

UHD’s 2023 to 2024 trust objectives are based upon the five strategic themes:

- Population Health and System working
- Our People
- Patient Experience
- Quality (Outcome and Safety)
- Sustainable Services

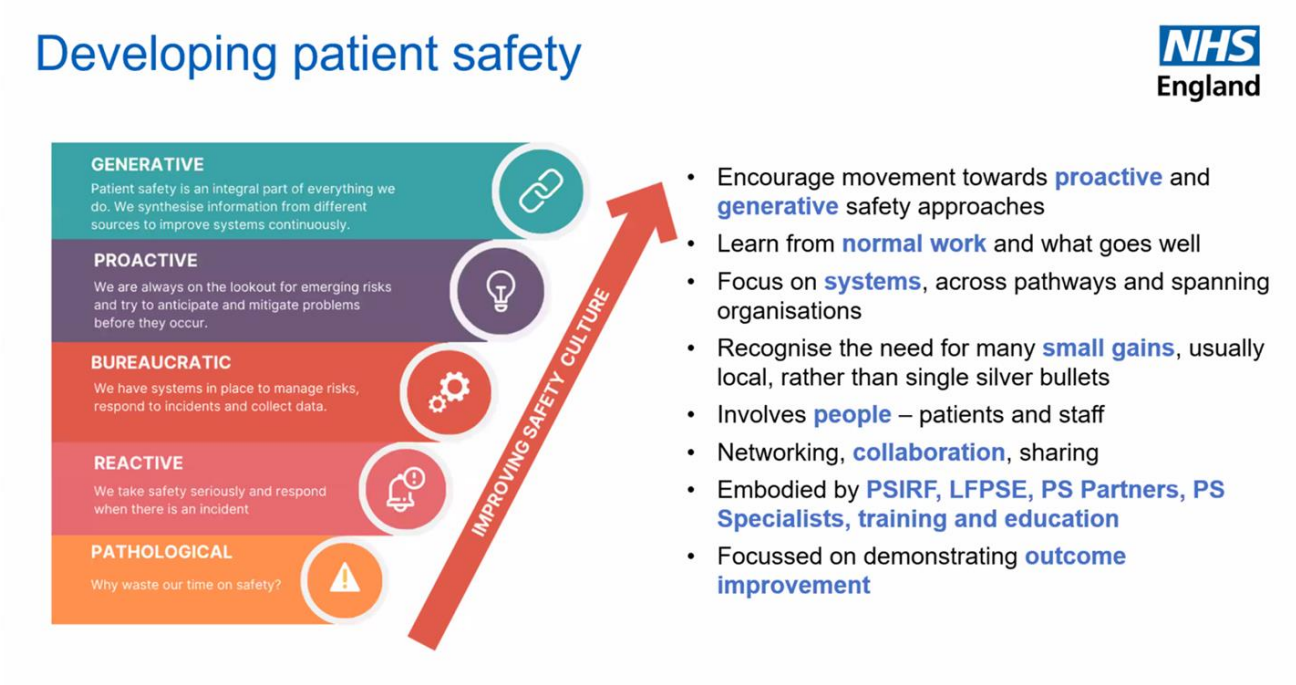
These goals are broken down into annual trust objectives, which are SMART (specific, measurable, achievable, resourced and timely). Every team and individual will be asked to consider how they can contribute to these objectives in their own area. Every team in UHD can contribute to the objectives.

Themes	Goals (over the next 3 years)	Annual objectives 2023/2024
Patient Experience	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.	Family and Friends Test (what our patients say) Feedback rates increase from baseline in all services over the next year Is in the top 20% rated good over a 3 year period Every ward/clinical service has access to monthly Have your say survey information and data
Quality (Outcomes and Safety)	To achieve top 20% of Trusts in the country for mortality (HSMR) To reduce moderate/severe harm patient safety through the development of an outstanding safety culture	To reduce HSMR over the next 18 months (by Sept 2024)

Patient Safety

Our main priorities for patient safety for 2023/24 continue to directly link to the key requirements of the National Patient Strategy including:

- Transition from National Reporting and Learning System (NRLS) and Strategic Executive Information Service (StEIS) to the new Learn from Patient Safety Events (LFPSE) service
- Implement the new Patient Safety Incident Response Framework (PSIRF)
- Improve Safety culture (moving towards a proactive and generative approach)



- Respond to National Patient Safety Alerts (ongoing)
- Improve Patient safety education and training
- Prioritise patient safety improvement (ongoing)
- Implement Medical examiners (completed)

Patient Experience

Our main patient experience objective for 2023/24 is to work with colleagues across the system to implement the requirements of the NHS Patient Safety Partners Framework including:

- Implement the Framework for Involving Patients in Patient Safety

Clinical Effectiveness

At University Hospitals Dorset NHS Foundation Trust, to reduce variation and ensure the best possible clinical outcomes, we strive to ensure our patients are provided with the most effective evidence-based care. The Trust participates in a robust clinical audit and clinical outcomes programme and over the forthcoming years our quality priorities are to:

- Develop and implement a UHD Clinical Audit plan for 23/24

Progress against these priorities will be monitored by the Board of Directors, Quality Committee and the Council of Governors Quality Strategy Group.

Statements of Assurance from the Board

This section contains eight statutory statements concerning the quality of services provided by University Hospitals Dorset NHS Foundation Trust. These are common to all trust quality accounts and therefore provide a basis for comparison between organisations.

Where appropriate, we have provided additional information that gives a local context to the information provided in the statutory statements.

1. Review of services

During 2022/23 University Hospitals NHS Foundation Trust provided and/or subcontracted eight relevant health services (in accordance with its registration with the Care Quality Commission):

- management of supply of blood and blood derived products
- assessment or medical treatment for persons detained under the Mental Health Act 1983
- diagnostic and screening procedures
- maternity and midwifery services
- family planning
- surgical procedures
- termination of pregnancies
- treatment of disease, disorder or injury

The Trust has reviewed all the data available to them on the quality of care in these eight relevant health services. This has included data available from the Care Quality Commission, external reviews, participation in National Clinical Audits and National Confidential Enquiries and internal peer reviews.

The income generated by the relevant health services reviewed in 2022/23 represents 100% of all the total income generated from the provision of relevant health services by the Trust for 2022/23.

2. Participation in clinical audit

During 2022/23, there were 53 national clinical audits which covered relevant health services that University Hospitals Dorset NHS Foundation Trust provides. During that period, University Hospitals Dorset NHS Foundation Trust participated in 92% of national clinical audits in which it was eligible to participate.

The national clinical audits and national confidential enquiries that University Hospitals Dorset NHS Foundation Trust participated in, and for which data collection was completed during 2022/23 are listed below.

National Clinical Audits for Inclusion in Quality Report 2022/23	Eligible	Participated in 2022/23	Purpose of audit
Breast and Cosmetic Implant Registry	Y	Y	The registry collects data on all types of breast implant and explant (removal) surgery. This includes revisions and reconstructions, such as temporary tissue expanders
Case Mix Programme (CMP)	Y	Y	The CMP is an audit of patient outcomes from adult general critical care units
Child Health Clinical Outcome Review Programme	Y	Y	Assists in maintaining and improving standards of care by reviewing the management of patients and publishing the results of such activities
Cleft Registry and Audit Network Database	N	N	
Elective Surgery (National PROMs Programme)	Y	Y	Patient reported outcome measures (PROMs) survey patients before and after surgery for the following planned procedures; 1) Hip replacement 2) Knee replacement
Emergency Medicine QIPs - Pain in Children (care in Emergency Departments)	Y	Y	Identify current performance in Emergency Department (ED) against nationally agreed clinical standards and show the results in comparison with other departments
Emergency Medicine QIPs - Infection Prevention and Control	Y	N	As above.
Emergency Medicine QIPs - Mental health self harm	Y	N	As above.
Epilepsy 12 - National Audit of Seizures and Epilepsies in Children and Young People	Y	Y	Audit of organisation of paediatric epilepsy services, epilepsy care provided to children and young people and patient reported experience measures
Falls and Fragility Fracture Audit Programme – Fracture Liaison Service (FLS) Database	Y	Y	Measure against NICE technology assessments and guidance on osteoporosis and clinical standards for FLS
Falls and Fragility Fracture Audit Programme – National Audit of Inpatient Falls	Y	Y	Inpatient falls: Evaluates compliance against best practice standards in reducing the risk of falls within hospitals

National Clinical Audits for Inclusion in Quality Report 2022/23	Eligible	Participated in 2022/23	Purpose of audit
Falls and Fragility Fracture Audit Programme – National Hip Fracture Database	Y	Y	Audits of patients with hip and femoral fractures aiming to improve their care through auditing which is fed back to hospitals through targeted reports and online reporting
GastroIntestinal Cancer Audit Programme: National Bowel Cancer Audit	Y	Y	The overarching aim is to improve the quality of services and patient outcomes for patients newly diagnosed with: a) bowel cancer, and b) oesophago-gastric cancer or high grade dysplasia of the oesophagus
GastroIntestinal Cancer Audit Programme: National Oesophago-gastric Cancer	Y	Y	As above
Inflammatory Bowel Disease Audit	Y	Y	Reports on key clinical indicators which are compliance with guidance on pre-treatment screening and compliance with NICE recommendations for follow-up review of patients receiving biological therapies
Learning Disabilities Mortality Review Programme	Y	Y	Programme to review the deaths of people with a learning disability, to learn from those deaths and to put that learning into practice
Maternal and Newborn Infant Clinical Outcome Review Programme	Y	Y	Analyses and reports national surveillance data in order to stimulate and evaluate improvements in health care for mothers and babies
Medical and Surgical Clinical Outcome Review Programme	Y	Y	Assists in maintaining and improving standards of care by reviewing the management of patients and publishing the results of such activities
Mental Health Clinical Outcome Review Programme	N	N	
Muscle Invasive Bladder Cancer Audit	Y	N	Management and outcomes of patients diagnosed with muscle invasive bladder at transurethral resection of the bladder and variations in pathways and treatment

National Clinical Audits for Inclusion in Quality Report 2022/23	Eligible	Participated in 2022/23	Purpose of audit
National Adult Diabetes Audit - National Diabetes Core Audit	Y	N	Measures the effectiveness of diabetes care compared to NICE guidance
National Adult Diabetes Audit - National Diabetes Footcare Audit	Y	Y	As above
National Inpatient Diabetes Audit, including National Diabetes In-patient Audit – Harms	N	N	As above
National Adult Diabetes Audit - National Pregnancy in Diabetes Audit	Y	Y	As above
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Adult Asthma Secondary Care	Y	Y	Aims to improve the quality of care, services and clinical outcomes for patients with asthma and chronic obstructive pulmonary disease (COPD)
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Chronic Obstructive Pulmonary Disease Secondary Care	Y	Y	As above
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Paediatric Asthma Secondary Care	Y	Y	As above
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Pulmonary Rehabilitation- Organisational and Clinical Audit	Y	Y	As above
National Audit of Breast Cancer in Older Patients	Y	Y	Improves the quality of hospital care for older patients with breast cancer by looking at the care received by patients with breast cancer and their outcomes
National Audit of Cardiac Rehabilitation	Y	Y	Aims to support cardiovascular prevention and rehabilitation services to achieve the best possible outcomes for patients with cardiovascular disease, irrespective of where they live
National Audit of Cardiovascular Disease Prevention	N	N	

National Clinical Audits for Inclusion in Quality Report 2022/23	Eligible	Participated in 2022/23	Purpose of audit
National Audit of Care at the End of Life	Y	Y	Focuses on the quality and outcomes of care experienced by those in their last admission in acute, community and mental health hospitals
National Audit of Dementia	Y	Y	Measures criteria relating to care delivery which are known to impact on people with dementia admitted to hospital
National Audit of Pulmonary Hypertension	N	N	
National Bariatric Surgery Registry	Y	Y	To accumulate sufficient data to allow the publication of a comprehensive report on outcomes following bariatric surgery. This will include weight loss, co-morbidity and improvement of quality of life
National Cardiac Arrest Audit	Y	Y	Audit of in-hospital cardiac arrests in the UK and Ireland
National Cardiac Audit Programme - National Congenital Heart Disease	N	N	
National Cardiac Audit Programme - Myocardial Ischaemia National Audit Project	Y	Y	To recognise areas of clinical excellence that can be adopted across the NHS. Standards should be used to determine local quality improvement aims for clinicians, service managers and commissioners
National Cardiac Audit Programme - National Adult Cardiac Surgery Audit	N	N	
National Cardiac Audit Programme - National Audit of Cardiac Rhythm Management	Y	Y	As above
National Cardiac Audit Programme - National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Y	Y	As above
National Cardiac Audit Programme - National Heart Failure Audit	Y	Y	As above
National Child Mortality Database	Y	Y	The National Child Mortality Database (NCMD) records comprehensive, standardised information collected by local the Child Death Overview Panels (CDOPs) as part of the Child Death Review (CDR) process

National Clinical Audits for Inclusion in Quality Report 2022/23	Eligible	Participated in 2022/23	Purpose of audit
National Clinical Audit of Psychosis	N	N	
National Early Inflammatory Arthritis Audit	Y	Y	Aims to improve the quality of care for people living with inflammatory arthritis, collecting information on all new patients over the age of 16 in specialist rheumatology departments in England and Wales
National Emergency Laparotomy Audit	Y	Y	Compares inpatient care and patient outcomes undergoing emergency abdominal surgery in England and Wales
National Joint Registry	Y	Y	Data analysis of joint replacement surgery in order to provide an early warning of issues relating to patient safety
National Lung Cancer Audit	Y	Y	Measure lung cancer care and outcomes to bring the standard of all lung cancer multidisciplinary teams up to that of the best
National Maternity and Perinatal Audit	Y	Y	Evaluates a range of care processes and outcomes in order to identify good practice and areas for improvement in the care of women and babies looked after by NHS maternity services
National Neonatal Audit Programme	Y	Y	The NNAP assesses whether babies admitted to neonatal units in England, Scotland and Wales receive consistent high quality care, and identify areas for quality improvement
National Obesity Audit	N	N	
National Ophthalmology Database Audit	Y	Y	Project includes large-scale audit for both cataract surgery and age related macular degeneration
National Paediatric Diabetes Audit	Y	Y	Audit of the care processes received and outcomes achieved by all children and young people attending paediatric diabetes units
National Perinatal Mortality Review Tool	Y	Y	The aim of the PMRT programme is introduce the PMRT to support standardised perinatal mortality reviews across NHS maternity and neonatal unit
National Prostate Cancer Audit	Y	Y	Data analysis on the diagnosis, management and treatment of every patient newly diagnosed with prostate cancer and their outcomes

National Clinical Audits for Inclusion in Quality Report 2022/23	Eligible	Participated in 2022/23	Purpose of audit
National Vascular Registry	Y	Y	Established in 2013 to measure the quality and outcomes of care for patients who undergo major vascular surgery in NHS hospitals
Neurosurgical National Audit Programme	N	N	
Out-of-Hospital Cardiac Arrest Outcomes Registry	N	N	
Paediatric Intensive Care Audit	N	N	
Perioperative Quality Improvement Programme	Y	Y	The Perioperative Quality Improvement Programme (PQIP) measures complications, mortality and patient reported outcome from major non-cardiac surgery
Prescribing Observatory for Mental Health Audit Programme: Improving the quality of valproate prescribing in adult mental health services	N	N	
Prescribing Observatory for Mental Health Audit Programme: The use of melatonin	N	N	
Renal Audits: National Acute Kidney Injury Audit	N	N	
Renal Audits: UK Renal Registry Chronic Kidney Disease Audit	N	N	
Respiratory Audits – Adult Respiratory Support Audit	Y	Y	The aim of the British Thoracic Society audit programme is to drive improvements in the quality of care and services for patients with respiratory conditions across the UK
Respiratory Audits – Smoking Cessation Audit- Maternity and Mental Health Services	N	N	Mental Health Trusts only for the Mental Health element - Project not currently running
Sentinel Stroke National Audit Programme	Y	Y	To provide timely information to clinicians, commissioners, patients, and the public on how well stroke care is being delivered so it can be used as a tool to improve the quality of care that is provided
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Y	Y	Analyses information on adverse events and reactions in blood transfusion with recommendations to improve patient safety

National Clinical Audits for Inclusion in Quality Report 2022/23	Eligible	Participated in 2022/23	Purpose of audit
Society for Acute Medicine Benchmarking Audit	Y	Y	A national benchmark audit of acute medical care. Provides a comparison for each participating unit with the national average (or 'benchmark')
Trauma Audit & Research Network	Y	Y	Analyses data of trauma care to improve emergency care management and systems
UK Cystic Fibrosis Registry	Y	Y	Non-identifiable Registry data is used to improve the health of people with cystic fibrosis through research, to guide quality improvement at care centres and to monitor the safety of new drugs
UK Parkinson's Audit	Y	Y	Audit investigates the quality and experience of care for people living with the condition in the UK

Learning from National Audits

The reports of 29 national clinical audits were reviewed by University Hospitals Dorset NHS Foundation Trust in 2022/23 and, as examples, the Trust intends to take the following actions to improve the quality of healthcare provided as a result:

- Society for Acute Medicine Benchmark Audit (SAMBA) - Implementation of handover web computer system at RBH for improved visibility and triage of take list.

- National Sentinel Stroke Audit Programme (SSNAP) - Transformation Action Groups were set up in SDEC and Inpatient Beds. Process mapping of Event at Front Door lead to a number of improvement actions including pre-alert phone implemented for calls direct to outreach team from paramedics.

- National Cardiac Audit Programme (NCAP) Heart Failure Audit – action taken to increase heart failure rehabilitation referrals via in-reach heart failure nurse.

- RCEM National Quality Improvement Project: Fractured Neck of Femur – Implementations of a new oramorph patient group direction (PGD) for analgesia. Training for the nursing staff on how to use the PGD to administer analgesia to patients in moderate to severe pain.

- NACAP Chronic Obstructive Pulmonary Disease (COPD) - Secondary Care Audit: Trust has employed a Smoking Cessation Team as part of the Addiction Services Team.

- MBRRACE UK Perinatal Mortality Surveillance Report - To re-introduce face-to-face antenatal booking appointments across the whole service to ensure improved compliance with Carbon Monoxide monitoring in the first trimester

Learning from Local Audits

The reports of 192 local clinical audits were reviewed by the Trust in 2022/23 and the Trust intends to take the following actions to improve the quality of healthcare provided:

- Vitamin B12 Screening of Type 2 Diabetes Patients on Metformin - Posters displayed in clinic room explaining the need to check B12 levels.
- Oral Maxillofacial (OMF) Department (Medical) Trust-wide Record Keeping Audit - Long term plan for operation notes to be moved to an electronic format.
- Children's Services Department (Nursing & Medical) Trust-wide Record Keeping Audit - Ensure iGrow access for doctors and nurses in ward settings.
- Improving the Quality of Care in the Outpatient Follow-up of Patients with Pulmonary Embolism after 3 months in PE Clinic - Both Bournemouth and Poole echocardiography now use the same software to report echocardiograms, this software includes optional drop-down menus which allow the reporter to state whether there is a low probability, intermediate probability or high probability of pulmonary hypertension on the echocardiogram.
- Local Audit of Transforming MND Care - To develop and start using a "My Clear Chest Plan" for all patients under the MND service where supportive respiratory interventions have been identified as being appropriate. This will be placed in the patients' home and updated as necessary.
- Hydroxychloroquine Retinopathy Monitoring in Dermatology Patients – An updated monitoring algorithm was made visible in all dermatology clinic rooms and in all systemics folders.
- Documentation of X-ray Report by Neonatal Team – Column added in the daily summary for checking the x-ray reporting each day. To be completed during each consultant round.
- Clinical Audit on Management of Immune Mediated Colitis - Business case for an immunotherapy toxicity team submitted which would help capture all relevant investigations for these patients.
- Assessment & Management of Low Back Pain and Sciatica in Spinal Triage & Treat Clinic - Introduction of documented evidence regarding information provided by using a patient information sheet ('Summary of Consultation').
- Re-audit of Completion of ADHD Documentation and Medication Prescribing - Development of an agreed paragraph to include on clinic letters advising on behavioural measures as part of a comprehensive treatment plan.
- Are the Hospital Guidelines Being Followed for Placental Histology – Implementation of a clear pathway for uploading and reviewing the results by the team, the lab now has a system in place to upload the results to EPR.
- Reporting of Nasogastric Tube (NGT) Position on Chest X-rays - Introduce coding onto Soliton to allow better management of the studies. New code for chest x-rays for NGT placement has been agreed across UHD through ICE.
- Emergency Management of Cauda Equina Syndrome - MRI is now available until 10pm, with emergency MRI available after this time.
- Communications Audit - Updated information, specific to departments, made available on the ‘Updates by Clinical Area’ section of the ‘Investing in our Hospitals’ intranet page on a regular basis.
- Audit of Legacy Treatment Escalation Plans on Electronic Patient Records - Roll out of UHD Treatment Escalation Plan completed.

- Radiation Doses from a Mobile Chest X-ray at RBH - Changed the pre-set ‘average’ exposure factors to be the same on both mobile machines. Image quality as well as dose to be considered when deciding which of the machines should be altered.

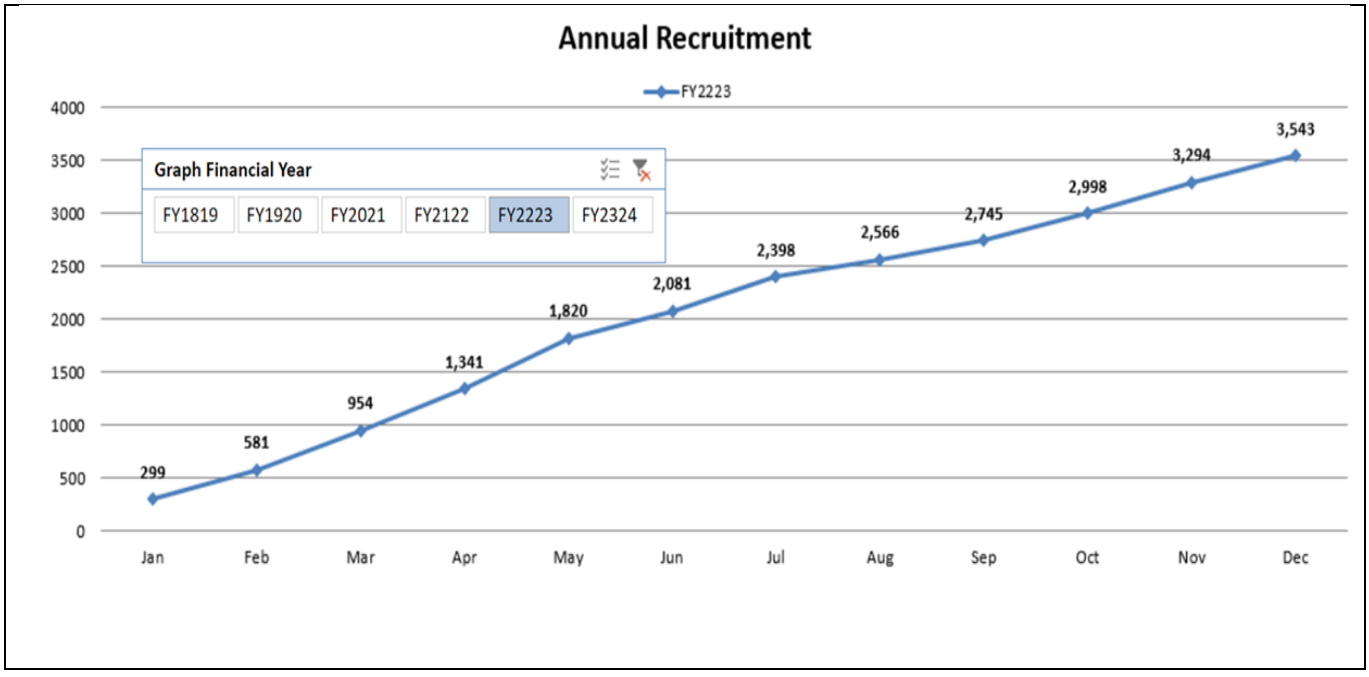
Meet Craig, our clinical audit and effectiveness manager

“Clinical audit measures current practice against best practice standards and addresses any shortfalls. The clinical audit team can help you design your project from the start – just email or call us for an initial discussion. We can help you set the standards against which you will be auditing. We can help to design your data collection questionnaire, and have software that can enable you to collect your data online. Once you have collected your data, we can help with collating the results, developing an action plan, writing your report, and preparing any presentations. For any completed projects, we would be more than happy to provide you with a certificate confirming your participation.

“I am very proud of our team as everything we do aims to make treatment safer and better for patients. It is great to help facilitate improvements that will make a difference and is really satisfying to see audits lead to positive changes for our patients.

3. Participation in clinical research:

Recruitment at UHD is recovering post the pandemic. Recruitment at UHD was 3,543 in the financial year, with an additional 198 participants recruited at Bournemouth as part of the Wessex Partnership collaboration. The Wessex Partnership collaboration offers research opportunities to residents in the local area and has a strong commercial pipeline of studies planned.



4. Use of Commissioning for Quality and Innovation (CQUIN) payment framework

The Trust's income in 2022/23 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation (CQUIN) payment framework because of the agreement reached with the Clinical Commissioning Group (CCG) to use the CQUIN payment to source a fund available non-recurrently to protect the quality of care and safety of the service with a particular focus on areas that are giving rise to the CQUIN areas. The Trust agreed use of this fund directly with the CCG.

5. Statements from the Care Quality Commission (CQC)

The Trust is required to register with the Care Quality Commission (CQC) and its current registration status is unconditional. This means that the Trust does not have any current restrictions on its practice or services.

CQC Inspection of Medicine and Surgery

The CQC undertook an unannounced focused inspection of on the 28th and 29th September 2022. The CQC did not look at all key lines of enquiry and limited their review to a small number of areas where concerns had been raised in older peoples services and surgery. The CQC rated Poole Hospital's Surgical Services as Requires improvement. The Inspectors' assessment of the hospital's Medical Care services did not lead to a rating being issued. The service remains rated good. The CQC rated Poole Hospital as "Requires improvement" overall. It was previously rated good.

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

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

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

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

However:

- Staff knew how to protect people from abuse, and managed safety well.
- Infection risk was controlled well.
- Staff mostly identified and quickly acted for people at risk of deterioration.
- Staff assessed and monitored people regularly to see if they were in pain, and they mostly administered pain relief in a timely way.
- Staff supported people unable to communicate using suitable assessment tools, and they gave additional pain relief when needed.
- Staff collaborated well to benefit people.
- Staff treated people with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues it faced.
- The service had an open culture where people, their families and staff could raise concerns without fear.

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

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

However:

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

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

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

CQC Inspection of Maternity Services

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

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

The inspection report was published on the 10 March 2023. The CQC rated Poole Hospital Maternity service inadequate. The service was previously rated good (January 2020).

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

- There were not always enough staff to keep women safe.
- Systems and processes for managing risk were not always effective, especially in maternity triage.

- Maintenance of the environment especially regarding the emergency call bell systems, were not adequate to maintain peoples safety. The CQC acknowledged that at the time of the inspection the trust was implementing a new call bell system and confirmed it had addressed this issue.
- Managers did not always investigate incidents thoroughly or in a timely manner.
- The maternity leadership team was new and did not always have enough capacity or experience.

However:

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

Following the inspection, the CQC served the Trust a formal Warning Notice under Section 29A of the Health and Social Care Act 2008. The Warning Notice notified the Trust that significant improvements were required in maternity services in relation to safety processes for staff accessing help in an emergency. The Trust has identified a detailed action plan to address the issues raised in the CQC report. The Quality Committee will ensure oversight of effectiveness of the actions identified.

"I know how hard our staff are working, often under pressure, so it is disappointing to receive the judgements. However, we know that these reports are reflective of the challenges across the trust as we are not currently providing consistent standards of care.

"I do believe though that the themes within the reports are fixable. We have already put improvements in place and addressed some of the issues raised. We recognise though that there is more to do and will ensure we take the actions needed.

"I was very pleased that the CQC reports also highlighted some best practice across our hospitals, including the caring nature of our colleagues, with the CQC stating that patients told them our staff treated them well, with compassion and kindness."

"In light of the CQC's advice we now need to make sure we have everything in place to improve processes, management and leadership across the trust that have been impacted by the disruption of our merger, the pandemic and industrial action. With the wonderful colleagues I have across UHD I know we can do this. We look forward to welcoming the CQC back to our hospitals to show them the changes we are making."

Siobhan Harrington, chief executive

"We recognise that we need to have clearer and more effective ways of making improvements and learning from ourselves and others. Working with our trust Board and receiving insights from our Council of Governors, we will continue to strengthen governance – how we work as an organisation - and risk management. We have a strong ambition to make UHD the best place for both our staff and our patients and these reports will help us in this work."

Rob Whiteman, chair of UHD

6. Data Quality

The University Hospitals Dorset NHS Foundation Trust submitted records during 2022/23 to the Secondary Uses Service (SUS) for inclusion in the hospital episode statistics which are included in the latest published data.

The percentage of records in the published data which included the patients' valid NHS number was 99.8% for admitted patient care; 99.9% for outpatient care; and 99.2% for accident and emergency care. The percentage of records in the published data which included the valid General Medical Practice code was 99.7% for admitted patient care: 99.9% for outpatient care; and 93.9% for accident and emergency care. (Taken from the National M12 22-23 SUS DQ report)

Collecting the correct NHS number and supplying correct information to the Secondary Uses Service is important because it:

- is the only national unique patient identifier
- supports safer patient identification practices
- helps create a complete record, linking every episode of care across organisations

The results for UHD are all better or equal to the national average.

Data management is largely handled by the Trust's Business Intelligence Department, Quality and Risk Management Department and the Clinical Audit Department, all of which are subject to internal and external quality checking and control. Aspects of these have been regularly checked and validated throughout the year as part of routine governance processes.

The Trust has a Data Quality Management Group which is responsible for ensuring robust mechanisms are in place for maintaining and improving the quality of data within the Trust and for monitoring compliance against national and local standards. The Data Quality Management Group is a formally constituted subgroup of Trust's Operational Performance Group and as such will receive the minutes / key actions of the Data Quality Management Group meetings.

The group is responsible for monitoring the quality of data used by the Trust, formulating a programme of work to improve data quality across UHD and approving action plans to address

poor data quality issues. This is achieved by raising awareness of data quality standards, monitoring compliance against National DQ Indicators and benchmarking against peers.

7. Data Security and Protection Toolkit attainment levels

All NHS trusts are required to complete an annual information governance assessment via the Data Security and Protection Toolkit (DSPT). This replaced the Information Governance Toolkit from April 2018 onwards. The self-assessment must be submitted to NHS England by 30th June each year.

The following section provides details of the 22/23 DSPT submission at the end of May 2023.

The Data Security and Protection Toolkit (DSPT) is a self-assessment audit completed by every NHS Trust annually and submitted to NHS England by 30th June; the purpose being to assure an organisation's Information Governance practices through the provision of evidence around 149 individual assertions which change slightly each year. For 2022/23, 113 of these assertions were mandatory.

The DSPT sets the standard for cyber and data security for healthcare organisations and places a much greater focus on assuring against modern threats. Based around the National Data Guardian's 10 Data Security Standards, a significant portion of this audit is underpinned by work associated with information risk assurance.

By the end of June 2023, it is expected that the Trust will be able to declare compliance with 103 of the 113 mandatory assertions. Areas requiring further work include the proactive audit of user account permissions and removal of unnecessary permissions on IT systems, having 95% of all staff completing IG training within the year, risk assessment and removal of unsupported software/hardware to the level specified within the DSPT, and connected medical devices.

As a result, the Trust is not expected to be able to submit a fully compliant assessment, but instead will complete action plan which will be submitted to NHS England with a view to its DSPT status for 2022/23 being set to "Approaching Standards". Work will then continue in the coming months to attain the necessary compliance.

In 2023/24, work will continue to establish and firmly embed the principles of information risk management and IG throughout the organisation, in order to ensure that the Trust is complying with its legal obligations. Key to this is the engagement and continued co-operation of subject matter experts and Information Asset Owners (IAOs), who provide assurance of practices within their respective departments across the organisation. Significant improvements made to the Trust's Information Asset Register during the year will facilitate this, and work will continue within year to embed and enhance this critical compliance tool.

8. Learning from deaths

All inpatient deaths receive a consultant review against a specific questionnaire. Reviews are discussed at specialty Mortality and Morbidity meetings and the chairs of these meetings attend the Trust Mortality Surveillance Group. This ensures that the reviews of all deaths within the hospital are discussed centrally and ensures actions for improvement are identified.

The Learning from Deaths pro forma also includes a nationally recognised grading system to ensure that avoidable mortality is clearly categorised. The tool codes the reviews into one of the following categories:-

- Grade 0-Unavoidable Death, No Suboptimal Care.
- Grade 1-Unavoidable Death, Suboptimal care, but different management would not have made a difference to the outcome.
- Grade 2-Possibly Avoidable Death, Suboptimal care, but different care might have affected the outcome.
- Grade 3-Probable Avoidable Death, Suboptimal care, different care would reasonably be expected to have affected the outcome.

Once any death is categorised as grade 2 or 3, a Patient Safety Incident LERN Form is completed and a root cause analysis investigation process is undertaken.

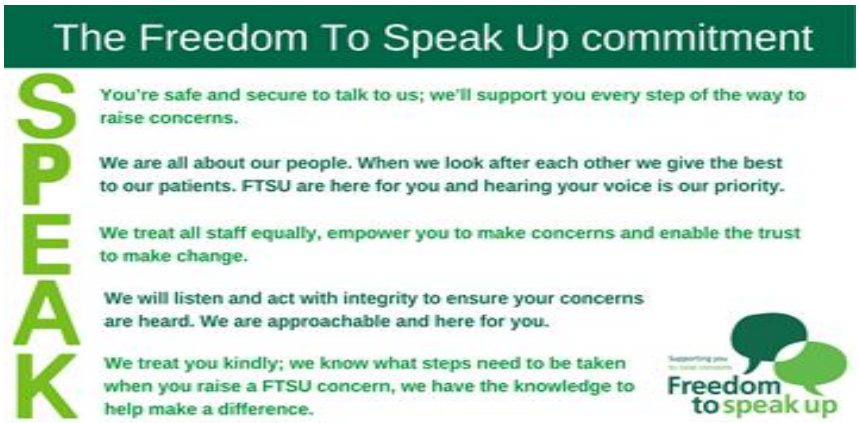
The Trust has a Medical Examiner process for all inpatient deaths. Part of the Medical Examiner process includes completion of an initial case note screen by a senior clinician. The aim of the screening process is to highlight any cases that require an urgent case note review or root cause analysis investigation.

The Trust has a multi-disciplinary Mortality Surveillance Group (MSG), chaired by the Chief Medical Officer, to review the Trust's Hospital Standardised Mortality Ratio (HSMR) and internal and external mortality risk reports. The group discusses areas of potential concerns regarding clinical care or coding issues and identifies further work, including detailed case note review and presentations from relevant specialties. Any learning points from the Group are disseminated through Directorate Mortality and Clinical Governance meetings.

A new electronic learning from deaths system was introduced across UHD in December 2022 in order to standardise the process for mortality reviews. Prior to implementation multiple different IT systems were in use and this meant that there was an inability to provide accurate data on the number and gradings of deaths reviewed across UHD. Once roll out is completed and the new process fully embedded, it is hoped that this data will be available for Quarter 1 23/24.

Themes for action and learning from mortality reviews and investigations have linked to the development of quality priority and quality improvement initiatives for 2023/24.

9. Freedom to Speak Up



Speaking up benefits everyone. Building a more open culture in which leadership encourages learning and improvement, leads to safer care and improved patient experience. At UHD, we have many routes that staff can use to speak up including our line managers, occupational health, staff governors, using our LERN forms, chaplains, education team and our HR team. Freedom to Speak Up (FTSU) is another alternative route which is both well used and evaluated by staff whom use it.

As previously mentioned in 2023/24 UHD will commence its exciting Patient first programme. Patient First will help us all by improving the way we work. It will give each of us the time, freedom and skills to make positive and long-lasting changes that will benefit ourselves, our colleagues and our patients. Speaking up is integral to this work and we look forward to supporting this moving forward.

Key Progress during 2022/23

Speaking up – Our Senior Leaders

Every year our board take time to reflect and publicly commit to the Sir Robert Francis principles of speaking up, alongside a declaration of their behaviours. This commitment was made in September and is a visual statement, reminding us that the board commit to speaking up and to developing a culture of safety. The declaration of behaviours sets out how the board will role model this and sets the tone of the culture for UHD.

A board development session is planned for 2023 to take time to assess where we are in terms of speaking up, where we need to be and how our senior leaders can support it.

Speaking up Month – October 2022

Speak Up Month is a chance to raise awareness of speaking up and the work which is going on to make speaking up business as usual. This October the theme was “Freedom to Speak Up for Everyone” with each week having a specific focus including safety, civility, inclusion and for everyone. Throughout the month we promoted the importance of speaking up through written articles, visual flags, post it notes, pens and literature, videos from our executives and staff who have used the service and worked alongside our staff networks jointly walking our clinical and non-clinical areas with our award winning decorative roaming trolley. Nearly 20,000 social media hits occurred from this work.

FTSU Networks – “Looking in and out”

Our networks are key to our success in sharing the speaking up message but also as a support for each-other. We have several networks which continue to grow and mature.

UHD FTSU Network**:** Our FTSU network meets monthly and discusses our observations and recent guidance. It allows us to quality assure the work we are doing and more recently focus on updating and reviewing the model going forward. We have planned a programme of work for 2023 including some personal development in September.

South-west regional Network**:** The National Guardians Office (NGO) recognises the need to develop and engage within formal regional networks. UHD has been co-chair for this network since 2020 and chairs quarterly regional meetings, six weekly check ins and mentoring for new guardians. This network is excellent for support and sharing good practice.

Dorset FTSU Network**:** UHD set up and chairs this network since September 2018. The vision of this group was agreed to share best practice and act as mentors for difficult cases. The membership has since expanded and now has representation across CCG, private healthcare, ambulance service, acute trusts and our regional lead for NGO. The focus of these meetings has consequently changed to supporting speaking up across our multi-agency systems in Dorset.

Speaking up Policy (June 2022)

NHS England published an updated national Freedom to Speak Up policy to be adopted by all Trusts by January 2024. The policy provides a minimum standard with space to add local information. It is designed to help organisations deliver the People Promise for workers, by ensuring they have a voice that counts, and by developing a speaking up culture in which leaders and managers value the voice of their staff as a vital driver of learning and improvement.

This Policy has been assured by People and Culture Committee in February 2023 and is anticipated to be approved and in place by May 23.

Freedom to Speak Up training programme

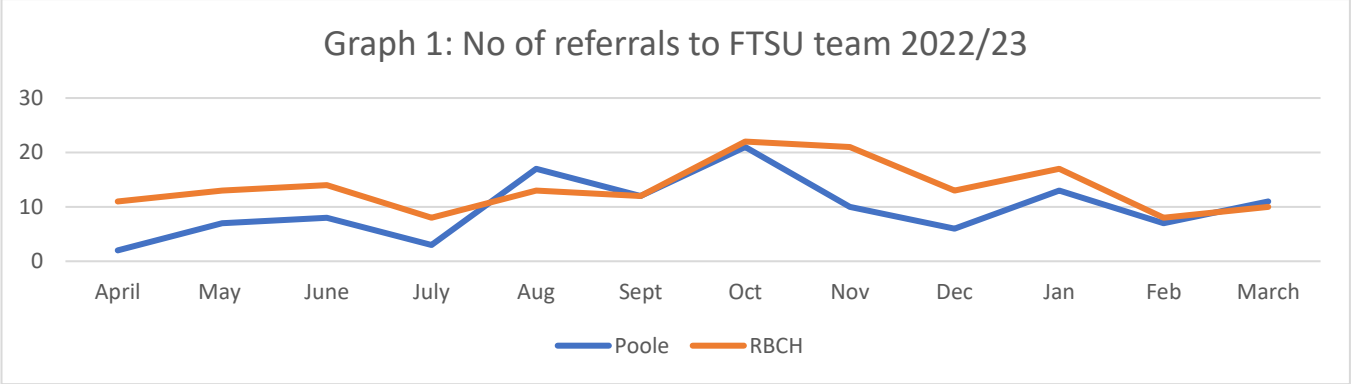
'Speak Up, Listen Up, Follow Up', is an e-learning package, aimed at anyone who works in healthcare. Divided into three modules, it explains in a clear and consistent way what speaking up is and its importance in creating an environment in which people are supported to deliver their best. A focused communications campaign is planned for spring 2023 and the module will be included into core induction programmes such as Trust induction, preceptorship, medical and international educated programmes.

Freedom to Speak Up Strategy at UHD

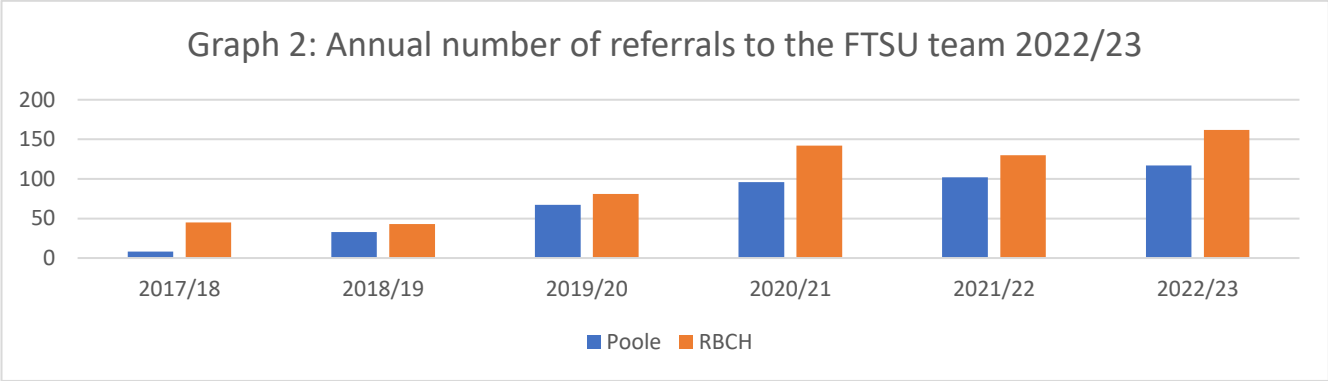
There is an expectation from National Guardian Office (NGO) that each Trust has a clear, robust and ambitious FTSU improvement strategy articulating our speaking up vision and goals. The strategy at UHD was built on national and local drivers, based on a diagnosis of speaking up issues within UHD and known areas for improvement. A detailed workplan sits beneath this strategy with planned progress updates. The strategy was signed off by the senior team/board in January 2023 and will be part of a communications programme over the Spring to ensure successful delivery.

Case Referrals

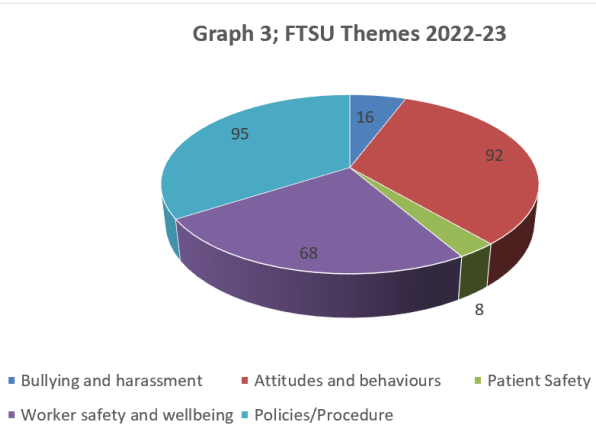
FTSU referrals come from a number of routes including trust communications, website, signposting from other departments such as OH and HR, word of mouth, LERNs, the UHD app and personal recommendation. The graph below highlights the number of referrals received on a monthly basis to the FTSU team over 2022/23.



Graph 2 shows that the number of referrals to the FTSU team increased by 20% from 2021/22. Forty-two per cent of referrals come from staff at our Poole site and 58% from RBCH. Five per cent of referrals to the FTSU team were made anonymously which is the same as 2021/22 and continues to be lower than that seen nationally (10.4%; NGO annual report 2022).



Staff approach the FTSU team for a number of reasons. Graph 3 illustrates the greatest theme had an element of behaviours (108 staff; 39%); of which 15% of those (16 staff) were raised as bullying and harassment. This is followed by process and procedures (95 staff; 34%) and then worker safety and wellbeing (68 staff; 24%). Only 3% of referrals were related to patient safety and may reflect strong LERN reporting culture in capturing our patient safety issues.



Eighteen per cent of staff (50 staff) raised a concern from an ethnic minority background. All staff were signposted to our BAME networks who were also able to support and advise. The FTSUG is an integral member of the Equality, Diversity and Inclusion Committee and will continue to work together to improve and support our ethnic minority employee experience.

Learning and reflections

Whilst each referral will have its own learning, themes can be drawn to help develop and embed into the culture at UHD. The following points are the learning and reflections of the FTSU team from referrals in 2022/23:

- Be mindful of how we speak/our tone to our colleagues or how we write emails can make our staff feel both un-important and undervalued.
- Invest time at the beginning of any re-structure or organisational change to explain the process and ensure their wellbeing is in the forefront of our minds with access to support if needed.
- Challenge the working patterns we offer.
- Improve clinical engagement and behaviours.
- Promote our leaders to attend Compassionate and Inclusive leadership programmes and People Management modules.
- Encourage our leaders to complete HEE/NGO Speak up, listen up and follow up modules on BEAT.
- Upskill our leaders on how to create psychological safe working environments to speaking up.
- Contribute, embrace and be involved in our Patient first programme. Patient First will help us all by improving the way we work. It will give each of us the time, freedom and skills to make positive and long-lasting changes that will benefit ourselves, our colleagues and our patients. Speaking up is integral to this work and we look forward to supporting this moving forward.

We are #TeamUHD

University Hospitals Dorset's values aspire to having an open and honest culture. Speaking up has never been as important as it is today and yet our staff are telling us that we do not address concerns nor make people feel safe to raise them. Speaking up takes courage and therefore deserves the time to listen and address them. It is everyone's business to encourage speaking up. We are #TeamUHD and collectively we need to Speak Up, Listen Up and Follow Up so to continually improve our culture of safety.

Reporting against core indicators

NHS foundation trusts are required to report against a set of core set of indicators using data made available to the Trust by the Health and Social Care Information Centre (HSCIC).

For each indicator the number, percentage, value, score or rate (as applicable) for the last two reporting periods (where available) are presented in the table below. In addition, where the required data has been made available by the HSCIC, a comparison with the national average and the highest and lowest national values for the same indicator has been included. The Trust considers that the data presented is as described for the reason of provenance as the data has been extracted from available Department of Health information sources.

Quality Indicator	Data Source	Trust rate for noted reporting period	National average value	Highest value	Lowest value
Summary hospital level mortality indicator (SHMI)	Health and Social Care Information Centre (HSCIC)	January 21 – December 21 0.9037 January 22 – December 22 0.8916	1.000 1.000	1.1897 1.2186	0.7127 0.7117
University Hospitals Dorset NHS Foundation Trust considers that this data is as described for the following reasons. The source data for this indicator is routinely validated and audited prior to submission to HSCIC. The data has been extracted from available Department of Health information sources. The SHMI data is taken from https://beta.digital.nhs.uk/data-and-information/publications/clinical-indicators/shmi					
University Hospitals Dorset NHS Foundation Trust has taken the following actions to continue to improve this rate, and so the quality of its services, by routinely monitoring mortality rates. This includes looking at mortality rates by specialty diagnosis and procedure. A systematic approach is adopted whenever an early warning of a potential problem is detected – this includes external review where appropriate. The Trust Mortality Surveillance Group (chaired by the Chief Medical Officer) routinely reviews mortality data and initiates quality improvement actions where appropriate.					
Quality Indicator	**Data Source**	**Trust rate for noted reporting period**	**National average value**	**Highest value**	**Lowest value**
The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust	NHS Digital	January 2021 – December 2021 45% January 2022 – December 2022 41%	39% 40%	64% 65%	11% 12%
The Trust considers that this data is as described for the following reason. The data has been extracted from available Department of Health information sources. Publication of data is found here https://beta.digital.nhs.uk/data-and-information/publications/clinical-indicators/shmi					

Figures reported are 'diagnosis rate' figures and the published value for England (ENG) is used for the national value.

University Hospitals Dorset NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services: - Routine review of mortality reports at the Trust Mortality Surveillance Group.

Quality Indicator	Data Source	Trust rate for noted reporting period	National average value	Highest value	Lowest value
Patient Reported Outcome measures (PROMS)	Case mix adjusted average health gains i) groin hernia ii) varicose vein iii) hip replacement iv) knee replacement	Latest data published (Feb 22) is for April 2020 – March 21. 2021/22 and 22/23 data for UHD is not available	No national data available		

Quality Indicator	Data Source	Trust rate for noted reporting period	National average value	Highest value	Lowest value
% of patients readmitted to a hospital which forms part of the Trust within 30 days of being discharged from a hospital which forms part of the trust during the reporting period (i) aged 0 to 15 (ii) aged 16 +	NHS Digital	April 2020 – March 2021 (i) = 13.3% (720) (ii) = 14.3% (8955) April 2021 – March 2022 (i) = 14.0% (1095) (ii) = 13.1% (8630)	(i) = 12.5% (ii) = 13.0% 12.5% 12.0%	(i) = 64.4% (**) (ii) = 11.2% (**) 46.9% 142.0%**	(i) = 2.8% (**) (ii) = 1.1% 3.3% 2.1%

* indicates suppressed values between 1 and 7

** indicates national dataset has marked this data item with 'caution in interpretation of data. Numbers of patients discharged too small for meaningful comparisons'

The Trust considers that this data is as described for the following reasons. The source data for this indicator is routinely audited prior to submission.

University Hospitals Dorset NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services: - Undertaken routine monitoring of performance data and root cause analysis investigations where appropriate.

Quality Indicator	Data Source	Trust rate for noted reporting period	National average value	Highest value	Lowest value
Responsiveness to the personal needs of patients	National Inpatient Survey – NHS Digital	2022 Figures for UHD not currently available			

Quality Indicator	Data Source	Trust rate for noted reporting period	National average	Highest value	Lowest value
Staff who would recommend the Trust to family or friends	National Staff Survey	2021 – 73.0% 2022 – 64.2%	66.9% 61.9%	89.5% 86.4%	43.6% 39.2%
The Trust considers that this data is as described for the following reason. The exercise is undertaken by an external organisation with adherence to strict national criteria and protocols.					
University Hospitals Dorset NHS Foundation Trust intend to take the following action to improve this percentage, and so the qualities of its services, by implementation of a detailed action plan. The results of the survey have been presented to the Workforce Committee (a sub-committee of the Board of Directors) and key actions agreed.					

Quality Indicator	Data Source	Trust rate for noted reporting period	National average value	Highest value	Lowest value
The rate per 100,000 bed days Of cases of C difficile infection reported within the trust during reporting period.	Public Health England (PHE)	2020/21 – 10.49 per 100,000 overnight bed days 2021/22 – 9.6 per 100,000 overnight bed days	15.79 16.46	80.65 53.62	0 0
The Trust considers that this data is as described for the following reasons. The source data for this indicator is routinely validated and audited prior to submission. All cases of Clostridium difficile infection at the Trust are reported and investigated by the Infection Control Team and reported monthly to the Board of Directors.					
University Hospitals Dorset NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by ensuring high standards of infection prevention and control are implemented, monitored and maintained.					

Quality Indicator	Data Source	Trust rate for noted reporting period	National average value (non-specialist acute trusts)	Highest value	Lowest value
Number of patient safety incidents reported during the reporting period	NRLS	See section in report	National data not available	Not available	Not available

Part 3 – Other information

Review of quality performance in 2022/23

The data reviewed for the Quality Account covers the three dimensions of quality – patient safety, clinical effectiveness and patient experience. Information reviewed included directorate clinical governance reports, risk register reports, clinical audit reports, patient survey feedback, real time monitoring comments, complaints, compliments, incident reports, quality dashboards and quality and risk data.

This information is discussed routinely at Trust and Directorate quality, risk and clinical governance meetings. There is a clear quality reporting structure where scheduled reports are presented from directorates and specialist risk or quality sub groups to the Quality Committee, Clinical Governance Group, Trust Management Group and Board of Directors. Many of the reports are also reported monthly and/or quarterly to our commissioners as part of our requirement to provide assurance on contract and quality performance compliance.

The Trust has a Quality Strategy split into three distinct sections - Patient Safety, Clinical Effectiveness and Patient Experience. This is reviewed and refreshed annually.

The Quality Strategy sets out the strategic quality goals of the Trust in relation to clinical priorities set against the previous year's risk profiles, patient outcomes and new clinically based evidence or published guidance. Each of the three sections has distinct quality patient focussed goals to achieve to deliver the strategic aim, and sets out how this will be monitored and the governance framework within which it will be monitored against. This is developed with key internal and external stakeholders and is approved and monitored by the Quality Committee as a committee of the Board of Directors. The Quality Committee scrutinises the plans and approves them, monitoring monthly the quality performance, together with the risk profiles and the Trust's Board Assurance Framework.

The following section provides an overview of the performance in 2022/23 against some of the quality indicators selected by the Board of Directors for the year. The indicators have been selected to demonstrate our commitment to patient safety, clinical effectiveness and enhancing the patient experience.

PATIENT SAFETY

Patient Safety Incidents

The following table provides details of the patient safety incidents reported during 2022/2023 and uploaded to the national reporting and learning

2021/22	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
No Harm/ Near Miss	747	952	965	932	989	867	1053	931	822	975	764	820	**10817**
Minor	402	384	375	437	432	404	393	486	417	435	420	395	**4980**
Moderate	10	12	10	22	11	10	8	8	7	9	2	3	**112**
Severe	5	7	2	3		2	2	1	3	1	2		**28**
Total	**1164**	**1355**	**1352**	**1394**	**1432**	**1283**	**1456**	**1426**	**1249**	**1420**	**1188**	**1218**	**15937**

Table: Patient safety incidents reported during April 2021 to March 2022 and uploaded via the national reporting and learning system (NRLS) (as at 31/03/2022)

2022/23	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
No Harm / Near Miss	**816**	**913**	**895**	**1005**	**994**	**881**	**978**	**970**	**957**	**1029**	**803**	**926**	**11167**
Minor	**449**	**395**	**396**	**456**	**401**	**413**	**490**	**395**	**469**	**449**	**455**	**435**	**5203**
Moderate	**8**	**9**	**5**	**9**	**8**	**8**	**9**	**9**	**2**	**16**	**12**	**6**	**101**
Severe	**0**	**3**	**3**	**8**	**7**	**4**	**4**	**1**	**8**	**5**	**8**	**2**	**48**
Total	**1273**	**1320**	**1299**	**1478**	**1410**	**1306**	**1481**	**1375**	**1436**	**1499**	**1278**	**1369**	**16524**

Table: Patient safety incidents reported during April 2022 to March 2023 and uploaded via the national reporting and learning system (NRLS) (as at 31/03/2023)

NHS England defines serious incidents in broad terms as events in health care where the potential for learning is significant or the consequences to patients, families and carers, staff or organisations. There is no definitive list of events / incidents that constitute a serious incident. The circumstances in which an incident would be considered include:

- unexpected or avoidable death
- unexpected or avoidable injury which resulted in serious harm or required treatment to prevent death or serious harm
- A Never Event
- Actual or alleged abuse
- Incidents that prevent or threaten an organisations ability to deliver an acceptable quality of care

The Trust has a policy that describes the process governing the investigating and reporting of all incidents which supports an open and honest culture and facilitates learning and improvements in clinical care and guidelines.

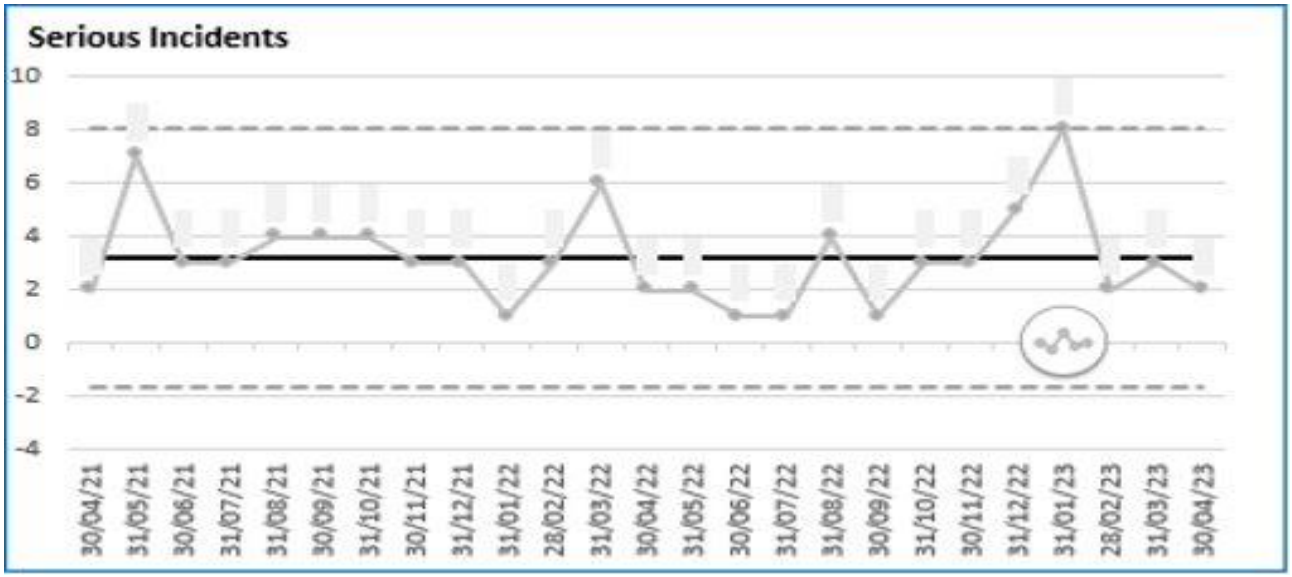
In 2022/2023 the Trust reported 35 serious incidents compared to 42 in 21/22

LERNS identified as External reports:

All External reports by date reported on STEIS and Care Group 22/23

UHD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	% to date
Surgical Care Group	0	2	1	0	1	0	0	2	0	1	0	2	9	26
Medical Care Group	2	0	0	0	2	1	2	1	4	6	2	1	21	60
Specialties Care Group	0	0	0	1	1	0	0	0	1	1	0	0	4	12
Corporate Directorates	0	0	0	0	0	0	1	0	0	0	0	0	1	2
Total	2	2	1	1	4	1	3	3	5	8	2	3	35	100

All External reports by date reported on STEIS (Month and year) (comparative 21/22 and 22/23)



Examples of Trust wide Learning Alerts shared across the Trust following serious incident investigations have included:

- Trust wide learning – sharing and storage of images taken in clinic
- Trust wide learning - Timely treatment of suspected Sepsis
- Trust wide learning - Review of Radiology results
- Trust wide learning - Specialty discharge from the ED Department
- Trust wide learning – Guidance to patients when prescribing
- Trust wide learning - Labelling pathology requests
- Trust wide learning - Amendment to consent forms following procedure
- Trust wide learning - Release of emergency equipment

- Trust wide learning - Acute Kidney Injury
- Trust wide learning - Access to Emergency Blood Transfusion
- Trust wide learning - Access to toilet cubicles in emergency
- Medicine Safety Notice - Security of Medicine Storage via Keypad Entry System
- Trust wide learning - Delayed prescription of antibiotics
- Trust wide learning - Interventional Radiology transfers
- Trust wide learning - NG/OG Tube placement

All safety alerts are discussed at the Trust Clinical Governance Group and shared in the monthly CGG Top 10 briefing. The Alerts are also made available to staff in the Quality and Risk pages of the Trust intranet.

Never Events

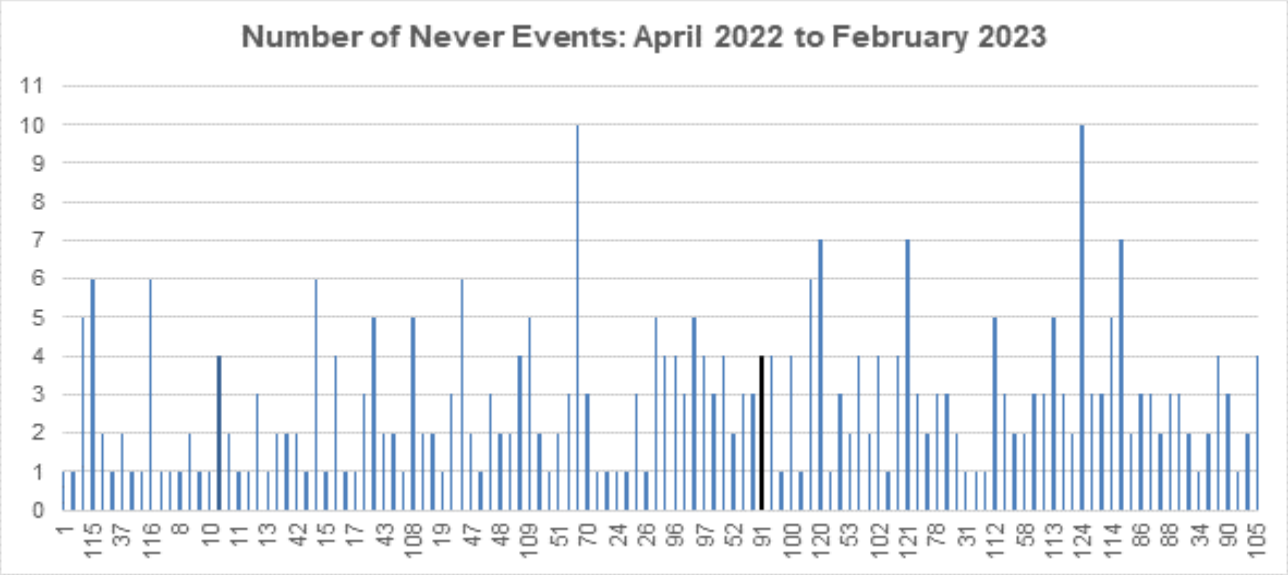
Never events are patient safety incidents that should be because there is national guidance in place requiring the use of strong systemic protective barriers.

The full list of Never Events is available on the NHS England website https://www.england.nhs.uk/wp-content/uploads/2020/11/2018-Never-Events-List-updated-February-2021.pdf

In the last 12 months (1 April 2022 – 31 March 2023) the Trust reported 4 never events.

UHD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Surgical Care Group	0	1	0	0	1	0	0	0	0	0	0	1	**3**
Medical Care Group	0	0	0	0	1	0	0	0	0	0	0	0	**1**
Specialties Care Group	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Total	**0**	**1**	**0**	**0**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**4**

Nationally 356 Serious Incidents met the definition of a Never Event and had an incident date between 1 April 2022 and 28 February 2023; this number is subject to change as local investigations are completed.



*** the black line indicates UHD**

All never events are fully investigated and any learning shared across the Trust.

Duty of Candour

The Duty of Candour requires healthcare providers to respond to safety incidents that result in moderate or severe harm or death in line with Statutory Duty of Candour as detailed in The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Any patient safety incident meeting the criteria must be notified to the patient or the 'relevant person', as soon as the organisation is aware. Organisations have a duty to:

- apologise
- inform patients that an investigation will be undertaken
- provide the opportunity for them to be involved in that investigation
- provide patients and their families with the opportunity, and support, to receive and discuss the outcomes of the investigation

Duty of Candour is managed within the structure of the Trust's web-based risk management reporting system and is an integral part of the reporting and subsequent incident management process.

All investigation processes require consideration and undertaking of the Duty of Candour in accordance with national legislation. A Duty of Candour "Toolkit" is available to support staff.

During 2022/23 NHS Dorset undertook an independent audit of the Trust arrangements for duty of candour. The Audit reported that the review provided moderate assurance that appropriate processes are in place and are being followed by staff.

National and Local Staff Survey

The **NHS Staff Survey** is the largest survey of staff opinion in the UK where staff are given the opportunity to share their views of experiences at work. It gathers views on staff experience at work around key areas, and including appraisal, health and wellbeing, staff engagement and raising concerns.

For the 2021 survey onwards the questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements:

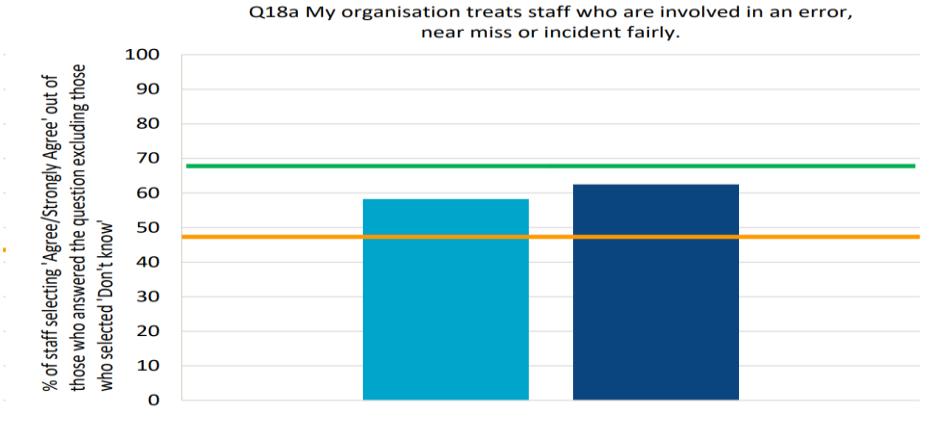
The national survey centre publishes full and summary reports of core survey responses appropriately benchmarked against national data for all trusts in England. The survey data is used in a variety of ways including:

- Care Quality Commission for ongoing monitoring of registration compliance.
- Department of Health for the development of NHS workforce policies.
- The Social Partnership Forum, where Unions, NHS Employers and the Department of Health, meet regularly to consider the results and influence national workforce policy.
- The survey provides valuable information about staff working conditions and practices, which are linked to the quality of patient care.

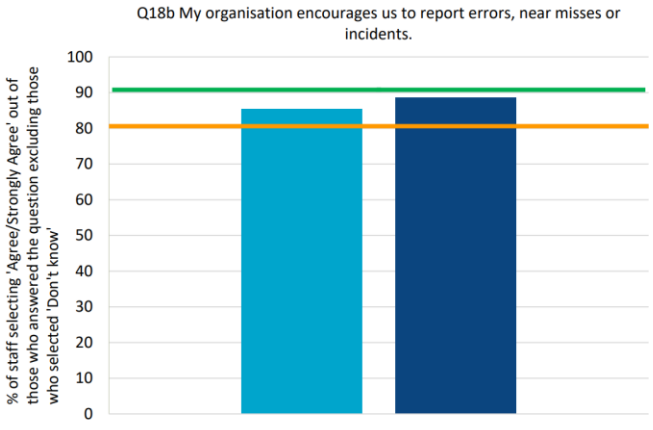
Within the Trust we analyse our data at team, subject and Trust level in order to understand:

- How we can celebrate and share good practice.
- How we can communicate results in a meaningful way and in the context of change to come.
- How we can channel resources to best support our teams.
- Areas and issues for particular attention.

The 2022 survey results were announced at the end of March 23. The results for safety culture, whilst slightly lower than 2021 were still significantly better than the sector average in a number of areas.



Your org	62.5%
Best	67.8%
Average	58.2%
Worst	47.3%
Responses	3253



Your org	88.6%
Best	90.8%
Average	85.5%
Worst	80.6%
Responses	4009

Your org	67.0%
Best	75.9%
Average	67.0%
Worst	52.7%
Responses	3680

Question		2021 Score	Significance	2022 Score	Significance	Sector Score
18a.	My organisation treats staff who are involved in an error, near miss or incident fairly.	-	N/A	62.5%	Significantly Better	58.6%
18b.	My organisation encourages us to report errors, near misses or incidents.	-	N/A	88.6%	Significantly Better	85.2%
18c.	When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.	-	N/A	67.1%	Not Significant	67.4%
18d.	We are given feedback about changes made in response to reported errors, near misses and incidents.	-	N/A	57.4%	Not Significant	59.0%

Schwartz rounds

Schwartz Rounds provide a structured forum where staff, clinical and non-clinical, come together to discuss the emotional and social aspects of working in healthcare. The purpose of Schwartz Rounds is to offer a safe, reflective space for staff to share stories with their peers about their work and its impact on them.

At UHD, Schwartz Rounds are open to all staff employed at UHD including our students and junior doctors. Schwartz Rounds follow a structured format. They start with refreshments to allow staff time to rest and network. The Schwartz round then starts with three or four presentations within the chosen title from staff, after which, the discussion is open to all. The one-hour sessions are led by our team of trained facilitators and all thoughts and views shared during the session are treated as confidential.

Attendance is associated with a statistically significant improvement in staff psychological wellbeing. Evidence shows that staff who attend Schwartz Rounds feel less stressed and isolated, with increased insight and appreciation for each other's roles. They also help to reduce hierarchies between staff and to focus attention on relational aspects of care.

Schwartz rounds are led by a Clinical Lead alongside which a steering committee sits which includes administrative support, trained Schwartz Round facilitators and communication support. The team represent what conversations are happening in the Trust and help set up, facilitate and promote the work of Schwartz Rounds as part of our health and wellbeing offering at UHD.

Schwartz rounds are licenced by Point of Care Foundation and provide structured training and mentor support.

Schwartz rounds 2022-23

The team in 2022 underwent a re-fresh and re-branding with the support of our Point of Care Foundation mentor. The steering committee set out an exciting 18 month programme.

Our communications and branding team have been integral to this refresh and integration of UHD teams.

Table 1 shows the number of rounds that have been set up since its refresh in June 2022.

Date	Title	Attend	Rate (good+)
July 22	*A picture tells 1000 words*	12	100%
Aug 22	*Small acts of kindness*	32	100%
Dec 22	*Working under pressure in the NHS*	29	91%
Jan 23	*When I am trying my best but it is still not enough*	24	100%
March 23	*Dealing with unexpected loss*	60	100%

All rounds are evaluated. Feedback includes:

- Very powerful stories; we are not frightened to talk about topics that are really difficult
- The panellists are amazing and made me realise that I am not the only one that thinks like this
- Today's Round will help me work better with my colleagues.
- The group discussion was helpful to me
- What a lovely session. Thank You
- Very valuable to see how the team work from all comes together
- Everyone was so positive - One big team
- The amazing power of compassion, empathy and team work.
- Emotional and uplifting stories. Thoroughly enjoyed it
- Made me feel connected and that I was not on my own

Schwartz rounds for 2023

- The programme has been set up for 2023 with 4 main rounds and up to 8 mini pop up rounds
- The membership of the steering committee will be reviewed annually to ensure they represent our workforce but also that they are able to contribute to the programme
- To review our team of facilitators and focus on increasing the number based at Poole site
- To succession plan for the clinical lead and administrative support tenure in March 2024
- To increase the attendance of our senior team and executives and support this wellbeing offering. To explore increasing clinical engagement attendance to rounds but also steering committee.

CLINICAL EFFECTIVENESS

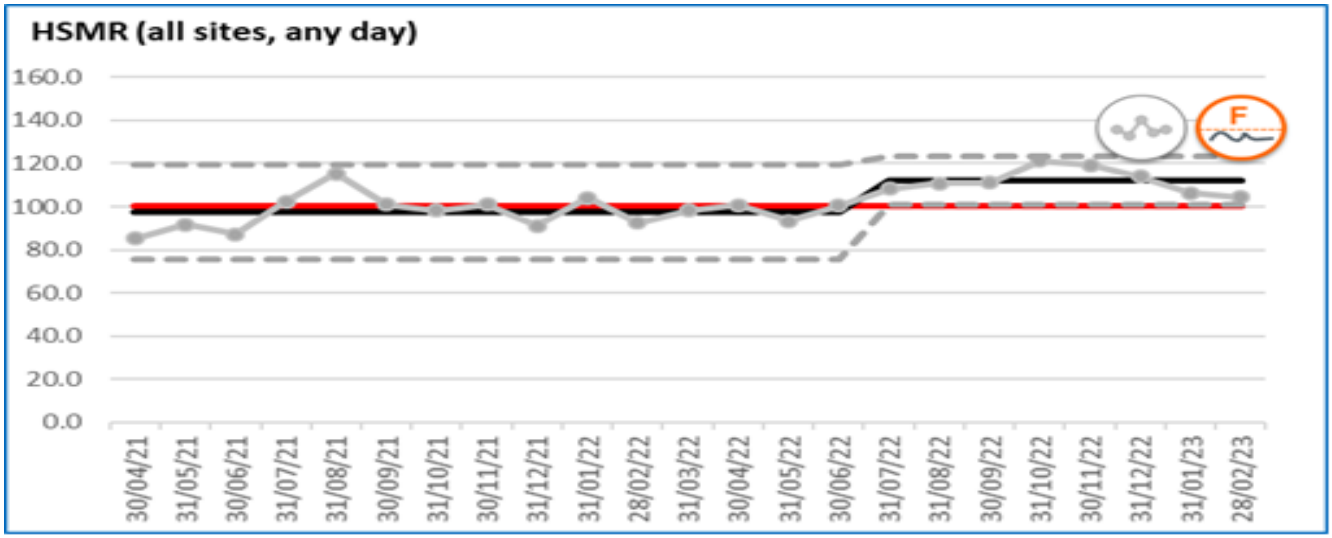
Reducing Mortality

The Dr Foster mortality metric, known as Hospital Standardised Mortality Ratio (HSMR) has become a recognised way of assessing hospital mortality. An HSMR value of 100 represents an average "expected" value and therefore a score below 100 demonstrates a better than average position. The NHS, via NHS Digital, has also developed a slightly different metric Summary Hospital Mortality Indicator (SHMI) which additionally includes patients that have died within 30 days of being discharged from hospital. SHMI is also calculated slightly differently.

The table below show the latest reported Standardised Mortality Ration (SMR) position for the Trust:

HSMR March 22 to February 23 (UHD) SHMI February 22 to January 23

Indicator	Site	Value	Range
HSMR	UHD	104.5	As expected
SMHI	UHD	89.6	As expected



The Trust has a multi-disciplinary Mortality Surveillance Group, chaired by the Chief Medical Officer, which reviews the Trust Mortality metrics on a monthly basis. The Trust also appointed a new clinical lead for mortality in April 2023. This is an opportunity to review the governance around mortality and learning from deaths.

Meeting National Institute for Health and Care Excellence (NICE) Guidance

This section covers the NICE process at UHD including the NICE procedure. The report provides: an overview of guidance published by NICE; an overview of the process for dissemination and reporting of NICE guidance; the status of all guidance published in 2022/23; developments undertaken in 2022/23; developments planned for 2023/24.

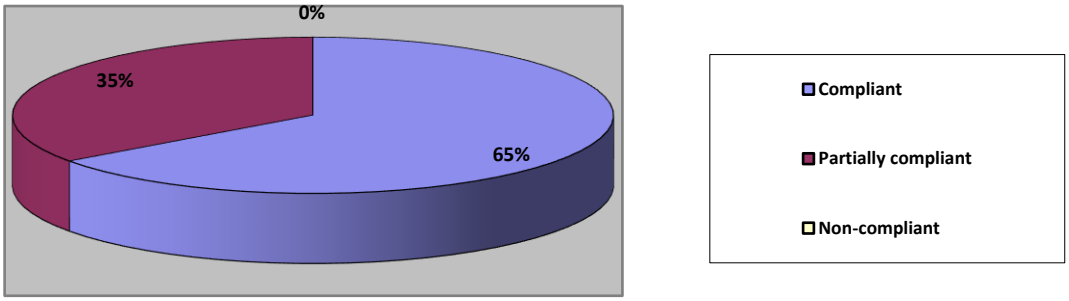
The final reportable position on current NICE Guidance for UHD (published from 1 April 2022 to 31 March 2023) for the financial year at Q4 2022/23 is as follows:

Care Group	Compliant	Partially Compliant	Non-Compliant	Not applicable	Grand Total
Medical	4	4	0	10	18
Surgical	3	0	0	15	18
Specialties	6	2	0	13	21
Operations	0	0	0	0	0
Corporate	0	1	0	4	5
Grand Total	**13**	**7**	**0**	**42**	**62***

*This figure does not include Technology Appraisals, updates to guidance that was previously published or guidance awaiting review of compliance.

Of those that were rated as applicable to UHD as per the table above (published from 1 April 2022 to 31 March 2023), the compliance status is recorded as follows:

Compliance status

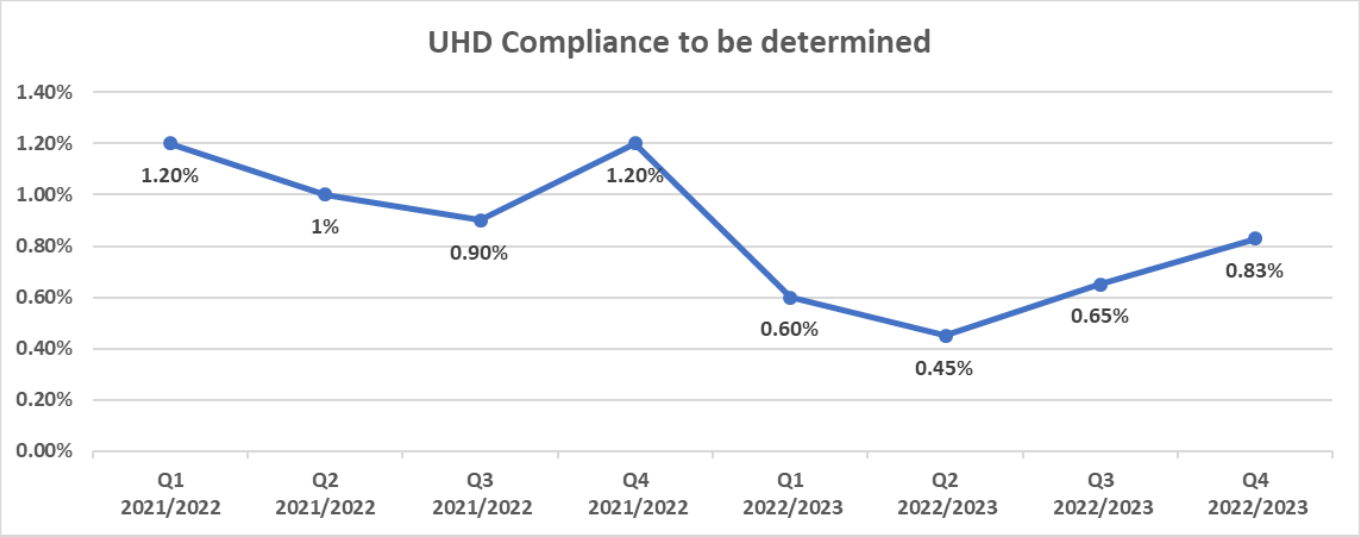


Of those that were rated as partially compliant for UHD (published from 1 April 2022 to 31 March 2023), the reasons for partial compliance are listed in the next table. Action plans are in place for each area of partial compliance. For example:

Guidance	Title	Specialty	Areas of partial compliance
NG 218	Vaccine uptake in the general population	Occupational Health/Maternity	Compliant for occupational health. Partially compliant for maternity Maternity are considering the appointment of a vaccine nurse later in the year, to vaccinate all service users with a regular service. In addition, from summer 2023 the Public Health Midwife will be able to focus on specific communities and demographics.
NG 217	Epilepsies in children, young people and adults	Neurology/ Paediatrics	Partially compliant due to epilepsy nurses' workload. Service to review need for additional admin support for epilepsy nurses. Continue to work with adult team to improve their capacity to take part in structured pathway for transition.
NG 220	Multiple sclerosis in adults: management	Neurology	Partial compliance. Due to the continual increase in patient numbers and complexity, the service is not always able to offer a full annual review to all NICE recommended patients.
NG 225	Self-harm: assessment, management and preventing recurrence	Acute Medicine	Partially compliant as awaiting IT support for electronic system update.
NG 229	Fetal monitoring in labour	Maternity	UHD follow 'Physiological interpretation of CTG' which is recognised nationally, rather than NICE interpretation. We are fully compliant with an equivalently recognised national CTG guideline.

At the 31/3/23, the number of guidance classed as “compliance to be determined” for UHD was 13 (for the previous financial year that number was 17). UHD have demonstrated effective processes of coordinating Trust responses to NICE guidance issued.

Level of Compliance to be determined for UHD in percentage:



Compliance is monitored quarterly via the Clinical Audit and Effectiveness Group.

Case studies of improvement following implementation of NICE Guidance

NG137 Twin and triplet pregnancy

In 2021 the Trust was partially compliant with this guidance but has now achieved full compliance following implementation of the NICE recommended care pathways. This includes the NICE recommendation that ‘antenatal clinical care for women with a twin or triplet pregnancy should be provided by a nominated multidisciplinary team.’ ‘This team should consist of a core team of named specialist obstetricians, specialist midwives and sonographers, all of whom have experience and knowledge of managing twin and triplet pregnancies’ . According to the Trust lead for this guidance, this means that the care pathway is evidenced based and has the potential to reduce twin stillbirths and perinatal morbidity.

QS38 Acute upper gastrointestinal bleeding

This QS recommends that ‘people admitted to hospital with acute upper gastrointestinal bleeding who are haemodynamically stable are given an endoscopy within 24 hours of admission’ . UHD are now fully compliant with this standard, as there are endoscopy slots available 7 days a week. When this guidance was last reviewed for RBCH, patients could only be offered endoscopy within 24 hours of admission, Monday to Friday. Therefore, this improved access to endoscopy can ‘help to avoid re-bleeding and can reduce the length of their hospital stay’, thus ensuring better outcomes for patients and saving Trust resources.

Development work and plans for the year ahead

The Clinical Audit Department has worked on streamlining NICE compliance recording on the newly merged NICE guidance database. This included seeking compliance updates from lead clinicians for guidance previously assessed as partially compliant and recording a status for UHD, rather than the old compliance status for RBCH/PH. This is an ongoing process.

Actions planned for 2023/24 include:

- To further work on maintaining the level of compliance to be determined at less than 10%.
- To carry on seeking compliance updates from lead clinicians for guidance previously assessed as partially compliant.

PATIENT EXPERIENCE

Measuring patient experience for improvement is essential for the provision of a high quality service. It is important to ensure that patients and the public are given an opportunity to comment on the quality of the services they receive.

Patient experience work at the Trust over the last year has included:

- National annual inpatient surveys, National cancer patient surveys, National Friends and Family Test monitoring
- Internal feedback via the use of real time patient feedback, patient surveys and focus groups
- Monitoring for any emerging issues via formal and informal complaints, issues raised by letters and compliments from patients, carers, relatives and the public.

Learning from complaints and concerns

Under the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, the Trust must prepare an annual report each year. This must specify the number of complaints received, the number of complaints which the Trust decided were well-founded and to summarise the subject matter of complaints, any matters of general importance arising from those complaints, or the way in which they have been managed and any actions that have been, or are to be taken to improve services as a consequence of those complaints.

Complaints made to the Trust are managed within the terms of the Trust's complaints procedure and national complaint regulations for the NHS. The overriding objective is to resolve each complaint with the complainant through explanation and discussion. It is important to note that the two Trusts had different approaches to managing and investigating complaints prior to the merger.

The number of formal complaints received and investigated can be seen below:

Formal complaints received	2022/23	2021/22	2020/21	2020/21	
			Q3 and 4	Q1 and 2	
	UHD	UHD	UHD	RBCH	PH
	984	491	447	169	75

The Trust has implemented an early resolution of complaints process, the data for these types of complaints was not included in the complaints figures previously however this is now part of the formal complaint process and reported as such. Early resolution is intended to provide a quicker response within 10 working days. The focus of the Patient Advice and Liaison Service (PALS) is to resolve concerns informally with front line staff. The table below shows that there has been an increase in the number of concerns being raised informally over the past year.

PALS concerns	2022/23	2021/22	2020/21	2020/21	
			Q3 and 4	Q1 and 2	
	UHD	UHD	UHD	RBCH	PH
	5530	5200	2347	1072	741

Complaint outcomes

At the close of the complaint investigation the investigation and findings are reviewed, and an outcome reached as to whether the complaint is upheld (well-founded), partially upheld or not upheld. The % of complaints upheld and not upheld can be seen in the Table below, together with a comparison against national average.

Outcome of complaints	2022/23		2021/22	2020/21		2020/21		
				Q3 and 4		Q1 and 2		
	UHD	Nat Ave	UHD	UHD	Nat Ave	RBCH	PH	Nat Ave
Upheld	18%	26.8%	14%	21%	24.6%	14%	20%	28%
Partially upheld	38%	37.5%	34%	29%	37%	33%	39%	35%
Not upheld	44%	35.7%	52%	50%	38.4%	53%	41%	37%

Subjects of complaints

Every complaint is assessed at the outset and the key themes extracted. The themes, (total of 1896 for the 984 complaints) based on the DOH submission dataset can be seen in the table below; recorded by number and % of total. Any emerging themes or hotspots are identified and escalated to the Directorate or Care Group triumvirate or to the relevant Director, depending on the seriousness, complexity and/or frequency of complaint theme monitored.

Complaints can have more than one theme assigned to them for example the complaint could be about the clinical treatment and communication and administration

Complaint themes	2022/23	2021/22	2020/21 Q3 and 4	2019/20 Q1 and 2	
	UHD	UHD	UHD	RBCH	PH
Clinical treatment	664 (35%)	373 (44%)	138 (32%)	103 (38%)	61 (30%)
Access to treatment	94 (4.9%)	2 (0%)	23 (5%)	14 (5%)	1 (0.5%)
Admission, discharge, transfers	97 (5.1%)	37 (4%)	27 (6%)	13 (5%)	7 (4%)
Delays & cancelled appointment	153 (8%)	16 (2%)	12 (3%)	4 (2%)	3 (2%)
Communication	435 (22.9%)	1 (0%)	92 (21%)	41 (15%)	37 (18%)
Consent	27 (1.4%)	211 (25%)	1 (0%)	1 (0.5%)	1 (0.5%)
End of life care	21 (1.1%)	6 (0.5%)	3 (0.5%)	0 (0%)	2 (1%)
Facilities	0 (0%)	0 (0%)	3 (0.5%)	1 (0.5%)	5 (3%)
Integrated care	0 (0%)	7 (0.5%)	2 (0.5%)	0 (0%)	0 (0%)
Patient care	90 (4.7%)	0 (0%)	97 (23%)	86 (31%)	35 (17%)
Mortuary	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Prescribing	43 (2.2%)	0 (0%)	3 (0.5%)	0 (0%)	8 (4%)
Privacy, dignity & wellbeing	22 (1.1%)	81 (10%)	3 (0.5%)	1 (0.5%)	5 (3%)
Restraint	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Staffing numbers	9 (0.5%)	4 (0%)	0 (0%)	0 (0%)	1 (0.5%)
Transport	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Administration	0 (0%)	39 (5%)	12 (3%)	0 (0%)	15 (8%)
Values & Behaviours	146 (7.7%)	39 (5%)	13 (3%)	1 (0.5%)	20 (10%)
Waiting Times	95 (5%)	32 (4%)	0 (0%)	3 (1%)	0 (0%)

The PALS concerns are themed using the same assessment used for formal complaints and are very similar percentages.

Changes resulting from Complaints

One of the main purposes in investigating complaints is to identify opportunities for learning and change in practice to improve services for patients.

Examples of changes brought about through complaints

You said

Patient information leaflets regarding post-surgery discharge care and given to patients on their discharge lacked detail and could be more clear.

We did

Surgical matron has reviewed the leaflets, and these have been updated, with clearer and more specific advice. The 'Information Following General Anaesthesia' leaflet has also been updated.

You said

Concerns raised regarding lack of updates from ward when father-in-law was an inpatient at Bournemouth Hospital.

We did

Complaint has been shared with staff anonymously for learning and staff training has been revisited with regard to communication.

You said

Concerns raised as mother of patient found a needle and syringe left in a cubicle in the Emergency Department, and the way in which it was handled.

We did

Staff members were identified, and additional training has been given regarding sharps safety and their disposal. Apologies given to patient and her mother.

You said

Feedback received regarding the lack of pillows available for patients in the Emergency Department.

We did

The Senior Matron for ED has ordered additional stock to ensure an adequate supply.

You said

Concerns raised regarding the Parkinson's service and the impacts of reduced staff in the service.

We did

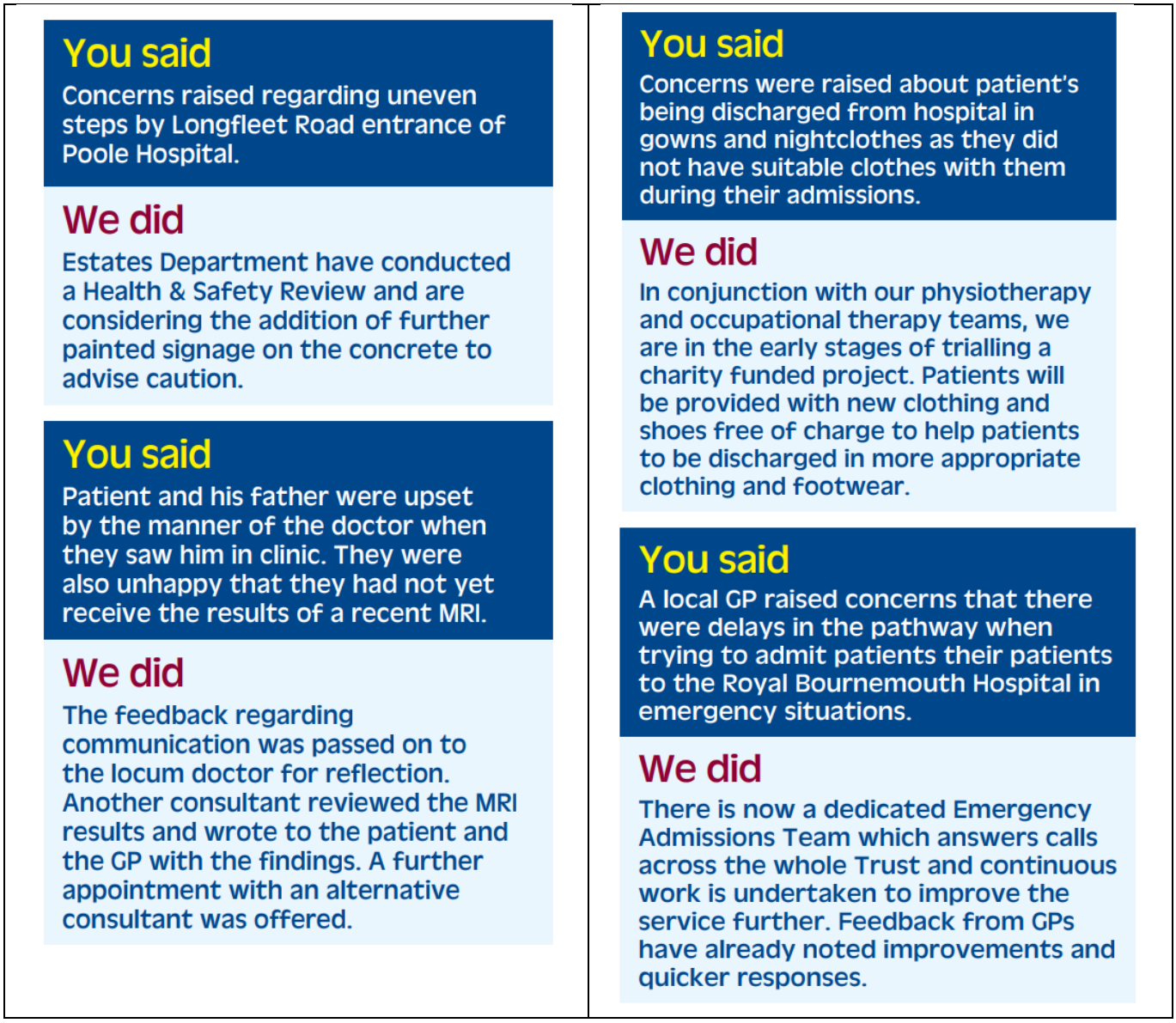
Further administration staff have been recruited to support the team and changes have been made to ways of working in order to improve the service, including the uploading of all correspondence to the electronic patient record so these are immediately accessible for GPs.

You said

Concerns raised regarding the Labour Line and the difficulties in accessing staff.

We did

Labourline now has a call waiting system so that staff can see when they have missed calls and can call people back. More staff are also being recruited to the team with an aim to provide a continuous 24-hour labourline.



Referrals to the Parliamentary and Health Service Ombudsman (PHSO)

Complainants who remain dissatisfied with the way the Trust has handled their complaint at local resolution level are able to request an independent review to be undertaken by the Parliamentary and Health Service Ombudsman (PHSO). Complainants are made aware of their right to take their complaint to the PHSO through the Trust information leaflet and in the written response to their complaint. During 2022/23 the PHSO advised of 13 cases that they were looking into. One of the cases opened by the PHSO has now been closed and not upheld. One case has resulted in a compensation payment of £750. The other cases are still with the PHSO being reviewed.

Performance against national priorities 2022/23

National Priority	2022/23 Actual	2022/23 Target	2021/22
18 week referral to treatment waiting times – admitted (31/03/2023)	49.8%	92%	**45.5%**
18 week referral to treatment waiting times – non admitted (31/03/2023)	54.6%	92%	**65.1%**
18 week referral to treatment waiting times – patients on an incomplete pathway (31/02/2023)	53.8%	92%	**61.0%**
Proportion of patients staying for over 12 hours in Emergency Departments	7.3%	<2%	**1.85%**
Maximum waiting time of 62 days from urgent referral to treatment for all cancers	67.8%	85%	**73.8%**
Maximum waiting time of 62 days following referral from an NHS Cancer Screening Service	82%	90%	**85.3%**
Maximum cancer waiting time of 31 days from decision to treat to start of treatment	97.1%	96%	**97.0%**
Maximum cancer waiting time of 31 days from decision to treat to start of subsequent treatment: Surgery	89.5%	94%	**88.8%**
Maximum waiting time of 31 days from decision to treat to start of subsequent treatment: Anti-cancer drug treatment	99.4%	98%	**99.6%**
Clostridium difficile year on year reduction	84	64	**70**
Certification against compliance with requirements regarding access to healthcare for people with a learning disability		Compliance certified	**Compliance certified**
Maximum 6 week wait for diagnostic procedures (31/03/2023)	93.0%	>99%	**84.1%**

Annex A

Glossary of Terms

ACP- Advance Clinical Practitioner

AMU – Acute Medical unit

BAUS – The British Association of Urological Surgeons

BEAT- Blended Education and Training team

CA UTI - Catheter Associated Urinary Tract Infections

CEPOD – Confidential Enquiry into Perioperative Deaths

Clostridium difficile, -also known as C. difficile, or C. diff, is a bacterium which infects humans, and other animals. Symptoms can range from diarrhoea to serious and potentially fatal inflammation of the colon. ... C. difficile is generally treated with antibiotics

COPD/COAD - Chronic Obstructive Pulmonary Disease/Chronic Obstructive Airways Disease

CQUIN The Commissioning for Quality and Innovation (CQUIN) framework supports improvements in the quality of services and the creation of new, improved patterns of care

CT – Computed tomography scan

ECG – Echocardiogram

ED – Emergency Department

EMIS – EMIS Health, IT Software company

eNA – Electronic nurse assessments

eMortality - Electronic Mortality capture form

GIRFT Get It Right First Time is a national programme, led by frontline clinicians, created to help improve the quality of medical and clinical care within the NHS by identifying and reducing unwarranted variations in service and practice

ITU – Intensive Care Unit

LERN – Learning Event Report Notification system

MRSA - Methicillin-resistant staphylococcus aureus. MRSA is a type of bacterial infection that is resistant to a number of widely used antibiotics. This means it can be more difficult to treat than other bacterial infections.

MUST – Malnutrition Universal Screening Tool

MSU – Midstream Specimen of Urine. The aim is to obtain a sample (specimen) of urine from the middle of your bladder. A midstream specimen of urine (MSU) is best, as the first bit of urine that you pass may be contaminated with bacteria from the skin.

NEWS - National Early Warning Score - An early warning score (EWS) is a guide used by medical services to quickly determine the degree of illness of a patient. It is based on the six cardinal vital signs (Respiratory rate, Oxygen saturations, Temperature, Blood pressure, Heart rate, Alert/Voice/Pain/Unresponsive scale). This gives a numerical score.

National Institute for Health and Care Excellence (NICE) – NICE is sponsored by the Department of Health to provide national guidance and advice to improve health and social care. NICE produce evidence based guidance and advice and develop quality standards and performance metrics for organisations providing and commissioning health, public health and social care services.

- **NICE Guidelines (NG)** are recommendations for care and services suitable for most people with a specific condition or need, and people in particular circumstances or settings. Since October 2014 NICE have published guidelines as a unified group of NICE Guidelines (NG), however, before this time they were published in a number of different categories. For further details see 1.2 below

- **Technology Appraisals (TA)** are recommendations on the use of new and existing health technologies. The Secretary of State has directed that the NHS provides funding and resources for medicines and treatments that have been recommended by NICE technology appraisals normally within 3 months (unless otherwise specified) from the date that NICE publishes the guidance (4).

- **Interventional Procedure Guidance (IPG)** covers the safety and efficacy of procedures that gain access to the patient's body via surgery, endoscopic instruments or radiation for the purpose of diagnosis or treatment.

- **Highly Specialised Technologies Guidance (HST)** evaluations are recommendations on the use of new and existing highly specialised medicines and treatments.

- **Medical Technologies Guidance (MTG)** are 'designed to help the NHS adopt efficient and cost-effective medical devices and diagnostics more rapidly and consistently. The types of products which might be included are medical devices that deliver treatment such as those implanted during surgical procedures, technologies that give greater independence to patients, and diagnostic devices or tests used to detect or monitor medical conditions' (2).

- **Diagnostics Guidance (DG)** designed to help the NHS adopt efficient and cost-effective medical diagnostic technologies more rapidly and consistently (5).

- **Quality Standards (QS)** are a set of specific, concise statements and associated measures collated from best evidence. The quality standards set out priority areas for quality improvement in health and social care and give a set of statements intended to help improve quality. Quality standards are based on NICE guidance and other NICE-accredited sources (3).

- **Health Technology Evaluations (HTE)** are an 'early value assessment (EVA) approach to assess those technologies that are most needed and in demand. This approach allows rapid assessment of digital products, devices and diagnostics for clinical effectiveness and value for money. So, the NHS and patients can benefit from these promising technologies sooner (1).

- **Cancer Service Guidelines (CSG)** provide guidance focused on the way services are organised for the treatment of different types of cancer.

- **Clinical Guidelines (CG)** provide guidance on the appropriate treatment and care of people with specific diseases and conditions.

- **Public Health Guidance (PH)** provides guidance on the promotion of good health and the prevention of ill health.

- **Social Care Guidelines (SC)** provide recommendations on 'what works' in terms of both the effectiveness and cost-effectiveness of social care interventions and services.

- **Medicines Practice Guidelines (MPG)** provide recommendations for good practice for those individuals and organisations involved in governing, commissioning, prescribing and decision-making about medicines.

- **Safe NHS Staffing Guidance (SG)** Following the Report of the Francis Inquiry and the Berwick Review into Patient Safety, NICE produced 2 guidelines on safe staffing capacity and capability in the NHS, but from June 2015 SSG was taken on by NHS England as part of a wider programme of service improvement.

NRLS – National Reporting and Learning System

Never Event - Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event. Never Events include incidents such as wrong site surgery, retained instrument post operation and wrong route administration of chemotherapy. The full list of Never Events is available on the NHS England website.

NCEPOD - National Confidential Enquiry into Patient Outcome and Death

NIHR - National Institute for Health Research (NIHR)

OPM – Older Persons Medicine

OPS coding – OPCS Classification of Interventions and Procedures is a World Health Organization measurement for all patient procedures.

Patient Reported Outcome Measure Scores - Patient reported outcome measures (PROMS) are recorded for groin hernia, varicose vein, hip replacement and knee replacement surgery.

National data (HSCIC) compares the post-operative (Q2) values, data collected from the patients at 6 months post-operatively by an external company. The data is not case mix adjusted and includes all NHS Trusts, Foundation Trusts, PCT and NHS Treatment Centre data. Private hospital data is omitted.

EQ-VAS is a 0-100 scale measuring patients' pain, with scores closest to 0 representing least pain experienced by the patient.

EQ-5D is a scale of 0-1 measuring a patient's general health level and takes into account anxiety/depression, pain/discomfort, mobility, self-care and usual activities. The closer the score is to 1.0 the healthier the patient believes themselves to be.

The Oxford Hip and Oxford Knee Score measures of a patient's experience of their functional ability specific to patients who experience osteoarthritis. The measure is a scale of 0-48 and records the patient ability to perform tasks such as kneeling, limping, shopping and stair climbing. The closer the score is to 48 the more functionally able the patient perceives themselves to be.

PDSA cycle is shorthand for testing a change by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made to the test (Act). Used in Quality Improvement

PSIRF Patient Safety Incident Response Framework

R&I – Research and Innovation

RATS – Rapid Assessment and Treatment area in Emergency Department

RCOG – Royal College of Gynaecologists

RCP – Royal College of Physicians

Serious Incident - In broad terms, serious incidents are events in healthcare where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. In general terms, a serious incident must be declared for where acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) result in:

- o Unexpected or avoidable death of one or more people.
- o Unexpected or avoidable injury to one or more people that has resulted in serious harm;
- o A Never Event

Full details of the NHS England Serious Incident Reporting Framework can be found on the NHS England website.

UKAS – United Kingdom Accreditation Service UKAS is the UK's National Accreditation Body, responsible for determining, in the public interest, the technical competence and integrity of organisations such as those offering testing, calibration and certification services.

University Hospitals Dorset NHS Foundation Trust

The Royal Bournemouth Hospital
Castle Lane East, Bournemouth, BH7 7DW

Poole Hospital
Longfleet Road, Poole, BH15 2JB

Christchurch Hospital
Fairmile Road, Christchurch, BH23 2JX

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University Hospitals Dorset
NHS Foundation Trust

COUNCIL OF GOVERNORS - PART 1 MEETING

Meeting Date: 27 July 2023

Agenda item: 6.10

Subject:	Membership Strategy Review
Prepared by:	Sarah Locke, Deputy Company Secretary (cover sheet) Sandy Wilson, Membership and Engagement Group, Council of Governors (paper)
Presented by:	Sandy Wilson, Public Governor Rob Whiteman, Trust Chair

Strategic themes that this item supports/impacts:	Systems working and partnership ☒ Our people ☒ Patient experience ☒ Quality: outcomes and safety ☒ Sustainable services ☐ Patient First programme ☐ One Team: patient ready for reconfiguration ☒
BAF/Corporate Risk Register: (if applicable)	Not applicable
Purpose of paper:	Decision/Approval
Executive Summary:	A separate Membership and Engagement Strategy meeting was held. At the meeting the strategy was reviewed, and the following amendments were discussed and updated within the strategy: • To rename the Membership Strategy 2020-2023 to Membership and Engagement Strategy 2023-2026 • To remove any references to the merger • To refer to the Trust as University Hospital Dorset (UHD) • To update the number of members in total • To focus more on hard-to-reach members The following points were discussed and will be updated in due course: • To align the Membership and Engagement Strategy with Communications Strategy and Patient Services Strategy • To include system working with Integrated Care System (ICS) • To include The Health and Care Act 2022 and its impact on ICS and members

	• To add feedback process and details of membership survey • To align with the Trust's Strategy, especially regarding equality, diversity, public patients and care involvement • To highlight the work with Communications Team • To remove the levels of membership (level 1 – informed, level 2 – involved, level 3 – active) • To strengthen the support for staff governors The action plan (appendix 2) is required to be updated.
Background:	This is the second Membership Strategy (the strategy) for UHD. The first strategy had been written and approved in April 2020 when the severity of the Covid pandemic was relatively unknown. The Membership and Engagement Group (MEG) had agreed to review the strategy given the changes in the way people work, communicate and engage with the Trust as the nation emerges from the restrictions of the pandemic. The objectives and the action plan from the 2023-23 strategy were discussed at the Board of Directors and Council of Governors Development Session that was held on 28 June 2023.
Key Recommendations:	To approve the Membership and Engagement Strategy for 2023-26.
Implications associated with this item:	Council of Governors ☒ Equality and Diversity ☒ Financial ☐ Operational Performance ☐ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☐ Regulatory ☐ Strategy/Transformation ☒ System ☒
CQC Reference:	Safe ☐ Effective ☐ Caring ☐ Responsive ☒ Well Led ☐ Use of Resources ☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Membership and Engagement Strategy Group	15/03/2023	Amendments as outlined in the Executive Summary were agreed.

Membership and Engagement Group	30/03/2023	Changes to the strategy were outlined.
Board of Directors and Council of Governors Development Programme	28/06/2023	Discussed the objectives and potential ways for the objectives to be met.

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	☐ ☐ ☐ ☐

MEMBERSHIP AND ENGAGEMENT STRATEGY

~~2021-2024~~

2023-2026

INTRODUCTION

This strategy outlines our plans for membership and engagement development for 20230-20263 following the merger between The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust to form for University Hospitals Dorset NHS Foundation Trust.

It sets out our vision for engaging with our Foundation Trust members and the communities we serve. We need members to be involved so they can hear first-hand what is going on, they can share their views and thoughts on our plans and they can help influence the development of our hospital services. This will help us improve our services for the benefit of all.

WHY MEMBERSHIP MATTERS

As an NHS Foundation Trust, we are accountable to our patients and the public. Our members have a key role in the Trust's governance; they elect representatives to sit on our Council of Governors, which in turn appoints the Chairman and Non-Executive Directors to the Board of Directors and oversees the Board's performance.

Members include our staff, our patients and members of the public. We believe that involving our members, patients and public in decisions about services is an integral part of meeting the needs of the communities we serve. Membership helps give those communities a voice in the running of the Trust and shaping our plans for the future.

This membership strategy sets out a series of objectives for the Trust to maintain, grow and engage its membership. It also describes how the Trust will evaluate the delivery of the strategy. The strategy will be delivered within the wider framework of Trust strategies, which address the issues and equality and diversity, public, patient and carer involvement, user engagement and communications.

Our vision is to develop an actively engaged and vibrant membership. Over the next three years, as a new rapidly changing organisation, we want to develop how we engage and involve our members, building a more active membership and giving members a voice in shaping how the organisation works. This strategy outlines the measures we will put in place during 2020-23 2023-26to achieve that vision.

We have developed this strategy based on the work of the Joint Governor meeting, between RBCH and PHFT, held in November 2019, This strategy builds on good practice from other Foundation Trusts and NHS Providers, and statutory and regulatory requirements. The Strategy is supported by an action plan which sets out what we will do in practice across the next three years to achieve our vision.

OUR MEMBERSHIP

Our members include our staff, our patients and people from across the diverse communities we serve both locally and regionally.

Who can be a member?

Public members

~~The Royal Bournemouth Hospital~~ UHD provides a wide range of hospital and community-based care to a population based in the Dorset, New Forest and South Wiltshire areas. This is a major tourist area and during the summer months over one million holidaymakers visit Bournemouth including substantial numbers of foreign students.

~~general health care for the residents of Bournemouth, Christchurch, East Dorset and part of the New Forest with a total population of over 550,000. This is a major tourist area and during the summer months over one million holidaymakers visit Bournemouth including substantial numbers of foreign language students. A district-wide strategic review has led to concentration of specialised services within particular provider units. Among the specialties at RBH are: The Dorset Heart Centre; elective orthopaedics; eye unit; cardiology; interventional radiology; stroke services.~~

~~Poole Hospital provides a wide range of acute services to people in Poole, east Dorset and Purbeck and serves as the major trauma centre for east Dorset. The hospital was built in 1970 and all the principal specialties are represented providing services for all medical, elderly, surgical and child health emergency admissions to include general surgery, trauma, ENT, oral and maxillofacial surgery, obstetrics, gynaecology, paediatrics, general medicine, neurology, rheumatology and dermatology. As the designated Cancer Centre for Dorset, the Trust provides cancer services for the whole of Dorset.~~

~~Following Dorset Clinical Commissioning Group's Clinical Services Review,~~ As a result of the Clinical Services Review, the Royal Bournemouth Hospital will become the major emergency care hospital for the region and Poole Hospital the major planned care hospital. This is already in progress with some changes already executed and considerable builds at both sites and we are seeing a significant investment across University Hospitals Dorset NHS Foundation Trust, providing much better facilities for both patients and staff. These developments will be implemented over the next three years.~~This will see a significant investment across University Hospitals Dorset NHS Foundation Trust, providing much better facilities for both patients and staff. These developments will be implemented over the next five years.~~

We offer all those interested in or with a connection to the Trust the opportunity to become a member. Members do not need any special skills or experience. It is free and open to anyone 16 years of age or older. Our public members include patients, volunteers and all other members of the public who wish to become involved. They come from our geographical constituencies of Bournemouth, Christchurch, East Dorset and rest of England and Poole and rest of Dorset. With our combined membership we currently have over 14,000 ~~15,401~~public members.

Staff members

We have c10~~9~~000staff members of the Trust. Any member of staff employed by the Trust on permanent contracts of fixed term contracts of 12 months or longer can become a member. Staff also employed through service partners including transport, catering and cleaning staff, also provide valuable services and are also eligible to become members.

Why become a member?

The core benefit of becoming a member is to have a regular voice – to shape the way services are provided, contribute to the future direction of the organisation, and ensure the Trust is responsive to the needs of people and communities it serves. Alongside this, membership provides opportunities to show support for the Trust and its work. In general terms, the benefits of membership include:

- Getting regular and up-to-date information about the Trust

- Invitations to attend free health talks and other events provident updates on Trust activities and the opportunity to speak with hospital representatives on a range of subjects and to attend and ask questions at the Annual Members' Meeting

- Voting for representatives on the Council of Governors and standing for election to the Council of Governors (for those age 16 years of over)

- ~~Taking part in surveys and consultations~~
- ~~Participating in patient involvement initiatives~~
- Access to NHS Discounts Scheme

- Appropriate involvement in matters affecting the progress of UHD

~~**Levels of Membership**~~

~~We recognise that some members may wish to be more actively involved in the work of the trust than others. Members in each of the trust's constituencies are therefore able to determine the level of engagement that they wish to have in the work of the trust, with one option being to participate in the election of the trust's Council of Governors during the governors' election process.~~

~~The trust asks its members to indicate the level of involvement that they wish to have, in order that it can manage its contacts and communications appropriately.~~

~~To help members decide their level of involvement, the trust has established three levels of membership:~~

~~**Level 1 – Informed**~~

~~Level 1 members are kept informed of new developments and information regarding the trust; they are able to participate in the elections of members to the council of governors and are able to attend and participate in the annual members' meeting.~~

~~**Level 2 – Involved**~~

~~In addition to the benefits of Level 1 membership, Level 2 members participate in a range of activities such as surveys, focus groups and special interest events.~~

~~**Level 3 – Active**~~

~~In addition to Level 1 and 2 benefits this level includes those members who have a more active role in the trust, either as an elected governor on the council of governors and / or who actively participate in the work of the trust in another way (including helping in service development meetings, compliance audits, staff interviews, attending board meetings and increasing their knowledge and skills in specific areas of interest).~~

~~Members may change their membership level at any time by contacting the trust's membership office.~~

Representing the interests of members

Members' views and opinions are heard through the Council of Governors, whose role is to represent the interests of members and hold the Board to account through the Non-Executive Directors. The Council of Governors is made up of 17 elected public members, five elected staff Governors and four~~5~~ appointed Governors from stakeholder organisations. All public members aged 16 or over are allowed to stand as a Governor or vote for a Governor. All staff members are able to stand as a Governor or vote for a Governor within their staff constituency. The Council of Governors is responsible for:

- Representing the interests of members and the public
- Appointing the Trust Chair~~man~~ and other Non-Executive Directors, and holding them to account for the performance of the Board
- Approving the appointment of the Chief Executive ~~by the Non-Executive Directors~~
- Receiving the Trust's Annual Report and Accounts
- Appointing the Trust's external auditors
- Being independent ambassadors of the Trust

The Trust is committed to developing and supporting Governors to enable them to carry out their role and contribute fully to the work of the Council of Governors. Our Governors attend Board meetings and Committees of the Board, giving our Governors broader access. Further details of the composition of the Council of Governors is set out in Appendix 1.

OUR MEMBERSHIP OBJECTIVES 2023~~0~~-2026~~3~~

Our vision is to build on ~~our~~ the engagement with ~~our~~ Trust members in order to create an active and vibrant membership community, one that is representative of the diverse population we serve and of the staff who work here, ~~and one~~ that has a real voice in shaping the future of the Trust and the services it provides. To achieve this vision our 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 our members are well informed, motivated and engaged;
3. To ensure our staff members have opportunities to become more actively engaged as members.

Delivering these aims is intended to support ~~University Hospitals Dorset NHS Foundation Trust (~~UHD~~)~~ in meeting its objectives, not least through being a responsive organisation with a good understanding of the needs of its patients and the communities it serves.

Objective 1: To build representative membership that reflects our whole population of Dorset and west Hampshire.

To achieve this we will:

- Maintain an accurate membership database and analyse our membership on a regular basis
- Develop targeted campaigns to recruit members from any group which is under-represented
- Promote membership opportunities to younger people in our communities
- Refresh the membership pages on the Trust's website
- Articulate clearly the benefits of membership
- Refresh our membership recruitment material
- Work more innovatively with our partners to promote membership

Objective 2: To improve the quality of mutual engagement and communication so our members are well informed, motivated and engaged

To achieve this we will:

- Promote the work of the Trust's governors, as representatives of our members
- Develop new opportunities for members to express their views
- Introduce new types of membership so members can choose how involved they want to be
- Refresh our existing ways of communicating with members and our approach to membership communication and engagement.
- Develop our programme of engagement events

Objective 3: To ensure our staff members have opportunities to become more actively engaged as members

To achieve this we will:

- Increase support to staff governors
- Develop a plan to increase awareness of staff governors through staff induction and other training events
- Promote the value of such a role to the benefit of both individual, their department and the constituency they represent

Delivering the strategy and evaluating success

Through this strategy, we want to achieve a step change in how we engage with members. To achieve this, we need to implement and deliver the strategy effectively. As an organisation committed to learning, we recognise the importance of measuring its impact and evaluating its success.

Implementation

We have developed an action plan which sets out the practical steps we will take in each year to implement the strategy. (To be developed)

Evaluating success

The Council of Governors is responsible for the delivery of the strategy, it will be supported by the Governors' Membership and Engagement Group which will report regularly to the Council of Governors.

The Governors' Membership and Engagement Group will directly oversee the Trust's efforts to engage with all of its members. It will receive updates at each meeting on the delivery of the strategy.

Appendix 1
Composition of the Council of Governors by Constituency

Public Constituencies	Number of governors
Bournemouth	6
Christchurch, East Dorset and Rest of England	5
Poole and Rest of Dorset	6

Staff Constituencies	Number of governors
Medical & Dental	1
Allied Health Professionals, Scientific & Technical	1
Nursing, Midwifery & Healthcare Assistants	1
Administration, Clerical & Management	1
Estates and Ancillary Services	1

Appointed Governors - Stakeholder organisations	Number of governors
~~NHS Dorset CCG~~	~~1~~
Dorset Council	1
Bournemouth, Christchurch and Poole Council	1
NHS Foundation Trust Volunteers Group	1
Bournemouth University	1

Membership Constituencies

Members currently fall into constituencies: Public and Staff. The following table includes a description of each constituency, the minimum membership required (as stated in the Constitution), the current number of members and the number of seats for the constituency on the Council of Governors:

Name of Constituency	For the residents of:	Minimum number of members	Members at 16 March 2023 ~~1 April 2021~~	Seats on the Council of Governors
Public	**Bournemouth** The following electoral wards: • Boscombe East & Pokesdown • Boscombe West • Bournemouth Central • East Cliff & Springbourne • East Southbourne & Tuckton • Kinson • Littledown & Iford • Moordown • Muscliff & Strouden Park • Queen's Park • Redhill & Northbourne • Talbot & Branksome Woods • Wallisdown & Winton West • West Southbourne • Westbourne & West Cliff • Winton East	50	~~6017~~5581	6
	Christchurch, East Dorset and Rest of England The following electoral wards and all electoral wards in the rest of	50	~~3539~~3382	5

Name of Constituency	For the residents of:	Minimum number of members	Members at 16 March 2023 ~~1 April 2021~~	Seats on the Council of Governors
	England not included in any other Area for the Public Constituency set out in this table: • Burton & Grange • Christchurch Town • Commons • Highcliffe & Walkford • Mudeford, Stanpit & West Highcliffe • Colehill & Wimborne Minster East • Corfe Mullen • Cranborne & Alderholt • Cranborne Chase • Ferndown North • Ferndown South • St Leonards & St Ives • Stour & Allen Vale • Verwood • West Moors & Three Legged Cross • West Parley • Wimbourne			
	Poole and Rest of Dorset The following electoral wards: • Alderney & Bourne Valley • Bearwood & Merley • Broadstone • Canford Cliffs • Canford Heath • Creekmoor • Hamworthy • Newtown & Heatherlands • Oakdale • Parkstone • Penn Hill • Poole Town • Beacon • Beaminster • Blackmore Vale • Blandford • Bridport • Chalk Valleys • Charminster St Mary's • Chesil Bank • Chickerell • Crossways • Dorchester East • Dorchester Poundbury • Dorchester West • Eggardon	50	~~5845~~5493	6

Name of Constituency	For the residents of:	Minimum number of members	Members at 16 March 2023 ~~1 April 2021~~	Seats on the Council of Governors
	• Gillingham • Hill Forts & Upper Tarrants • Littlemoor & Preston • Lyme & Charmouth • Lytchett Matravers & Upton • Marshwood Vale • Melcombe Regis • Portland • Puddletown & Lower Winterborne • Radipole • Rodwell & Wyke • Shaftesbury Town • Sherborne East • Sherborne Rural • Sherborne West • South East Purbeck • Stalbridge & Marnhull • Sturminster Newton • Swanage • Upwey & Broadwey • Wareham • Westham • West Purbeck • Winterbourne and Broadmayne • Winterbourne North • Yetminster			
Staff	• Medical & Dental • Allied Health Professionals, Scientific & Technical • Nursing, Midwifery & Allied Healthcare Professionals • Administration, Clerical & Management • Estates & Ancillary Services	4 4 4 4 4	C10~~9~~000	5
Totals		170		22

Appendix 2
Membership Strategy Action Plan

The following action plan sets out how the vision and objectives set out in our Membership Strategy 2020-2023 will be implemented in practice:

Overarching Objective	Supporting aims	What will we do to deliver the objective?		
		Year 1	Year 2	Year 3
Objective 1: To build a representative membership that reflects our whole population of Dorset and West Hampshire	Maintain an accurate membership database and analyse our membership on a regular basis	• Ongoing monitoring and management of the membership database	• As year 1	As year 1
	Develop targeted campaigns to recruit members from any group which is under represented	• Develop proposals for engaging with groups that are less well represented within the Trust's membership, in particular the age group age 16+. Engage with other Trusts to understand how they have approached engagement with these groups and use this to inform the development of tailored engagement plans. • Introduce membership recruitment stand at Bournemouth University freshers' fair.	• Subject to learning from year 1 activities, roll out comprehensive plans for engagement with younger people. • Use membership database to track changes in the composition of Trust's membership within these age groups	• Use membership database to track changes in the composition of the Trust's membership within these age groups
	Promote membership opportunities to younger people in our communities	• Pilot engagement opportunities in schools and colleges •		
	Refresh the membership pages on the Trust's website	• Refresh membership pages on the Trust's website to make them more accessible and informative.	• Keep membership pages up to date with new content • Make improvements based on feedback from membership survey.	• As year 2

Overarching Objective	Supporting aims	What will we do to deliver the objective?		
		Year 1	Year 2	Year 3
	Articulate clearly the benefits of membership	• Define clear articulation of the benefits of being a member of the Trust and ensure Governors are supported to articulate these benefits to potential members at events to meet 'your Governor'.	• Publish annual membership report which showcases work how the Trust has responded to issues raised by members	• Publish second annual membership report which showcases work how the Trust has responded to issues raised by members
	Refresh our membership recruitment material	• Undertake review of existing membership recruitment and engagement material • Develop new material (e.g. posters, flyers) using the Trust's forthcoming new branding	• Review impact of the new materials through feedback from members via the membership survey and engagement events and refresh this where appropriate	• As year 2
	Work more innovatively with our partners to promote membership	• Identify a range of key partners to work with and explore opportunities for joint work to help recruit new members.	• Begin joint campaign with partner groups selected on recruiting new members, including members from under represented or hard to reach groups.	• Evaluate joint working with partner groups and identify further opportunities for engagement and recruitment of members.
Objective 2: To improve the quality of mutual engagement and communication so our members are well informed, motivated and engaged.	Promote the work of the Trust's governor, as representatives of our members	• Introduce a new contact email address for members to submit questions or raise issues with Governors, and publicise this on the membership pages on the Trust website. • Develop a model for Governor communication with Members tailored to local level. • Include a regular section focusing on the work of Governors in new electronic membership newsletter. • Develop promotional material and aids to promote the role and work of Governors, using the opportunity of the	• Publish first annual membership report which showcases the work of Governors • Use second survey of membership to record member awareness of Governors • Develop video content for the Trust's website, where Governors talk about their work and their reasons for becoming Governors.	• Publish second annual membership report which showcases the work of Governors • Use third survey of membership to record member awareness of Governors

Overarching Objective	Supporting aims	What will we do to deliver the objective?		
		Year 1	Year 2	Year 3
		Governor elections in Winter 2020 to do this. • Governors to introduce member health talks • Governor participation in new constituency level events		
	Develop new opportunities for members to express their views	• Membership Engagement Committee to receive reports at each meeting on issues raised by members and actions being taken in response, and committee to report on these to the Council of Governors.	• Publish first annual report which showcases work on how the Trust has responded to issues raised by members	• Publish second annual report which showcases work on how the Trust has responded to issues raised by members
	Introduce new types of membership so members can choose how involved they want to be	• Confirm the definitions of the three levels of membership, ensuring these are sufficiently flexible to allow members to engage more or less depending on their areas of interest. • Introduce these categories on all new membership application forms • Contact existing members to confirm preferences on level of engagement and involvement	• Seek feedback from members through the membership survey to establish the degree to which the introduction of the new levels of membership has helped members have the opportunity to engage on the issues they care about • Use new levels of membership to target members for participation in surveys, workshops and focus groups • Monitor changes in number of members in each category as a proxy for measuring levels of active engagement	• Use levels of membership to target members for participation in surveys and workshops • Monitor changes in number of members in each category as a proxy for measuring levels of active engagement
	Refresh our existing ways of communicating with members and our approach to membership	• Launch new electronic membership newsletter which is visually more appealing and engaging and more informative about key developments in and affecting the Trust	• Undertake analysis of which issues and stories have been read most in the most in the membership newsletter.	• Launch third membership survey and reflect learning from this in activities to be delivered in the final year of the Strategy and in the planning of

Overarching Objective	Supporting aims	What will we do to deliver the objective?		
		Year 1	Year 2	Year 3
	communication and engagement	• Refresh membership pages on the Trust's website to make them more accessible and informative • Develop plans for an annual survey of members, refining key questions and issues where members feedback is needed	• Develop options for introducing a quarterly hard copy newsletter for staff, patients and the public. • Launch second membership survey and update Membership Strategy Actions Plan to reflect feedback from the survey.	the new Membership Strategy from 2023.
	Improve our programme of engagement events	• Develop plans for and launch pilot of constituency events in (TBC) constituency/s, introduced by Governor from that area. Assess impact and practicality of Member face to face meetings locally. • Develop a programme of member health talks for the full year ahead and seek views on topics for inclusion in future talks. Governor to be selected to introduce each speaker. • Seek to increase member turnout at Annual Members meeting by 20% (with a target of 100 attendees)	• Subject to feedback from constituency event pilots, roll out an annual programme of constituency engagement events (TBC) Constituencies. • Introduce updated member health talks with broader range of topics • Seek to increase member turnout at the Annual Members meeting by a further 20% (with a target of attracting over 120 attendees)	• Seek to increase member turnout at the Annual Members meeting by 25% (with a target of attracting over 150 members)
Objective 3: To ensure our staff members have opportunities to become more actively engaged as members	Increase support to staff governors	• Develop a suite of tools and resources specifically for staff governors • Develop a range of activities for staff governors to raise their profile and to engage with staff members, e.g. department walkabouts, drop-in sessions, sessions to build connections	• Review tools and resources for staff governors	•
	Develop a plan to increase	• Promote staff governors in a range of staff	• Increase staff governor visibility	• Seek to increase the number of staff

Overarching Objective	Supporting aims	What will we do to deliver the objective?		
		Year 1	Year 2	Year 3
	awareness of staff governors through staff induction and other training events	publications, hard copy , email and IT e.g. newsletters • Staff governor attendance at staff meetings and huddles by way of introduction • Introduce a generic email address for staff governors • Introduce staff governors at the staff induction day	in key areas of the Trust • Survey of staff membership to record member awareness of Staff Governors	members voting at governor elections • Seek to increase the number of staff members interested in becoming a staff governor

University Hospitals Dorset
NHS Foundation Trust

COUNCIL OF GOVERNORS - PART 1 MEETING

Meeting Date: 27 July 2023

Agenda item: 6.11

Subject:	Terms of Reference: Nominations, Remuneration and Evaluation Committee, Membership Engagement Group, Quality Group, Effectiveness Group, Constitution Group
Prepared by:	Sarah Locke, Deputy Company Secretary Yasmin Dossabhoy, Associate Director of Corporate Governance
Presented by:	Rob Whiteman, Chair

Strategic themes that this item supports/impacts:	Systems working and partnership ☒ Our people ☒ Patient experience ☒ Quality: outcomes and safety ☒ Sustainable services ☐ Patient First programme ☒ One Team: patient ready for reconfiguration ☐
BAF/Corporate Risk Register: (if applicable)	Not applicable
Purpose of paper:	Decision/Approval
Executive Summary:	The Nominations, Remuneration and Evaluation Committee is a committee constituted by the Council of Governors as provided for within the Trust's constitution. Its terms of reference are now due for annual review by the Council of Governors. <u>Nominations, Remuneration and Evaluation Committee</u> An update of the Terms of Reference (ToR) has been carried out and the following are the key amendments made for review and if thought fit approval by the Council of Governors: • Alignment with the Trust format for ToRs. • Terminology has been amended in line with Trust style (e.g. Chairman changed to Trust Chair). In addition, following discussions at recent Council of Governors meetings and development sessions in relation to the following informal groups (which are not Council of Governors' committees), the following terms of reference are presented to the Council of Governors for consideration and if thought fit approval.

	<u>Membership and Engagement Group and Quality Group</u> A full review of the ToR have been carried out. <u>Effectiveness Group and Constitution Group</u> New ToR to be approved.
Background:	The Nominations, Remuneration and Evaluation Committee ToR are required to be reviewed annually. The previous ToR were approved in July 2022. There has been a full review of the Council of Governors' Informal Groups. As part of this, a review has been undertaken of the ToR for the Membership and Engagement Group and the Quality Group. There are two new Informal Groups proposed to be created.
Key Recommendations:	To consider and if thought fit approve the terms of reference for: • Nominations, Remuneration and Evaluation Committee • Membership and Engagement Group • Quality Group • Effectiveness Group • Constituency Group
Implications associated with this item:	Council of Governors ☒ Equality and Diversity ☐ Financial ☐ Operational Performance ☐ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☒ Regulatory ☒ Strategy/Transformation ☐ System ☐
CQC Reference:	Safe ☐ Effective ☐ Caring ☐ Responsive ☐ Well Led ☒ Use of Resources ☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Nominations, Remuneration and Evaluation Committee	27/07/2023	Only applicable to the NREC ToR: meeting has not yet taken place at the time of submission.

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

TERMS OF REFERENCE

for the

University Hospitals Dorset NHS Foundation Trust

Council of Governors' Nominations, Remuneration and Evaluation Committee

July 2023

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

DOCUMENT DETAILS

Author:	Sarah Locke
Job Title:	Deputy Company Secretary
Signed:	
Date:	July 2023
Version No: (Author Allocated)	2.0
Next Review Date:	July 2024

Approving Body/Committee:	Council of Governors
Chair:	Rob Whiteman
Signed:	
Date Approved:	
Target Audience:	Council of Governors

Document History

Date of Issue	Version No:	Next Review Date:	Date Approved:	Director responsible for Change	Nature of Change
July 2022	1.0	July 2023	July 2022	Company Secretary	Full review and revision of terms of reference
July 2023	2.0	July 2024		Company Secretary	Full review and revision of terms of reference

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INDIVIDUAL APPROVAL			
Job Title	N/A	Date	N/A
Print Name	N/A	Signature	N/A
COUNCIL OF GOVERNORS APPROVAL			
If the Council of Governors has approved this document, please sign and date it and forward copies for inclusion on the Intranet.			
Name of approving body	Council of Governors	Date	27 July 2023
Print Name	Rob Whiteman	Signature of Chair	

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

NOMINATIONS, REMUNERATION AND EVALUATION COMMITTEE

TERMS OF REFERENCE

1. PURPOSE

1.1 The Trust's vision is to positively transform its health and care services as part of the Dorset Integrated Care System. Its mission is to provide excellent healthcare for its patients and wider community and be a great place to work now and for future generations.

1.2 Under the Trust's Constitution, the Nominations, Remuneration and Evaluation Committee (the Committee) is:

- To determine the criteria or process for the selection of candidates for office as Trust Chair or other Non-Executive Director of the Trust, having regard to such views as may be expressed by the Board of Directors.
- To seek by way of open advertisements and other means candidates for office and to assess, shortlist and select for interview such candidates as are considered appropriate.
- To make recommendations to the Council of Governors as to potential candidates for appointment as Trust Chair or other Non-Executive Director, as the case may be.
- To monitor the performance of the Trust Chair and other Non-Executive Directors and make reports to the Council of Governors from time to time on such performance.
- To consider and make recommendations to the Council of Governors about the remuneration and allowances and other terms and conditions of office of the Trust Chair and Non-Executive Directors.
- To review the structure, size and composition of the Board of Directors from time to time and make recommendations to the Council of Governors.

1.3 The Committee is a committee of the Council of Governors and has no delegated authority but will assist the Council of Governors in carrying out its role.

2. RESPONSIBILITIES

To advise and/or make recommendations to the Council of Governors relating to:

2.1 The evaluation of the performance of the Trust Chair and Non-Executive Directors. The Committee will on an annual basis monitor the performance of the Trust Chair and other Non-Executive Directors and make reports on the same to the Council of Governors when requested to do so by the Lead Governor or when in the opinion of the Committee the results of such monitoring ought properly to be brought to the attention of the Council of Governors.

2.2 The remuneration, allowances and other terms and conditions of office for the Trust Chair and Non-Executive Directors.

2.3 The composition of the Board of Directors and the skill mix of the Non-Executive Directors.

2.4 The recruitment process for the selection of candidates for the office of Trust Chair or other Non-Executive Directors. In this context:

- The Committee shall determine the processes for the selection of candidates for office as Trust Chair of other Non-Executive Director of the Trust having first consulted with the Board of Directors as to these matters and having regard to such views as may be expressed by the Board of Directors.

- The Committee shall, using the Trust's HR Services, seek candidates for office and to assess, shortlist and select for interview such candidates as are considered appropriate and in doing so the Committee shall be at liberty to seek advice and assistance from persons other than members of the Committee or of the Council of Governors such as external organisations recognised as experts in recruitment and remuneration.

- The Committee shall make recommendations to the Council of Governors of the candidate for appointment as the Trust Chair or other Non-Executive Directors, as the case may be.

2.5 The consideration of the continuing tenure of absentee Governors.

3. MEMBERSHIP AND ATTENDANCE

3.1 The Trust Chair, or in their absence, the Vice Chair is to preside at meetings of the Committee. If the Trust Chair is absent from a meeting or temporarily absent on grounds of a declared interest the Vice-Chair shall preside. If the Trust Chair and Vice Chair are absent, such Non-Executive Director as the governors present shall choose shall preside.

3.2 The Committee will comprise of one governor from each of the public constituencies, one appointed governor and one governor from a staff constituency.

3.3 Governors comprising the Committee will be nominated by constituency. Where there is more than one nomination a ballot of that constituency will take place. The term of office will be for a three-year term with a permitted maximum of two three-year terms.

3.4 If the Lead Governor is not one of the Governors nominated by constituency, then the Lead Governor will automatically be co-opted to the Committee as a member. The term of office will coincide with such person holding the role of Lead Governor.

3.5 In discharging its responsibilities, the Chief Executive of the Trust will be entitled to attend meetings of the Committee unless the Committee decides otherwise, and the Committee will be required to take account of the Chief Executive's views.

3.6 In addition, the Chief People Officer may from time to time attend the Committee to provide information, advice and/or to present to the Committee:

3.7 Committee members should aim to attend all scheduled meetings.

3.8 Subject to paragraphs 3.5 and 3.6 above, only members of the Committee have the right to attend Committee meetings.

4. AUTHORITY

4.1 The Committee is authorised by the Council of Governors to carry out any activity within its Terms of Reference.

4.2 For the appointment of the Trust Chair, the Committee will seek the services of an independent assessor.

4.3 For all appointments and matters relating to remuneration, the Committee will seek advice from the professional human resource services of the Trust who may in turn seek professional external support.

5. CONDUCT OF BUSINESS

5.1 The Trust's Constitution shall apply to the Committee, to the extent applicable, and any its meetings.

5.2 The Committee will meet as a minimum, twice per year and at such other times as the Committee Chair shall require.

5.3 Meetings of the Committee will be quorate if at least three members are present, one of whom must be a publicly elected governor.

5.4 Meetings of the Committee shall be called by the Company Secretary (or nominee on their behalf) at the request of the Committee Chair.

5.5 The Company Secretary (or their nominee) is responsible for preparing the agenda for agreement by the Committee Chair. The Company Secretary (or their nominee) shall collate and circulate papers to Committee members.

5.6 Unless otherwise agreed by the Committee Chair, agenda and papers should be circulated no less than five working days before the meeting.

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

5.8 The Committee Chair should draw attention of the Council of Governors any matters relevant to the Committee's duties.

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

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

6. RELATIONSHIPS AND REPORTING

6.1 The Committee shall be accountable to the Council of Governors.

6.2 The Committee Chair will report back to the next formal meeting of the Council of Governors.

7. MONITORING

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

7.2 On an annual basis, the Committee will provide a report of its own work.

8. REVIEW

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

APPENDIX A

ATTENDANCE AT NOMINATIONS, REMUNERATION AND EVALUATION COMMITTEE MEETINGS

NAME OF COMMITTEE:	Nominations, Remuneration and Evaluation Committee			
Present *(including names of members present at the meeting)*	**Meeting Dates**			
Was the meeting quorate? Y/N *(Please refer to Terms of Reference)*				

TERMS OF REFERENCE

for the

University Hospitals Dorset NHS Foundation Trust

Council of Governors' Informal Membership and Engagement Group

July 2023

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

DOCUMENT DETAILS

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

Approving Body/Committee:	Council of Governors
Chair:	Rob Whiteman
Signed:	
Date Approved:	
Target Audience:	Council of Governors

Document History

Date of Issue	Version No:	Next Review Date:	Date Approved:	Director responsible for Change	Nature of Change
January 2021	1	January 2023	March 2021	Carrie Stone	New Terms of Reference.
January 2023	1.1	January 2026	March 2023	Company Secretary	The new review date of January 2026. To add a comma in the first paragraph of section 1.1, page 4 after “discussion on membership”.
July 2023	2.0	July 2024		Company Secretary	Full review and revision of terms of reference

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INDIVIDUAL APPROVAL			
Job Title	N/A	Date	N/A
Print Name	N/A	Signature	N/A
COUNCIL OF GOVERNORS APPROVAL			
If the Council of Governors has approved this document, please sign and date it and forward copies for inclusion on the Intranet.			
Name of approving body	Council of Governors	Date	
Print Name	Rob Whiteman	Signature of Chair	

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS' INFORMAL MEMBERSHIP AND ENGAGEMENT GROUP

TERMS OF REFERENCE

1. PURPOSE

1.1 The Membership and Engagement Group (the Group) is a forum for discussion on membership, engagement, development and recruitment of members and to informally oversee and review the Membership and Engagement Strategy on behalf of the Council of Governors, reporting to and making recommendations to the Council of Governors on this.

1.3 The Group is an informal group of the Council of Governors of University Hospitals Dorset NHS Foundation Trust and has no delegated authority.

2. RESPONSIBILITIES

2.1 To review the Membership and Engagement Strategy and associated action plans and receive regular reports on implementation.

2.2 To develop a work programme and action plan in relation to the Membership and Engagement Strategy for consideration by the Council of Governors and review and monitor progress.

2.3 To consider actions for growing membership numbers, highlighting any potential barriers and work to resolve their resolution.

2.4 To provide focus on encouraging membership amongst "hard to reach" groups and any develop membership representative of the population served by the Trust.

2.5 To agree upon and co-ordinate the involvement of governors to support recruitment activity and more broadly, as part of its ambassadorial role, the Council of Governors taking appropriate opportunities to promote the Trust within the local community both as an acute trust and as an anchor institution.

2.6 To review the public membership profile against the demography of the population to inform decisions on future membership recruitment strategy and recruitment activities.

2.7 To assist the Trust Chair in engaging with members to support initiatives to meet broader Trust objectives when and where required.

2.8 To develop communication tools (working with internal stakeholders) to support implementation of the Membership and Engagement Strategy that are of use to all membership and the wider public.

2.9 To consider the requirements of governors in communicating with:

- Their constituencies;
- Between themselves;
- With the Board of Directors;
- With other governors in the Dorset system;
- Other stakeholders;

In relation to the Membership and Engagement Strategy and recommend tools to aid communication.

2.10 To review membership recruitment material (which may include, but not limited to, a welcome and introduction pack for members).

2.11 To contribute to the planning and promotion of the Annual Members' Meeting and the Membership Strategy in the Trust's Annual Report.

2.12 To work closely with the Communications Team to maximise opportunities for positive public relations using the media and other forums to promote the Trust.

3. MEMBERSHIP AND ATTENDANCE

3.1 Membership of the Group comprises of up to seven governors.

The process for membership of the Group shall be agreed by the Council of Governors, taking into account the skills of governors to contribute and collectively deliver the responsibilities of the Group.

3.2 In addition, the following will attend the Group to provide information, advice and/or to present to the Group as agreed with the Group Chair (or in their absence the Deputy Chair):

- Senior Stakeholders Officer
- Corporate Governance Assistant

3.3 With agreement of the Group Chair (or the Deputy Chair), the Group may invite others, including any Director, employee, or external partner to attend meetings.

3.4 The Group Chair and Deputy Chair will be chosen in accordance with a process agreed by the Council of Governors.

4. AUTHORITY

4.1 None of the powers of the Council of Governors are delegated to the Group.

5. CONDUCT OF BUSINESS

5.1 The Group will meet as a minimum, on a quarterly basis.

5.2 Additional meetings of the Group can be scheduled as requested by the Group Chair.

5.3 The meeting will be declared quorate if at least three members are present, one of whom will be the Group Chair or Deputy Chair.

5.4 If a meeting of the Group is inquorate, the meeting can proceed if those present agree. Items requiring approval will be submitted to the next Group meeting or Council of Governors whichever comes first.

5.5 Meetings of the Group shall be called by the Company Secretary (or nominee on their behalf) at the request of the Group Chair.

5.6 The Corporate Governance Assistant (or their nominee) is responsible for preparing the agenda for agreement by the Group Chair. The Corporate Governance Assistant (or their nominee) shall collate and circulate papers to Group members.

5.7 Unless otherwise agreed by the Group Chair, agenda and papers should be circulated no less than five working days before the meeting.

5.8 The agenda and papers shall be made available, upon request, to the Council of Governors.

5.9 A brief summary of proceedings will be noted by the Company Secretary Team. The summary notes will be submitted to the next meeting of the Group for approval.

6. RELATIONSHIPS AND REPORTING

6.1 The Group shall be accountable to the Council of Governors.

6.2 The Group Chair (or their nominee) will report back to the next formal meeting of the Council of Governors.

6.3 The Group shall refer to the Communications Team in relation to the Communications Strategy.

7. MONITORING

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

8. REVIEW

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

8.2 The position of the Chair and Deputy Chair will be reviewed after an initial two years and subsequently at least every two years, or sooner if appropriate. The maximum term of office of the Chair and Deputy Chair will be three two-year terms.

APPENDIX A

ATTENDANCE AT MEMBERSHIP AND ENGAGEMENT GROUP MEETINGS

NAME OF GROUP:	Membership and Engagement Group		
Present ***(including names of members present at the meeting)***	**Meeting Dates**		
Was the meeting quorate? Y/N *(Please refer to Terms of Reference)*			

TERMS OF REFERENCE

for the

University Hospitals Dorset NHS Foundation Trust

Council of Governors' Informal Quality Group

July 2023

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

DOCUMENT DETAILS

Author:	Sarah Locke
Job Title:	Deputy Company Secretary
Signed:	
Date:	July 2023
Version No: (Author Allocated)	2
Next Review Date:	July 2024

Approving Body/Committee:	Council of Governors
Chair:	Rob Whiteman
Signed:	
Date Approved:	27 July 2023
Target Audience:	Council of Governors

Document History

Date of Issue	Version No:	Next Review Date:	Date Approved:	Director responsible for Change	Nature of Change
July 2021	1	July 2022	TBC	Company Secretary	New Terms of Reference
July 2023	2	July 2024	27 July 2023	Company Secretary	Full review and redraft

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INDIVIDUAL APPROVAL			
Job Title	N/A	Date	N/A
Print Name	N/A	Signature	N/A
COUNCIL OF GOVERNORS' APPROVAL			
If the Council of Governors has approved this document, please sign and date it and forward copies for inclusion on the Intranet.			
Name of approving body	Council of Governors	Date	
Print Name	Rob Whiteman	Signature of Chair	

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

QUALITY GROUP

TERMS OF REFERENCE

1. PURPOSE

1.1 The Quality Group (the Group) is a forum for discussion on matters relating to quality and the Quality Account, on behalf of the Council of Governors.

1.2 The Group is an informal group of the Council of Governors of University Hospitals Dorset NHS Foundation Trust and has no delegated authority.

2. RESPONSIBILITIES

2.1 To receive and discuss the draft Quality Account.

2.2 To receive and discuss any pertinent reports related to the Quality Account.

2.3 To co-ordinate with governors various quality related initiatives proposed by the Head of Patient Experience.

3. MEMBERSHIP AND ATTENDANCE

3.1 Membership of the Group comprises of up to seven governors.

The process for membership of the Group shall be agreed by the Council of Governors, taking into account the skills of governors to contribute and collectively deliver the responsibilities of the Group.

3.2 In addition, the following will attend the Group to provide information, advice and/or to present to the Group as agreed with the Group Chair (or in their absence the Deputy Chair):

- Associate Director of Clinical Governance and Risk
- Deputy Company Secretary
- Corporate Governance Assistant.

3.3 With agreement of the Group Chair (or the Deputy Chair), the Group may invite others, including any Director, employee, or external partner to attend meetings.

3.4 The Group Chair and Deputy Chair will be chosen in accordance with a process agreed by the Council of Governors.

4. AUTHORITY

4.1 None of the powers of the Council of Governors are delegated to the Group.

5. CONDUCT OF BUSINESS

5.1 The Group will meet as a minimum, twice a year.

5.2 Additional meetings of the Group can be scheduled as requested by the Group Chair.

5.3 The meeting will be declared quorate if at least three members are present, one of whom will be the Group Chair or Deputy Chair.

5.4 If a meeting of the Group is inquorate, the meeting can proceed if those present agree. Items requiring approval will be submitted to the next Group meeting or Council of Governors whichever comes first.

5.5 Meetings of the Group shall be called by the Company Secretary (or nominee on their behalf) at the request of the Group Chair.

5.6 The Corporate Governance Assistant (or their nominee) is responsible for preparing the agenda for agreement by the Group Chair. The Corporate Governance Assistant (or their nominee) shall collate and circulate papers to Group members.

5.7 Unless otherwise agreed by the Group Chair, agenda and papers should be circulated no less than five working days before the meeting.

5.8 The agenda and papers shall be made available upon request to the Council of Governors.

5.9 A brief summary of proceedings will be noted by the Company Secretary Team. The summary notes will be submitted to the next meeting of the Group for approval.

6. RELATIONSHIPS AND REPORTING

6.1 The Group shall be accountable to the Council of Governors.

6.2 The Group Chair will report back to the next formal meeting of the Council of Governors.

7. MONITORING

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

8. REVIEW

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

8.2 The position of the Chair and Deputy Chair will be reviewed after an initial two years and subsequently at least every two years, or sooner if appropriate. The maximum term of office of the Chair and Deputy Chair will be three two-year terms.

APPENDIX A

ATTENDANCE AT QUALITY GROUP MEETINGS

NAME OF GROUP:	Quality Group		
Present ***(including names of members present at the meeting)***	**Meeting Dates**		
Was the meeting quorate? Y/N *(Please refer to Terms of Reference)*			

TERMS OF REFERENCE

for the

University Hospitals Dorset NHS Foundation Trust

Council of Governors' Informal Effectiveness Group

July 2023

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DOCUMENT DETAILS

Author:	Yasmin Dossabhoy
Job Title:	Associate Director of Corporate Governance
Signed:	
Date:	July 2023
Version No: (Author Allocated)	1
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Approving Body/Committee:	Council of Governors
Chair:	Rob Whiteman
Signed:	
Date Approved:	
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July 2023	0.1	July 2024		Company Secretary	New Terms of Reference

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

COUNCIL OF GOVERNORS APPROVAL			
If the Council of Governors has approved this document, please sign and date it and forward copies for inclusion on the Intranet.			
Name of approving body	Council of Governors	Date	
Print Name	Rob Whiteman	Signature of Chair	

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS' INFORMAL EFFECTIVENESS GROUP

TERMS OF REFERENCE

1. PURPOSE

1.1 The Effectiveness Group (the Group) is a forum for discussion about the effectiveness of the Council of Governors and to informally oversee the development and implementation of plans to enhance Council of Governors' effectiveness, reporting to and making recommendations to the Council of Governors on this.

1.2 The Group is an informal group of the Council of Governors of University Hospitals Dorset NHS Foundation Trust and has no delegated authority.

2. RESPONSIBILITIES

2.1 To develop a draft work programme and responses/actions to address the Council of Governors' Assessment of Collective Performance (including, but not limited to, any training or development needs) for consideration by the Council of Governors.

2.2 To support the implementation of the work programme and responses/actions developed pursuant to paragraph 2.1 above and to monitor progress.

2.3 To construct and support the implementation of a draft development plan to further equip Governors in carrying out their roles (working with other stakeholders within the Trust, as appropriate).

2.4 To evaluate the effectiveness of activities and events and progress on the actions agreed to be taken in relation to membership consequent upon the Membership and Engagement Strategy and reporting to the Council of Governors on this.

2.5 To consider and provide feedback to the Company Secretary Team in relation to the draft form of document used to solicit governors' views on the Council of Governors' collective performance.

2.6 To work closely with the Communications Team to maximise opportunities for positive public relations using the media and other forums to promote the Trust.

3. MEMBERSHIP AND ATTENDANCE

3.1 Membership of the Group shall comprise of up to seven governors.

The process for membership of the Group shall be agreed by the Council of Governors, taking into account the skills of Governors to contribute and collectively deliver the responsibilities of the Group.

3.2 In addition, the following will attend the Group to provide information, advice and/or to present to the Group as agreed with the Group Chair (or in their absence, the Deputy Chair):

- Senior Stakeholders Officer

- Corporate Governance Assistant.

3.3 With agreement of the Group Chair (or the Deputy Chair), the Group may invite others, including any Director, employee, or external partner to attend meetings.

3.4 The Group Chair and Deputy Chair will be chosen in accordance with a process agreed by the Council of Governors.

4. AUTHORITY

4.1 None of the powers of the Council of Governors are delegated to the Group.

5. CONDUCT OF BUSINESS

5.1 The Group will meet as a minimum, on a quarterly basis.

5.2 Additional meetings of the Group can be scheduled as requested by the Group Chair.

5.3 The meeting will be declared quorate if at least three members are present, one of whom will be the Group Chair or Deputy Chair.

5.4 If a meeting of the Group is inquorate, the meeting can proceed if those present agree. Items requiring approval will be submitted to the next Group meeting or Council of Governors whichever comes first.

5.5 Meetings of the Group shall be called by the Company Secretary (or nominee on their behalf) at the request of the Group Chair.

5.6 The Corporate Governance Assistant (or their nominee) is responsible for preparing the agenda for agreement by the Group Chair. The Corporate Governance Assistant (or their nominee) shall collate and circulate papers to Group members.

5.7 Unless otherwise agreed by the Group Chair, agenda and papers should be circulated no less than five working days before the meeting.

5.8 The agenda and papers shall be made available, upon request, to the Council of Governors.

5.9 A brief summary of proceedings will be noted by the Company Secretary Team. The summary notes will be submitted to the next meeting of the Group for approval.

6. RELATIONSHIPS AND REPORTING

6.1 The Group shall be accountable to the Council of Governors.

6.2 The Group Chair will report back to the next formal meeting of the Council of Governors.

6.3 The Group shall co-ordinate their activity, as appropriate, with the Communications Team particularly to align to the Trust's Communications Strategy.

7. MONITORING

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

8. REVIEW

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

8.2 The position of the Chair and Deputy Chair will be reviewed after an initial two years and subsequently at least every two years, or sooner if appropriate. The maximum term of office of the Chair and Deputy Chair will be three two-year terms.

APPENDIX A

ATTENDANCE AT EFFECTIVENESS GROUP MEETINGS

NAME OF GROUP:	Effectiveness Group		
Present ***(including names of members present at the meeting)***	**Meeting Dates**		
Was the meeting quorate? Y/N *(Please refer to Terms of Reference)*			

TERMS OF REFERENCE

for the

University Hospitals Dorset NHS Foundation Trust

Council of Governors' Informal Constitution Review Group

July 2023

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

DOCUMENT DETAILS

Author:	Sarah Locke
Job Title:	Deputy Company Secretary
Signed:	
Date:	July 2023
Version No: (Author Allocated)	1
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Approving Body/Committee:	Council of Governors
Chair:	Rob Whiteman
Signed:	
Date Approved:	
Target Audience:	Council of Governors

Document History					
Date of Issue	**Version No:**	**Next Review Date:**	**Date Approved:**	**Director responsible for Change**	**Nature of Change**
July 2023	1	July 2024		Company Secretary	New Terms of Reference

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Job Title	N/A	Date	N/A
Print Name	N/A	Signature	N/A
COUNCIL OF GOVERNORS APPROVAL			
If the Council of Governors has approved this document, please sign and date it and forward copies for inclusion on the Intranet.			
Name of approving body	Council of Governors	Date	
Print Name	Rob Whiteman	Signature of Chair	

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS' INFORMAL CONSTITUTION REVIEW GROUP

TERMS OF REFERENCE

1. PURPOSE

1.1 The Constitution Review Group (the Group) is a forum for discussion on matters relating to the review and updating of the Trust's Constitution triennially on behalf of the Council of Governors.

1.2 The Group is an informal group of the Council of Governors of University Hospitals Dorset NHS Foundation Trust and has no delegated authority.

2. RESPONSIBILITIES

2.1 To receive, discuss and propose amendments to the Trust's Constitution.

2.2 To review the Trust's Constitution in line with current and updated national legislation.

2.3 To present all recommended amendments to the Board of Directors and the Council of Governors for consideration.

3. MEMBERSHIP AND ATTENDANCE

3.1 Membership of the Constitution Review Group compromises of up to seven governors.

The process for membership of the Group shall be agreed by the Council of Governors, taking into account the skills of Governors to contribute and collectively deliver the responsibilities of the Group.

3.2 In addition, the following will attend the Group to provide information, advice and/or to present a report to the Group as agreed with the Group Chair (or in their absence the Deputy Chair).

- Lead Governor
- Deputy Company Secretary

3.3 With agreement of the Group Chair (or the Deputy Chair), the Group may invite others, including any Director, employee, or external partner to attend meetings.

3.4 The Group Chair and Deputy Chair will be chosen in accordance with a process agreed by the Council of Governors.

4. AUTHORITY

4.1 None of the powers of the Council of Governors are delegated to this Group.

5. CONDUCT OF BUSINESS

5.1 The Group will meet as a minimum, twice a year. When the Trust constitution is due for review within the following six months, the meetings will increase to a minimum of monthly.

5.2 Additional meetings of the Group can be scheduled as requested by the Group Chair.

5.3 The meeting will be declared quorate if at least three members are present, one of which will be the Group Chair or Deputy Chair.

5.4 If a meeting of the Group is inquorate, the meeting can proceed if those present agree. Items requiring approval will be submitted to the next Group meeting or Council of Governors whichever comes first.

5.5 Meetings of the Group shall be called by the Company Secretary (or nominee on their behalf) at the request of the Group Chair.

5.6 The Corporate Governance Assistant (or their nominee) is responsible for preparing the agenda for agreement by the Group Chair. The Corporate Governance Assistant (or their nominee) shall collate and circulate papers to Group members.

5.7 Unless otherwise agreed by the Group Chair, agenda and papers should be circulated no less than five working days before the meeting.

5.8 The agenda and papers shall be made available, upon request, to the Council of Governors.

5.9 A brief summary of proceedings will be noted by the Company Secretary Team. The summary notes will be submitted to the next meeting of the Group for approval.

6. RELATIONSHIPS AND REPORTING

6.1 The Group shall be accountable to the Council of Governors.

6.2 The Group Chair will report back to the next formal meeting of the Council of Governors.

7. MONITORING

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

8. REVIEW

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

8.2 The position of the Chair and Deputy Chair will be reviewed after an initial two years and subsequently at least every two years, or sooner if appropriate. The maximum term of office of the Chair and Deputy Chair will be three two-year terms.

APPENDIX A

ATTENDANCE AT CONSTITUTION REVIEW GROUP MEETINGS

NAME OF GROUP:	Constitution Review Group		
Present ***(including names of members present at the meeting)***	**Meeting Dates**		
Was the meeting quorate? Y/N *(Please refer to Terms of Reference)*			

		27 April 2023	27 July 2023	26 October 2022	10 January 2024
Present	Rob Whiteman				
	Lesley Baliga				
	Daniel Banfield				
	Mandi Barron				
	Robert Bufton				
	Sharon Collett				
	Sue Comrie				
	Steve Dickens				
	Beryl Ezzard				
	Rob Flux				
	Paul Hilliard				
	Marjorie Houghton				
	Dimitri Ilic				
	Susanne Lee				
	Andrew McLeod	A			
	Keith Mitchell				
	Markus Pettit				
	Patricia Scott				
	Jeremy Scrivens				
	Diane Smelt				
	Carrie Stone				
	Kani Trehorn				
	Michele Whitehurst				
	Sandra Wilson				
In Attendance	Karen Allman				
	Yasmin Dossabhoy				
	Ewan Gauvin				
	Peter Gill				
	Judy Gillow				
	Siobhan Harrington				
	Sarah Locke				
	Irene Mardon				
	Mark Mould				
	Pete Papworth				
	Sharath Ranjan				
	Richard Renaut				
	Paula Shobbrook				
	Caroline Tapster				
	Peter Wilson				
	Klaudia Zwolinska				
Was the meeting quorate?		Y			

Key

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