University Hospitals Dorset
NHS Foundation Trust

University Hospitals Dorset NHS Foundation Trust

Council of Governors Meeting - Part 1

Thursday 27 October 2021

14:00 – 15:30

Via Microsoft Teams

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

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS

The meeting of the University Hospitals Dorset NHS Foundation Trust Council of Governors will be held at **14:00** on **Thursday 27 January 2022** via Microsoft Teams

If you are unable to attend please notify the Company Secretary's Team, telephone 0300 019 8723.

Chairman
David Moss

AGENDA – PART 1					
Time	**Item**		**Method**	**Purpose**	**Lead**
14:00	**1**	Welcome, Introduction, Apologies for Absence and Quorum	**Verbal**		**Chair**
	2	Declaration of Interests	**Verbal**		**Chair**
	3	Minutes of the Meeting held on 28 October 2021	**Paper**	**Approval**	**Chair**
14:05	**4**	**QUALITY AND PERFORMANCE**			
	4.1	Update on Covid	**Verbal**	**Noting**	**CNO/COO**
	4.2	Integrated Quality, Performance, Workforce, Finance and Informatics Report	**Paper**	**Assurance**	**Chief Officers**
	4.3	2022/23 Annual Plan	**Slides**	**Discussion**	**CFO**
	4.4	Annual External Audit Plan	**Paper**	**Noting**	**CFO**
	4.5	Board Assurance Framework Six Monthly Report	**Paper**	**Noting**	**CNO**
15:15	**5**	**GOVERNANCE**			
	5.1	Chairman Recruitment Update	**Verbal**	**Noting**	**CPO**
	5.2	Plans for Non-Executive Director Recruitment	**Verbal**	**Noting**	**CPO**
	5.3	The Role of the Lead Governor	**Verbal**	**Discussion**	**Lead Governor**
	5.4	Proposed Process for the Appointment of the Lead Governor and the Deputy Governor	**Paper**	**Approval**	**Dep. CoSec**
	6	Urgent Motions or Questions	**Verbal**		**Chair**
	7	Any Other Business	**Verbal**		**Chair**

15:30	**8**	**Date of next meeting: Thursday 28 April 2022 at 4.30pm location tbc**
		Note: A glossary of abbreviations that may be used in these papers will be found at the back of this document

AGENDA – PART 2					
15:45	**9**	Welcome, Introduction, Apologies for Absence and Quorum	**Verbal**		**Chair**
	10	Declaration of Interests	**Verbal**		**Chair**
	11	Minutes of the meeting held on 28 October 2021	**Paper**	**Approval**	**Chair**
	12	Minutes of the meeting held on 15 December 2021	**Paper**	**Approval**	**Chair**
	13	Feedback from 26 January 2022 Board Meeting	**Verbal**	**Noting**	**Chair/ CEO**
16:05	**14**	**STRATEGY AND TRANSFORMATION**			
	14.1	ICS Update	**Verbal**	**Discussion**	**CEO**
16:25	**15**	Any Other Business	**Verbal**		**Chair**
	16	Reflections on the Meeting	**Verbal**		**Chair**
16:30	**17**	**Date of next meeting: Thursday 28 April 2022 at approximately 6.15pm location tbc**			

* Late Paper

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS PART 1 – PUBLIC MEETING

Minutes of the meeting of the Council of Governors held on Thursday 28 October 2021 at 16:30 via Microsoft Teams.

Present:	David Moss	Chairman
	Judith Adda	Bournemouth
	Diane Smelt	Bournemouth
	Sharon Collett	Bournemouth. Deputy Lead Governor
	Keith Mitchell	Bournemouth
	Andrew McLeod	Poole and Rest of Dorset
	Patricia Scott	Poole and Rest of Dorset
	Michele Whitehurst	Poole and Rest of Dorset
	David Triplow	Poole and Rest of Dorset, Lead Governor
	Robert Bufton	Poole and Rest of Dorset
	Sandra Wilson	Christchurch, East Dorset and Rest of England
	Chris Archibold	Christchurch, East Dorset and Rest of England
	Richard Allen	Christchurch, East Dorset and Rest of England
	Robin Sadler	Christchurch, East Dorset and Rest of England
	Carole Light	Christchurch, East Dorset and Rest of England
	Marie Cleary	Staff Governor: Administration, Clerical and Management
	Cameron Ingham	Staff Governor: Allied Health Professionals, Scientific and Technical
	David Richardson	Appointed Governor: NHS Dorset CCG
	Paul Hilliard	Appointed Governor: Bournemouth, Christchurch and Poole Council
	Beryl Ezzard	Appointed Governor: Dorset Council
In attendance:	Caroline Tapster	Non-Executive Director, Chair of the Quality Committee
	Debbie Fleming	Chief Executive
	Pete Papworth	Chief Finance Officer
	Karen Allman	Chief People Officer
	Peter Gill	Chief Informatics Officer
	Matt Hodson	Deputy Chief Nursing Officer
	Donna Parker	Deputy Chief Operations Officer
	Abigail Daughters	Director of Operations, Surgery
	Richard Moremon	Head of Communications
	Fiona Ritchie	Company Secretary
	Sarah Locke	Deputy Company Secretary
	Ewan Gauvin	Corporate Governance Assistant (minutes)
	Jonathan Brown	External Auditor, KPMG (item 5.4)

CoG 39/21	**Welcome, Introduction and Apologies for Absence** The Chair welcomed everyone to the meeting. Apologies were received from: • Marjorie Houghton - Bournemouth The Council of Governors were introduced to two new members of the Company Secretary Team: Sarah Locke, Deputy Company Secretary and Ewan Gauvin, Corporate Governance Assistant. The Chair informed the Council of Governors that there was an on-going

	process to appoint a new Governor for Bournemouth and a new Governor, Richard Ferns, had been appointed for Poole & The Rest of Dorset. The Company Secretary explained that as these changes were being made within twelve months of an election the candidate with the next highest number of votes was being considered, in accordance with the constitution.
CoG 40/21	**Declarations of Interest** No further interests were declared.
CoG 41/21	**Minutes of the meeting held on 29 July 2021** The minutes were APPROVED as an accurate record of the meeting.
CoG 42/21	**CEO Retirement and Recruitment of Replacement** The Chief People Officer presented a verbal update on the retirement of the Chief Executive and the recruitment of a replacement. The following key points were highlighted: • The Trust had appointed Odgers Berndtson to manage and advertise the vacancy. • The closing date for applications was the 29th October 2021. • The Trust would receive a long-list of candidates on week commencing 8th November 2021. • Shortlisting would occur on week commencing 22nd November 2021. • There was a proposed stakeholder event on the 6th December 2021 with interviews on the 7th December 2021. • There would be 3-4 stakeholder groups which Governors would be a part of. The Company Secretary reminded the Council of Governors that it would need to approve the appointment of the new Chief Executive and that an extraordinary meeting of the Council of Governors would be called to this end. This was likely to occur on week commencing 13th December 2021. The Council of Governors requested to know what qualities were being looked for in candidates. The Chief People Officer advised that this could be found within the job description and person specification and the Company Secretary agreed to share this with Governors as part of the next newsletter. The Council of Governors NOTED the Chief People Officer's verbal update. The Chair announced the retirement of Non-Executive Director Christine Hallett on the 31st December 2021 and asked the Council to agree for the Nominations, Remuneration and Evaluation Committee (NREC) to progress the recruitment of a replacement in conjunction with the Chief People Officer. An update on the process would then be provided to the January 2022 Council of Governors meeting. The Council of Governors AGREED for NREC to progress recruitment of a new Non-Executive Director alongside the Chief People Officer and formally expressed it's thanks to Christine Hallett for her service to the organisation.
CoG 43/21	**Integrated Quality, Performance, Workforce and Finance Report** The Chief People Officer presented highlights from the workforce report, noting the following key points: • Work to merge data from electronic staff records from the two sites

remained on-going.

- There had been an improvement in appraisals but further work to develop education and training continued in care groups and with individual directors.
- There was positive progress on statutory and mandatory training.
- Covid sickness absences were dropping.

The Chief Finance Officer presented highlights from the finance report, noting the following key points:

- There was a deficit of £528,000 against the break-even budget to end the H1 period. This reflected the difference between the elective recovery expenditure and the elective recovery income.
- The Trust was £1.8m ahead of the capital spend plan.
- The cash position was significantly below plan due to three key drivers: pay award, timing of elective recovery fund payments and timing of the capital programme.
- The better payment practice code was at 93% against a target of 95%. Improvement was being seen following tier 3 consultations and the embedding of updated authorisations.
- Funding settlement for H2 had been received and a draft plan had been submitted to the ICS.
- £4.4m in capital funding had been secured as well as £0.6m in revenue funding through a targeted investment fund.
- H2 would present a significant financial challenge due to the H2 settlement being significantly less than for H1.
- There was a 2% cost improvement target, translating to £7m in H2 which would be a challenge to deliver.

The Deputy Chief Operations Officer presented highlights from the operational performance report, noting the following key points:

- Key areas of focus for H2 included health and wellbeing of staff, Covid vaccination programme, restoration of elective and cancer care, expanding primary care capacity, transforming urgent & emergency care and tackling health inequalities.
- Key performance elements for H2:
  - Eliminating waits of over 104 weeks by March 2022
  - Reduce number of patients waiting over 52 weeks
  - Stabilise waiting lists around September 2021 levels
  - Return to February 2020 level of patients waiting longer than 62 days for cancer care by March 2022.
  - Meet the Faster Diagnosis Standard (FDS)
  - Reduce ambulance handover delays
  - Eliminate 12 hour waits within Emergency Departments
- Current performance indicators:
  - 64% Referral to Treatment (RTT) within 18 weeks
  - 104 week wait deteriorated in September 2021
  - Slight deterioration in 52 week waits
  - Improvement in ambulance handover and long ED waiting times
  - Occupancy was consistently over 90%
  - Top 3 in the region for cancer performance
  - On track for FDS
  - Strong activity recovery particularly in outpatients

The Deputy Chief Nursing Officer presented highlights from the quality report, noting the following key points:

- There had been a reduction in pressure ulcers with no category 4s reported with the previous month.

- There were three falls with moderate harm reported and one severe incident.
- There were four new serious incidents in September with no Never Events.
- Electronic Nursing Assessments remained unchanged at six hours from admission.
- There had been a decrease in patients experiencing multiple moves.
- Significant increase in Friends & Family Test (FFT) responses and 86.6% patients rated care as good or very good.
- The volume of complaints through PALS had increased 20% over the last 12 months.
- There had been a rise in section 42 enquiries, this had been reported back to the CQC and no further concerns had been raised.

The Chief Informatics Officer presented highlights from the informatics report, noting the following key points:

- There had been a major dip in infrastructure availability in July 2021. This was due to a planned evacuation of a data centre which had caused some outage. This indicator was then recovered in September 2021.
- An uptime of 99.99% had been achieved.
- The percentage of obsolete systems was high but this would be completely recovered by December 2021.
- Freedom of Information Act compliance had improved significantly to more than 80% compliance in the required time frame.
- High priority projects included the Dorset Care Record and Single Sign-on.

In response to the reports, Governors made several enquiries:

- A question was raised as to whether future financial plans had accounted for Covid. The Chief Finance Officer responded that financial plans for future years were not currently available due to having moved to national interim financial arrangements and being given six month allocations. Planning guidance was expected before Christmas 2021 to set out expectations for the next year. The continuation of Covid costs was expected.
- There was an enquiry into the number of serious incidents in maternity and how they were being followed up. The Deputy Chief Nursing Office provided assurance that all incidents were reviewed via scoping meetings. Some incidents also undergo external review through the Healthcare Safety Investigation Branch (HSIB). The Chair of the Quality Committee added that all serious incidents are reviewed in detail at the Quality Committee.
- Regarding the data for bed moves, it was asked whether this was broken down to specifically end of life patients. The Deputy Chief Nursing Officer was unsure whether this specific metric was captured and would investigate outside of the meeting.
- Further detail around workforce temporary staffing developments was requested. The Chief People Officer responded that a new structure was being developed and that teams had been combined. This work also linked with reducing temporary staffing agency spending.
- There was an enquiry regarding the increase in hospital acquired infections. The Deputy Chief Nursing Officer provided assurance that learning was being shared across the organisation and the Integrated Care System. There was quality improvement work on-going around MSSA and C.Diff. Infections were monitored through the IPC Group and the Quality Committee.

	The Council of Governors was ASSURED by the Integrated Quality, Performance, Workforce and Finance Report.
CoG 44/21	**Waiting List Recovery** The Director of Operations for the Surgical Care Group presented the waiting list recovery update, highlighting the following key points: • The waiting list at the time of the meeting was 52,008 patients. In contrast, the waiting list before Covid was approximately 40,000. This increase was therefore not just attributed to Covid as there was a building picture beforehand. • 104-week waits were down to 1,443 patients. There was a plan in place for each patient and work continued to eliminate 104 week waits by the end of March 2022. • Winter pressures, bed pressures and reduction in theatre occupancy due to cancellations would provide challenges. • Use of external facilities such as the Dorset Health Village would allow for high volume clinics and reduce follow-ups. • There was positive progress around achieving 31-day cancer targets, however the achieving of 62-day targets was proving challenging. The Council of Governors was ASSURED by the waiting list recovery update.
CoG 45/21	**UHD Annual Report and Accounts: October 2020 – March 2021** The Chief Finance Officer presented the Annual Report and Accounts, highlighting the following key points: • This had previously been presented to the Annual Members Meeting. • The report covered the period from 1st October 2020 to 31 March 2021. • The report was prepared in accordance with accounting standards and national guidance. • The document was approved by the Board on the 9th June 2021 and successfully laid before parliament on the 6th September 2021. • All financial requirements were delivered and significant additional capital funding had been received. The Council of Governors was ASSURED by the Annual Report and Accounts.
CoG 46/21	**External Audit Highlights** The External Auditor began by outlining their role and responsibilities. The External Auditor then presented the external audit highlights, noting the following key points: • All requirements had been completed against the plan. • The scope had been slightly updated as a result of Covid; more time was given and some disclosure requirements relaxed. • The Trust complied with the timetables where nationally other Trusts had not been able to. • Areas of scrutiny included financial risk statements, valuation of land and buildings, revenue recognition and expenditure. • There were no significant issues identified during the audit. • An annual audit report on value for money was available to read on the Trust website. Governors asked for further detail on the scope of the value for money audit. The External Auditor stated that the scope was set by NHSI and the National

	Audit Office. The scope was tightened as a result of Covid, with a focus on financial sustainability. It was added that further details could be found in the report available on the Trust website. The Council of Governors was ASSURED by the external audit highlights. *The External Auditor left the meeting.*
CoG 47/21	**Annual Review of the Effectiveness of the External Auditor** The Chief Finance Officer lead the Annual Review of the Effectiveness of the External Auditor, highlighting the following key points: • The Trust received an excellent service from KPMG which was professional, responsive and in line with the contract. • There was significant added value not outlined in the report from contributions to the Audit Committee and knowledge and expertise. • This report would be used to determine whether to continue with KPMG and extend the contract by a further year. The Audit Committee had recommended this extension. The Council of Governors AGREED to extend the contract by a further year.
CoG 48/21	**Annual Complaints Report** The Deputy Chief Nursing Officer presented the Annual Complaints Report, highlighting the following key points: • Learning from complaints could be found in the appendix of the report. • Policies and procedures were in place to meet statutory requirements. • 574 complaints were received during the reporting period, which was a reduction when compared to previous years. • Statutory targets for acknowledgement and response were being met, with more work being done on internal targets with a focus on early resolution. • 61% of complaints were related to clinical care of which 52% were upheld or partially upheld. • 29% of complaints were related to relational aspects of care. • Complaint processes were being aligned from legacy organisations and best practices from the ombudsman would be adopted. A question was raised as to whether patients were receiving a good service from the complaints procedures. The Deputy Chief Nursing Officer reiterated that from a statutory perspective all targets were being met but that further improvement internally was on-going. In response to a Governor query, the Deputy Chief Nursing Officer clarified that data from Christchurch hospital was included as part of the RBH data. The Council of Governors was ASSURED by the Annual Complaints Report.
CoG 49/21	**Council of Governors' Informal Groups** The Chair presented an update on the Council of Governors' Informal Groups. The report was discussed and CoG agreed that Richard Ferns would replace Christine Cooney and the "Sue Parsons replacement Governor" would replace Sue Parsons on their respective Groups. This would ensure that each publicly elected Governor sat on one of the three CoG Groups.

	The Council of Governors NOTED the report.
CoG 50/21	**Report from the Membership & Engagement Group** Sandy Wilson, acting Chair of the Membership & Engagement Group (MEG) for the September 2021 meeting presented a verbal report, highlighting the following key points: • There were a good number of actions going forward. • There was positive work on-going alongside the Communication team including an upcoming event at GATHER in the Dolphin Centre Poole from the 9th to 11th of November 2021. Chris Archibold, Chair of the Membership & Engagement Group, expressed his thanks to Governor Sue Parsons, who was stepping down, for her work both as a Governor and Chair of the MEG. It was added that Governors should inform the Associate Director of Communications should they be able to support the event at the Dolphin Centre. The Council of Governors NOTED the report from the Membership & Engagement Group.
CoG 51/21	**Urgent Motions or Questions** There were no urgent motions or questions.
CoG 52/21	**Any Other Business** An update on the alcohol care and treatment service (ACTS) was requested. The Chief Executive suggested that this could be the topic of a presentation at a future Informal Governor Briefing session The Deputy Chief Nursing Officer informed the Council of Governors that work was on-going to expand this service to include tobacco addiction and national funding had been received to this end. It was added that the ACTS also provided support to members of staff and that there was a focus on the upcoming “Alcohol Awareness Week”.
	The date and time of the next meeting of the Council of Governors were announced as Thursday 27 January 2022 at 2.00pm at The Hamworthy Club or via Microsoft Teams.

University Hospitals Dorset
NHS Foundation Trust

COUNCIL OF GOVERNORS PART 1 – COVER SHEET

Meeting Date: 27 January 2022

Agenda item: 4.2

Subject:	University Hospitals Dorset (UHD) NHS Foundation Trust Integrated Performance Report (IPR) December 2021

Prepared by:	Executive Directors, Alex Lister, Sophie Jordan, Judith May, David Mills, Fiona Hoskins, Matthew Hodson, Carla Jones, Irene Mardon, Jo Sims, Andrew Goodwin
Presented by:	Executive Directors for specific service areas

Purpose of paper:	To inform the Board of Directors and Sub Committees members on the performance of the Trust during December 2021 and consider the content of recovery plans
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. The operational planning guidance (outlining the priorities for the year ahead) are detailed below: **Systems are being asked to deliver on the following ten priorities in 22/23:** A. Investing in the workforce and strengthening a compassionate and inclusive culture B. Delivering the NHS COVID-19 vaccination programme C. Tackling the elective backlog D. Improving the responsiveness of urgent and emergency care and community care E. Improving timely access to primary care F. Improving mental health services and services for people with a learning disability and/or autistic people G. Developing approach to population health management, prevent ill-health, and address health inequalities H. Exploiting the potential of digital technologies I. Moving back to and beyond pre-pandemic levels of productivity J. Establishing ICBs and enabling collaborative system working
Key points for Board members:	**Areas of Board Focus** High Bed occupancy levels. Current Ambulance handover delays and the amount of time patients are spending in the emergency department. Continuing challenges with 'No Reason to Reside' (NRTR) and the increase in bed pressure, with the number of Covid is contributing to maintain a high bed occupancy across the 1tandardized. Impact on reduced hospital flow

has the potential to impact on patient safety, experience and increased cancellations. Workforce availability to meet escalating capacity levels, that driving increased agency costs and staff wellbeing. Impact on hospital reputation and increased challenge to elective care recovery as a result of having to more capacity aside for emergency /urgent care response. The impact this may have on the fundamentals of care in particular deconditioning of patients.

Operational Performance

Urgent and Emergency Care – National

The national 10 Point Action Plan for Urgent and Emergency Care has been fully reviewed and workstream action plans under our UEC Quality & Performance Improvement Programme are focusing on the key priorities of the plan. We are also in the process of reviewing internally and with System partners the guidance relating to addressing Ambulance Handover Delays to consider further actions required. Our ongoing escalation beds, enhanced Same Day Emergency Care (SDEC) Services and discharge pathway work will also be key. The 2tandardized has now received additional support through ECIST with 5 initial key areas of focus shared with the teams. The programme forms part of the enhanced support for the emergency departments triggered through the Trust accountability framework.

Emergency Care @ UHD

UHD continues to experience significant challenges with its emergency flow. All ED attendances remain 2.8% (YTD) above those reported in same period in 2019/20.

Daily Ambulance activity is similar to November but lower than the same period in 2019 (c30 per day as an average). Ambulance delays were consistent with November with 164 waiting over 60 minutes (175 November). The Trust have been advised by SWAST that in in with national guidance Ambulance crews will no longer support 'cohorting' patients in corridors from January 11th, and the implications of this are being worked through including staffing cohort areas.

Emergency Departments

The IPR provides the detailed performance against the new national Urgent & Emergency Care standards. Headlines include:

- Ambulance conveyances are YTD 0.4% below those observed same period in 2019/20, and YTD ED attendances are 2.8% above 2019/20.
- ED mean time on both sites declined and remains significantly above the national indicated standard
- There were 34 x 12 hour waits from Decision to Admit (DTA) an increase in month compared to October (+13 breaches)

(colours based on change from last month)

		Dec-21		
Standard	**Aim**	**Poole**	**RBCH**	**Combined**
Operational (Field testing standards)				
Mean time in the dept	200 mins	298	304	301
Time to Initial Assessment	15 mins	6	3	4
12 Hour ED Waits	0	215	203	418
Internal Care Standards				
Time to first clinician seen (*RBCH: to Dr seen*)	60 mins	112	159	137
Mean Clinically Ready To Proceed to Left Dept	60 mins	243	122	177

The work and support from ECIST will be presented to the Trust

Management Group in early January for review of the opportunities with all directorates and to agree the priorities and associated governance. There is a clear message that a high number of patients could be effectively seen in an alternative setting, both within UHD and in Primary care..

The above pressures continue to reflect a regional and national picture and there is ongoing concern across the Dorset and National Systems that this trend will continue.

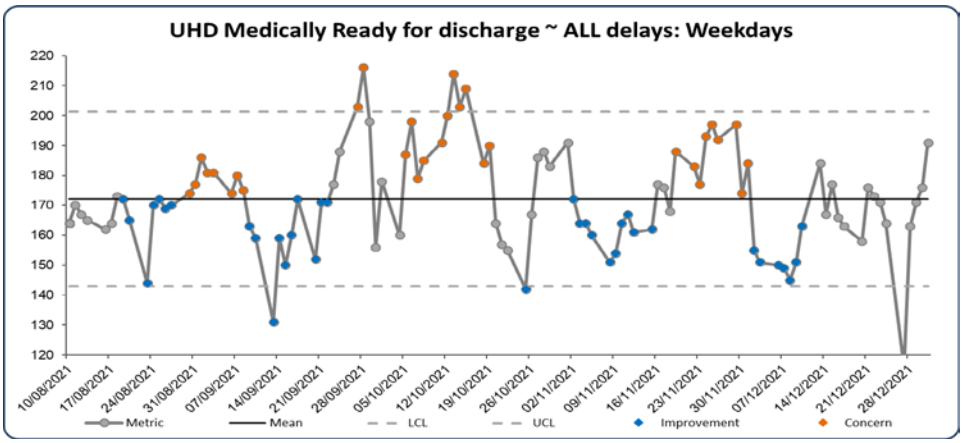
Occupancy, Flow and Discharge

Both sites continued to have all escalation beds open in December alongside the majority of infection control closed beds using robust risk assessment and mitigation plans to ensure we optimally offset risks. However, despite this, occupancy remained high at 91.3%.

The number of patients ready to leave with No Reason to Reside (NRTR) decreased in month (average of 8 patients). Occupied bed days also marginally decreased for patients with a longer length of stay (7/14/21+). The latter continues to exceed the national standards as a proportion of all inpatients.

Externally we continue to work with partners on the Home First programme developing several initiatives to manage the increasing discharge challenges. The introduction of block booked beds, commissioning of the Care Home Selection Service (CHS) and domiciliary rapid response initiatives have positively impacted the position in December.

Further strategies are being adopted to manage the emerging pressures including introduction of Care Hotels and enquiries with specific care homes to support Omicron surge plans into January as a designated Covid settings.



For the period August to date, 'special cause – concern' was witnessed in November with a small measure of improvement in the first week of December with a reduction in delays to an average of 166 per day. Internal delays also improved during this period. As the Covid position continues with significant concerns raised through the Epicell 3tandard it is imperative that the improvement work and decant plans continue in readiness for a predicted surge and the impact this may have on the hospitals and individual patients. Additional extremis surge plans have been developed to provide assurance that the Trust can manage the predicted surge in January, noting the operational pressures of safely staffing extended capacity.

Surge, Escalation and Operational Planning
At the time of writing, we have 75 confirmed Covid inpatients, below the levels experienced in Wave 2 (January/February) but above the 5% national planning requirements. This has resulted in additional covid inpatient capacity being operationally required and has reduced the availability of 'green' (non Covid) elective and non-elective capacity. This has had a negative impact on flow throughout the hospital and directly on ED and Critical Care Units. Further initiatives/capacity has had to be developed to manage the predicted Omicron surge; teams are working across the Dorset system to align plans.

Referral to Treatment (RTT)

92% of all patients should wait no more than 18 weeks for treatment

	Nov 21	**Dec 21**	
Referral to treatment 18 week performance	**64.0%**	**61.6%**	**Target 92%**
104 weeks	248	273	**Target 0 by March 22**
Hold or reduce >52+ weeks compared to Sept 21	3,322	2,968	**-512 v Sept 21**
Stabilise Waiting List size compared to Sept 21	52,383	52,972	**+1,481 v Sept 21**

H2 Requirements

- Eliminate waits of over 104 weeks by March 2022 except where patients choose to wait longer (Patients codes P6 on the national prioritization coding).
- Hold or where possible reduce the number of patients waiting over 52 weeks.
- Stabilise the waiting list to the level seen at end of September 2021.

Factors impacting on the RTT standard
The high number of RTT waits over 52 weeks is mainly due to a reduction in theatre/treatment and outpatient capacity during the pandemic in 2020-21. An improving and reducing monthly trajectory continues in line with the trust's operational plan for 2021/22. A reducing proportion of these are waits over 78 weeks, however the number waits over 104 weeks has increased marginally (+25) in December 21.

The Trust is currently working to a national ambition to eradicate 104 week waits by March 2022. As noted above the requirements for additional Covid inpatient capacity has reduced the availability of 'green' (non Covid) elective capacity in December which has impacted on the 104 week wait recovery plan. Overall patient cancellations in outpatients were also high in December, increasing to 7.1% (an increase of 2.2% on last month).

High level elective care recovery actions include:

- ***Ongoing clinically led waiting list validation*** A digitally enabled validation programme is also live in ENT, OMF, Orthopaedics, General Surgery, Gynaecology, and Cardiology, with Neurology also having commenced in December 2021.
- ***Further expansion and improved utilisation of additional internal or insourcing and outsourcing capacity*** to
- ***A High flow clinical assessment facility at Dorset Health Village***

- ***Continuing to promote use of digital technology***
- ***Increased use of Patient Initiated Follow Ups and Advice and Guidance***
- ***Delivery of capital transformation through initiatives under the Targeted Investment Fund to support elective recovery.***
- ***Two organisational-wide improvement programmes:***
    a. Theatre improvement programme: value and efficiency
    b. Outpatient Enabling Excellence and Transformation programme

DM01 (Diagnostics report)
1% of patients should wait more than 6 weeks for a diagnostic test

November	Total Waiting List	< 6weeks	>6 weeks	Performance
UHD	11220	9,614	1606	**14.3%**

The DM01 standard has achieved 85.7% of all patients being seen within 6 weeks of referral, 14.3% of diagnostic patients seen >6weeks.

High level diagnostic recovery actions include:
- Continuation of additional temporary endoscopy capacity
- Working collaboratively across both sites to standardise and reduce waiting times for cardiology, ultrasound, MRI and CT
- Outsourcing Ultrasound to the Independent Sector
- Insourcing radiological reporting to provide additional capacity
- Additional MRI capacity brought online

Cancer Standards

	Measure	Target	Q4 20/21 - FINAL	Q1 21/22 - FINAL	Q2 21/22 - FINAL	Nov 21 - FINAL
UHD	Cancer Plan 62 Day Standard (Tumour)	85%	77.8%	79.1%	76.9%	71.4%
	62 Day Screening Standard (Tumour)	90%	88.1%	88.1%	81.0%	84.0%
	31 Day First Treatment (Tumour)	96%	96.7%	97.1%	97.4%	96.8%
	Subsequent Treatment - Surgery	94%	90.5%	91.2%	92.2%	95.5%
	Subsequent Treatment - Radiotherapy	94%	99.0%	99.0%	97.8%	100.0%
	Subsequent Treatment - Anti Cancer Drugs	98%	99.7%	98.8%	98.1%	100.0%
	Faster Diagnosis	75%	79.1%	76.5%	75.4%	66.4%
	Over 104 days (treated in month)	N/A	16.5	30	28	15

The Trust continued to receive a significant increase in referral numbers in November (16% increase compared to same period last year) and a 14% increase against the planned trajectory. The tumour sites seeing the highest increases were colorectal (30%), lung (24%), skin (27%), and hematology (39%). The number of patients on a fast track pathway continued to challenge all performance standards.

Performance against the 28-day faster diagnosis standard in November fell to below the 75% threshold, reporting 66.4%. First OPA capacity was the main breach reason (56%). Sites that are most challenged are breast, colorectal, gynae and urology.

The Trust has consistently achieved the 31-day standard between April – November 2021 and is also expected to be achieved in December. The Trust also achieved 2 out of the 3 subsequent treatment KPI's in November with similar performance expected in December. The 62-day performance was below the 85% threshold (71.4%), this is above the current national average of 68.3%.

Factors impacting on standard

Demand	• Referral numbers continue to put additional pressure on several services at all stages of the pathway
Clinical Processing Capacity	• Patient choice continues to impact across all specialties – especially causing delays at diagnostic stage in some pathways • Specific challenges in several pathways – due to capacity to manage the increased demand – especially head and neck and breast. • Delays in histopathology reporting turnaround times, mainly affecting patients on a pathway at Poole Hospital. • Workforce capacity to manage the large 2 week wait volume

High level actions include:

- Pathway analysis supported by Wessex cancer alliance to identify opportunities – to 6tandard capacity and improve flexibility – initially focusing on lung and head and neck. Wessex Cancer Alliance have agreed to fund an intensive 12 week cancer improvement programme which aims to commence in January 2022.
- Commencing work to move towards a Dorset wide cancer PTL as per National guidance, looking to incorporate the use of existing IT (DiiS)
- One stop opportunities at the start of the pathway to improve time to diagnosis- sarcoma/ lump clinic and neck lumps

Health Inequalities

The Trust continues to support work to tackle health inequalities through the Dorset ICS Health Inequalities in Elective Care Programme. The programme is in the intervention design stage for two cohorts of patients waiting elective care i) People waiting times > 18 weeks and from deprived communities ii) People on Orthopaedic waiting lists. Currently a process of re-identification of patients to identify named patients in these cohorts is taking place. Patients in these cohorts will then be contacted to support them to access community services that will enable them to wait well. For example, community groups, exercise and weight loss programmes, support with shopping or transport or stop smoking services/advice.

Quality, Safety, & Patient Experience

Infection Prevention and Control:

- Covid19 outbreak report now finalised and an action plan sent to the CCG.
- Community cases of COVID-19 in December increased, translating to an increase in hospital admissions and increase into Critical care admissions.
- Outbreaks have been reported within Wards on both sites.
- The impact of the new variant, Omicron is being felt but the majority of admissions for this remain (>40%) in the London area hospitals.
- MRSA – 1 HA case reported this year, 2 CA cases reported. This is in line with previous trends. The Post Infection Review for the HA case did not identify actions for the Trust.
- MSSA and E.coli now have additional case definitions that include community cases with previous hospital admission (last 28 days) so comparison to the previous year is not possible by these number. However, we do know that MSSA blood stream infections

	are increasing within UHD and across the South West – within UHD the case rate has increased over the past 1 year from 10/100k bed days to 17/100K bed days. A collaborative project looking at MSSA has commenced within Dorset. Themes identified within the PIR for these cases point towards poorly maintained vascular access devices and poor skin integrity being a common factor in bacteraemia, there may be some benefit in looking at skin decolonisation for high risk patients. It is an aim of the team to look at this within the business plan. Hospital associated E.coli blood stream infections remain steady however the ambition set out by NHS Improvement to reduce these and other gram –ve infection has not proven to be successful. • Case of Clostridioides Difficile have increased for those patients with a hospital onset and community onset healthcare associated infection in conjunction with this, the frequency of relapse and the severity of cases has also increased. This is a common trend across the South West, an ongoing collaborative project across the region is gathering data to help us to understand the reasons behind this increase. However, our rates per 100K admissions is below the England rate (36 vis 45 per 100K). Current themes from Post Infection Review indicate the challenge of ensuring prompt identification, sampling and isolation of patients is a key factor to improve upon. **Clinical Practice Team:** **Moving & Handling** • Inability to meet M&H training demands for UHD remains as 12 on the Risk Register. Level 2 essential core skills training has continued to be delivered during the periods of Trust escalation. • Notified that 7tandar 30 pieces of M&H equipment (hoists/stand aids) on the Poole site have been classed as obsolete by the manufacturer. This means they are no longer supported by replacement parts and have lapsed into being considered as uneconomical for repair. With support from Estates we are drafting a risk register entry supported by an SBAR. Equipment has been checked and is safe for use at present. Moving & handling equipment provision and subsequent testing is regulated under the PUWER and LOLER statutory regulations. **Falls prevention & management** • We continue to see peaks in the number of falls being reported resulting in no or minor patient harm. On investigation staffing and our inconsistent ability to provide enhanced care requirements are contributing factors. **Tissue Viability** • We have successfully recruited into the vacant Band 6 Tissue Viability Nurse post and we look forward to welcoming a colleague from the community in April. • The team continue to work through standardising and refining processes. Cross site working is now an established routine and we can now adopt a more flexible approach supporting the site with the greatest clinical need on a daily basis. The Clinical Practice Team have also been supporting ward teams when staffing has been challenging across both sites.

Patient Experience:

Friends & Family Test

- Across our sites, we received 3,585 FFT responses this month and overall, 91% of patients who responded rated their care as good or very good. This is an improving trend for the third consecutive month.
- The highest number of responses (1182) came from our outpatient services, with the general outpatient departments on both main sites achieving 95% good/very good feedback ratings.

'Very caring, listened and made me feel at ease, the doctor and the lady that accompanied her were both great'
'Thoroughly professional, punctual, kind service, thanks'.
'Thorough, took time and empathy was clearly a factor…..ably assisted by her support staff and it was a team effort…This was a very special interaction'.
'Understanding and listened to everything I had to say. They have been very helpful and given me hope that whatever is going on they will try to help me….Thank you to all the staff working hard at this difficult time'.

PALS and Complaints

Trust records show that 27 complaints were received during December. However, this is only part of the picture. During the last two months, the patient experience team have focused on promoting early resolution of complaints as an integral part of the new UHD complaints model. However, due to gaps in the workforce, some of this data has not been accurately recorded and this may account for the lower numbers. This data will be corrected for next month.

The number of complaints responded to in month has significantly improved over the last four months, with a total of 58 complaint responses sent out this month. This has reduced the backlog of complaints, primarily caused by significant gaps in the PALS and complaints workforce. Plans remain in place to continue to drive the backlog down to more reasonable levels.

Key themes from PALS and complaints

- Long waits in ED
- Lack of communication and inability to get through to wards and departments by phone
- Poor staff attitude

Workforce

YTD Indicators to December 2021:

		21/22 YTD	20/21 YTD	Variance
Turnover		12.0%	12.3%	-0.3%
Vacancy		5.2%		N/A
Sickness Rate		5.0%	4.5%	0.5%
Appraisals	Values Based	34.5%	42.1%	-7.6%
	Medical & Dental	57.3%	54.6%	2.7%
Statutory and Mandatory Training		87.3%	86.7%	0.6%

December indicators:

		Actual this month	Variance on last month
Turnover		12.8%	0.2%
Vacancy		5.0%	0.4%
Sickness Rate		6.6%	0.7%
Covid-absence non-sickness		0.4%	0.0%
Appraisals	Values based	58.4%	0.2%
	Medical & Dental	54.0%	-9.1%
Statutory and Mandatory		86.2%	0.4%

Month	Sickness Covid	Sickness Other	Sickness Total	Other Covid
Oct -21	0.20%	5.56%	**5.76%**	0.60%
Nov – 21	0.20%	5.69%	**5.89%**	0.42%
Dec – 21	0.29%	6.33%	**6.61%**	0.41%

Performance:

UHD turnover has risen slightly to 12.8% actual this month and is tracking at 12.0% year to date.
Vacancy Rate is showing at 5.2%, an increase of 0.4% on last month. This reflects the increase we have seen in the number of staff leaving the trust. Work continues to refine our data analysis and establishment processing.
Overall Sickness Overall Sickness levels have again increased this month noting added pressure felt on the operations across the site and the impact felt from the Omicron variant. Sickness aligned to Covid has seen a rise from 0.20% to 0.29%.
Medical & Dental appraisal levels have fallen by 9% this month, but overall are tracking higher than last year by 2.7%.

Value based appraisal levels are up slightly again this month by 0.2%. but are still tracking low year to date.
Statutory and Mandatory training compliance continues strong despite continuing disruption to training due to operational pressures.
Temporary Staffing: Volume of requests for temporary staffing is high across all staff groups and specialties; fill rates are lower than previous months for Clinical and Health Care support staff

CPO Headlines:

HR Operations

Covid-19 Mandatory Vaccination Regulations
The Operational HR and Occupational Health teams are working closely together to prepare for 1st April 2022, when healthcare staff (whose roles meet the necessary criteria), will need to be fully vaccinated, unless they meet the exemption criteria. Staff with incomplete vaccination records have been contacted and asked to provide evidence of their vaccination status and/or NHS number, which allows us to check their status, and managers asked to hold sensitive and supportive conversations with colleagues, to actively encourage staff to take up the vaccinations. The HR Operational team is also working collaboratively with Infection Control to ensure that the Trust's Covid Staff FAQ's are amended as Government advice changes. Further Government guidance on the handling of staff who choose not to receive full vaccination is expected week commencing 14th January 2022.

The HR Operational team continue to focus on coaching line managers to address lower level employee relations issues through early intervention. Since the introduction of the HR Triage process in December 2021, 11 cases have been referred to HR for formal conduct/performance investigations. These cases have been triaged, which has resulted in 36% of cases being handled outside of the formal investigation process. These have been dealt with swiftly, effectively and in line with Just and Learning Culture Principles.

Occupational Health and Enhanced Wellbeing Service
The Occupational Health team have been heavily immersed in the vaccination programme and in total 3,100 vaccinations were delivered to UHD staff, family, friends and the public from 19th to 24th December 2021.
Increased waits are being experienced with Psychological Support and Counseling referrals and Management and Musculoskeletal referrals due to high demand and staff absence. No delays are being experienced with pre-employment checks due to the service being supported by bank. Vaccinations are still available to staff via the Occupational Health service.

Resourcing
The number of posts being advertised and new joiners across all staff groups, including medical, has been increasing over the year, as detailed in the table below. Applicant numbers are being affected by market conditions, and additional activity at both trust and system level is taking place for international recruitment, Health Care Support Worker (HCSW) initiatives, widening access to NHS roles, digital marketing and national campaigns for hard to fill roles.

Additional work is in progress to support the mandatory vaccination regulations, develop electronic employment contracts, progress Bournemouth University partnership working, together with a review of the trust's recruitment practice for Equality, Diversity & Inclusion actions.

	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	A
General Recruitment - Number of Applications	2105	2048	2166	2315	2657	2838	2222	2029	
General Recruitment - Candidates Offered	234	258	229	256	257	247	299	229	
General Recruitment - Adverts Posted	206	263	282	277	295	257	299	345	
General Recruitment - New Joiners to the Trust	61	83	62	90	125	123	129	60	
General Recruitment - Internal Candidates Started	70	105	91	123	121	143	121	90	

Blended Education & Training (BEAT)
International recruitment and simulation training has moved across to BEAT and a Band 2 – 4 clinical skills review is being undertaken at PHT site, and a Health Care Support Worker (HCSW) retention project has now been completed. This is due to be shared with appropriate forums shortly. Work has commenced with the Integrated Care System on a HCSW vocational scholarship.

Workforce Systems:
1969 changes came through the Workforce Systems team in December. This was 209 more than November. These related to an increase in the amount of Fixed Term Contract changes, position moves and hour changes. Terminations were down slightly from 142 in November to 119 in December.

Temporary Workforce:
Workforce supply gaps are at an all-time high and reflect the current national trends across all sectors and specialties; fill rates are lower than previous months for clinical (50%) and Heath Care support staff (34%). We are seeing a significant increase in the number of Medical bank shifts posted with a fill rate of 57% as well as increased demand for administrative and transformation projects. External agencies have been supporting with sourcing of candidates. Staff movements across the system have been necessary and are being monitored regularly to respond to local system pressures.

Finance

The Trust set a breakeven budget for the second half of the year (the 'H2' period to 31 March) supported by the continuation of national top-up funding and funding to cover specific COVID costs. The national financial framework during this period includes an Elective Recovery Fund (ERF) to support the necessary increases in capacity to see and treat those patients still awaiting planned care. This is accounted for on a monthly basis, reported as a variance against both expenditure and income budgets. The full year deficit budget of £528,000 reflected the shortfall in ERF income received in the H1 planning period however this has now been fully funded through ERF+ resulting in a forecast breakeven position for the financial year ending 31 March 2022.

At the end of December, the Trust is reporting a £45,000 variance ahead of plan due to the phasing of ERF+ funding. Additional expenditure of £11.178 million has been incurred in the Trusts elective recovery programme and, pending national validation, income has been matched in full. Within this aggregate position, the Surgical Care Group report an adverse variance of £1.436 million, mainly due to CIP performance, additional medical staffing costs and partially offset by reduced activity particularly within Orthopaedics; the Medical Care Group report an adverse variance of £157,000, mainly due to an over achievement in cardiac private patient income together with the cessation of Bowel Scope and Bowel Cancer screening services; and the Specialties Care Group report a favourable variance of £1.093 million

	principally due to vacancies within Pathology and Pharmacy. Cost savings of £2.869 million have been achieved to date against a target of £5.870 million, representing an under achievement of £3.001 million. Full year savings of £4.241 million have currently been identified of which 80% is non-recurrent. The refreshed H2 budget includes a significant increase in the savings requirement to £10.124 million for the full year, which if not achieved recurrently will result in further and considerable pressure on future years budgets. Currently the Trust is forecasting to deliver a shortfall of £5.884 million and a recurrent shortfall of £9.267 million. The Trust has set a very challenging capital programme for the year, with many priority schemes deferred due to the restrictive capital allocation for the Dorset Integrated Care System. This presents a considerable risk for the Trust and requires very careful ongoing management. As at 31 December capital spend is £32.297 million, being £10.814 million behind plan. This largely relates to underspends in the Maternity Children Emergency Centre and the Theatres Programme (STP Wave 1). The Trust is currently holding a consolidated cash balance of £75.376 million, which is fully committed in support of the medium-term strategic reconfiguration programme.
Options and decisions required:	No decisions required
Recommendation:	**Members are asked to note:** • The areas of Board focus for discussion
Next steps:	Work will continue in addressing the actions raised as part of the escalation reports and through Trust Management Group.

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	**To be a great place to work**, by creating a positive and open culture, and supporting and developing staff across the Trust, so that they are able to 12tandar their potential and give of their best. **To ensure that all resources are used efficiently to establish financially and environmentally sustainable services** and deliver key operational standards and targets. **To continually improve the quality of care** so that services are safe, compassionate timely, and responsive, achieving consistently good outcomes and an excellent patient experience **To be a well governed and well managed 12tandardized** that works effectively in partnership with others, is strongly connected to the local population and is valued by local people. **To transform and improve our services in line with the Dorset ICS Long Term Plan**, by separating emergency and planned care, and integrating our services with those in the community.
BAF/Corporate Risk Register: (if applicable)	**Risks scoring ≥12:** **UHD 1342** – The inability to provide the appropriate level of services for patients during the COVID-19 outbreak – increased score to 16 **UHD 1131** – inability to effectively place patients in the right bed at the right time (Flow) **UHD 1387** – Demand for acute inpatient beds will exceed bed capacity (Demand & Capacity) **UHD 1460** – UEC national metrics **UHD 1429** – Ambulance handovers

	UHD 1053 –Long Length of Stay / Discharge to Assess /NRTR **UHD 1430** – ED workforce **UHD 1074** – Risks associated with breaches of 18 week Referral to Treatment and 52 week wait standards **UHD 1292** – Outpatient Follow-up appointment backlog. Insufficient capacity to book within due dates **UHD 1386** – Cancer waits increasing due to increased referrals. **UHD 1276** – Delayed patient care due to delays in surgery for #NOF patients **UHD1447** – Adverse Outcomes for Orthodontic Patients due to COVID restrictions and lack of additional facilities and manpower **UHD1024** – Risks associated with continuity, capacity and staffing during Pandemic Infectious Disease and seasonal flu **UHD1574 –** Lack of Breast screening staff impacting on waiting times **UHD1437** – Loss of IT Service **UHD1592** – Electronic Prescribing and Medicines Administration Project Delay **UHD1599** – Safety checklist process for all interventional procedures (Never Events) **UHD1260** – Ensuring Estates are compliant with regulatory standards (SFG20/HTM00) across fire, water, electricity, gases and air handling **UHD1607** – Failure to maintain Hospital 13tandardized mortality **UHD1640** – Fetal Monitoring equipment **UHD1577** – Unsafe Storage (Fire and Infection Control Compliance) – PH **UHD1591** – Information Asset Management **UHD1202** – Medical Staffing Women's Health **UHD1378** – Lack of Electronic results acknowledgement system **UHD1355** – Lack of integration between the Electronic Referral System (eRS) & Electronic Patient Record (ePR)
CQC Reference:	All 5 areas of the CQC framework

Committees/Meetings at which the paper has been submitted:	**Date**
Finance & Performance Committee (Operational / Finance Performance)	Jan 2022
Trust Management Group	Jan 2022
Board of Directors	Jan 2022

University Hospitals Dorset
NHS Foundation Trust

INTEGRATED PERFORMANCE REPORT




December 2021

Created January 2022

Performance at a Glance - Key Performance Indicator Matrix

			standard	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	ytd	ytd var	trend
SAFE																							
Quality	Presure Ulcers (Cat 3 & 4)			12	6	10	8	12	12	13	16	11	15	12	15	8	10	6	7	7	91	-17	
	Inpatient Falls (Moderate +)			5	2	3	5	4	4	5	2	4	6	2	7	1	3	6	1	1	31	-3	
	Medication Incidents (Moderate +)			1	2	5	4	9	2	4	4	1	0	1	1	1	6	2	8	2	22	-2	
	Patient Safety Incidents (NRLS only)			1379	1341	1654	1581	1537	1492	1239	1006	1029	752	959	1022	1012	871	1064	888	871	8468	-3672	
	Hospital Acquired Infections	MRSA		0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	
		MSSA		1	2	3	9	8	4	6	4	3	2	4	5	5	3	3	4	0	29	-8	
		C Diff		7	6	1	3	1	2	9	3	4	8	8	8	5	8	6	6	0	53	14	
		E. coli		3	12	5	8	2	11	3	3	4	4	9	8	10	7	8	7	0	57	9	
EFFECTIVE																							
Mortality	SMR Latest Jan 21	(source Dr Foster)		104.042	97.2055	111.664	113.307	96.5075	171.543	119.6	87.4												
	Patient Deaths	YTD		207	185	265	244	249	469	299	217	165	185	170	232	223	202	222	238	247	1884	6	
	Death Reviews	Number		105	85	124	111	127	207	152	103	78	71	57	78	61	47	13	18	1	424		
	Deaths within 36hrs of Admission			30	35	40	36	49	47	39	37	30	29	33	48	38	19	33	44	36	310	-16	
	Deaths within readmission spell			15	13	15	22	25	36	18	16	12	14	10	26	22	17	13	12	12	138	-7	
CARING																							
	Complaints Received			57	48	51	56	62	53	53	51	60	68	62	52	57	51	39	20	27	436	23	
	Complaint Response in month			57	48	51	48	49	43	59	59	47	26	64	53	55	28	32	39	58	402	14	
	Section 42's			0	2	0	0	0	0	1	0	0	0	5	0	0	7	0	0	2	14	-12	
	Friends & Family Test			90%	91%	91%	91%	91%	91%	91%	93%	90%	89%	89%	86%	86%	87%	87%	89%	91%	88%	-3%	
WELL LED																							
Safety	Risks 12 and above on Register			36	38	39	31	32	27	31	34	35	40	43	44	47	44	49	44	44	49	15	
	Red Flags Raised*			31	47	51	43	73	129	51	28	41	45	56	80	117	105	160	209	35	848	550	
	*different criteria across RBCH & PHT																						
	Overall CHPPD			9.5	8.8	9.0	9.4	9.4	8.3	9.4	9.3	5.7	5.3	5.2	5.0	5.2	5.0	4.7	4.8	3.3	4.8	-1.6	
	Patient Safety Alerts Outstanding			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
People	Turnover			10.40%	10.70%	10.40%	10.20%	10.00%	9.80%	9.40%	9.20%	9.00%	9.20%	11.50%	12.20%	12.40%	12.10%	12.20%	12.60%	12.81%	12.0%	-0.3%	
	Vacancy Rate *(only up to Oct 2020)*			1.0%	0.7%	1.3%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
	Sickness Rate			4.2%	4.2%	4.2%	4.4%	4.5%	7.1%	4.9%	7.1%	4.7%	4.7%	4.8%	4.9%	5.0%	5.1%	5.2%	5.2%	5.3%	5.0%	0.5%	
	Appraisals	Values Based		41.6%	53.5%	57.3%	61.5%	63.9%	63.7%	63.1%	62.9%	4.6%	9.0%	16.7%	25.7%	35.7%	48.7%	54.5%	58.2%	58.4%	34.5%	-7.6%	
		Medical & Dental		52.0%	45.9%	37.5%	29.9%	50.3%	61.6%	62.7%	56.8%	55.4%	52.5%	50.3%	61.0%	62.8%	54.4%	61.1%	63.1%	54.1%	57.3%	2.7%	
	Statutory and Mandatory Training			86.52%	86.96%	88.37%	85.90%	85.80%	87.20%	86.50%	86.40%	87.20%	87.90%	88.20%	88.10%	88.60%	87.70%	86.50%	85.80%	86.18%	87.3%	0.6%	

Performance at a Glance - Key Performance Indicator Matrix

			standard	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	ytd	ytd var	trend
RESPONSIVE																							
Quality	Patient with 3+ Ward Moves (Non-Clinically Justified Only)			8	20	25	17	29	36	10	17	14	8	9	11	5	3	7	9	5	71	-87	
	Patient Moves Out of Hours (Non-Clinically Justified Only)			58	64	84	106	103	187	75	70	67	72	98	122	65	51	82	45	53	655	-65	
	ENA Risk Assessment	Falls		62%	61%	61%	61%	58%	51%	59%	59%	65%	62%	62%	57%	55%	56%	55%	53%	58%	57%	-3%	
	infection eNA assessment went live at RBCH during April 20	Infection*		74%	73%	70%	64%	73%	54%	62%	64%	70%	66%	66%	61%	58%	59%	58%	56%	58%	62%	-12%	
		MUST		64%	64%	63%	65%	61%	57%	63%	63%	69%	66%	65%	61%	59%	60%	59%	57%	58%	62%	-2%	
		Waterlow		61%	61%	61%	61%	60%	52%	59%	60%	65%	62%	62%	57%	55%	56%	55%	53%	53%	58%	-2%	
RTT	18 week performance %		92%	49.0%	56.2%	60.4%	63.4%	64.8%	63.0%	59.3%	58.2%	59.6%	63.2%	65.7%	65.2%	65.4%	64.1%	64.0%	64.0%	61.6%			
	Waiting list size		44,508	41,172	43,123	44,320	44,349	44,117	44,615	45,524	47,133	47,984	48,773	49,099	48,687	49,906	51,491	52,787	52,383	52,972			
	Waiting List size variance compared to Mar 2019 %, and Jan 2020 for 21/22		0%	-3%	1.3%	4.1%	4.1%	3.6%	4.8%	6.9%	10.7%	7.8%	9.6%	10.3%	9.4%	12.1%	15.7%	18.6%	1.7%	2.9%			
	No. patients waiting 26+ weeks			16,950	17,001	14,220	12,131	10,738	10,904	11,672	12,408	12,692	12,682	11,972	11,085	10,929	11,508	11,600	11,746	12,904			
	No. patients waiting 40+ weeks			6,395	6,921	7,197	7,799	8,031	7,258	7,006	6,727	6,474	6,151	5,962	5,872	5,971	5,922	5,559	5,413	5,374			
	No. patients waiting 52+ weeks		0	2,050	2,636	2,998	3,242	3,439	4,273	5,325	5,595	4,816	4,156	3,737	3,402	3,408	3,480	3,442	3,322	2,968			
	No. patients waiting 78+ weeks			0	70	92	149	291	542	726	979	1,176	1,268	1,180	1,318	1,635	1,740	1,416	1,329	952			
	No. patients waiting 104+ weeks			0	0	0	0	0	0	0	0	9	24	66	101	133	178	247	248	273			
	Average Wait weeks		8.5	20.8	20.6	19.5	18.3	18.6	18.3	18.3	20.1	19.5	19.5	20.1	20.1	20.1	20.1	17.8	17.8	19.5			
Theatre	Theatre utilisation - main		98%	67%	71%	71%	71%	73%	69%	67%	73%	73%	74%	75%	72%	73%	74%	75%	72%	70%			
	Theatre utilisation - DC		91%	70%	73%	59%	61%	63%	60%	62%	67%	59%	60%	61%	60%	64%	58%	65%	63%	61%			
	NOFs (Within 36hrs of admission - NHFD)		85%	40%	10%	26%	29%	25%	42%	67%	63%	20%	29%	23%	30%	30%	39%	20%	42%	4%			
Outpatients	**Referral Rates**																						
	GP Referral Rate	*(20/21 baseline)*	-0.5%										200.1%	127.3%	86.0%	66.7%	50.5%	42.0%	38.3%	34.3%			
	year on year +/-	*(19/20 baseline)*	-0.5%	-45.8%	-37.8%	-34.4%	-32.0%	-28.2%	-29.5%	-29.0%	-22.4%	-12.6%	-10.2%	-8.6%	-10.8%	-10.8%	-10.9%	-11.3%	-10.7%	-10.2%			
	Total Referrals Rate	*(20/21 baseline)*	-0.5%										169.1%	120.5%	87.2%	70.3%	53.5%	42.6%	37.1%	31.2%			
	year on year +/-	*(19/20 baseline)*	-0.5%	-45.3%	-37.1%	-32.2%	-28.7%	-24.5%	-22.8%	-22.2%	-17.2%	-8.9%	-8.0%	-3.9%	-6.2%	-6.0%	-5.6%	-5.8%	-5.0%	-4.6%			
	Outpatient metrics																						
	Overdue Follow up Appts			13,652	13,941	13,722	13,099	13,941	14,883	15,775	15,669	15,404	15,266	15,330	15,389	16,272	16,487	16,174	15,846	16,393			
	Follow-Up Ratio		1.91	1.46	1.44	1.44	1.48	1.44	1.63	1.54	1.44	1.40	1.36	1.37	1.40	1.47	1.48	1.43	1.44	1.49			
	% DNA Rate		5%	5.7%	6.6%	7.0%	6.6%	6.0%	5.5%	5.0%	5.0%	5.7%	5.8%	6.3%	6.6%	6.7%	6.9%	6.9%	6.8%	7.1%			
	Patient cancellation rate			9.2%	9.9%	10.3%	9.5%	10.4%	12.1%	8.8%	5.4%	8.3%	9.1%	10.5%	12.2%	11.7%	13.0%	12.4%	11.8%	14.0%			
	30% reduction in face to face attendances																						
	% telemedicine attendances		25%	52.9%	44.5%	42.0%	43.1%	39.4%	52.1%	52.8%	42.5%	37.3%	34.1%	31.3%	28.7%	28.5%	26.1%	26.6%	26.7%	27.8%			
DM 01	**Diagnostic Performance (DM01)**																						
	% of <6 week performance		1%	19.5%	16.9%	9.8%	1.4%	2.7%	6.4%	5.9%	2.9%	3.7%	2.6%	1.8%	3.3%	6.1%	5.5%	5.5%	7.8%	14.3%			
Cancer	2 week wait (RBH not being monitored)			99.3%	95.4%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-			
	62 day standard		85%	76.6%	76.1%	77.9%	80.3%	77.5%	78.5%	71.6%	83.2%	76.1%	76.9%	79.8%	78.8%	77.3%	74.6%	71.3%	71.4%	66.8%	*(December predicted)*		
	28 day faster diagnosis standard		75%	80.3%	72.9%	76.6%	86.7%	78.6%	72.5%	80.2%	83.6%	75.9%	77.6%	75.3%	78.2%	75.2%	72.8%	68.0%	66.4%	62.9%	*(December predicted)*		
Emergency Dept	Arrival time to initial assessment		15	5.7	5.7	5.1	5.0	6.0	6.0	5.0	6.0	9.0	9.0	13.0	14.0	10.0	7.0	5.0	4.0	4.0			
	Clinician seen <60 mins %			31.0%	36.2%	39.9%	43.7%	41.8%	50.5%	52.9%	45.2%	30.6%	27.0%	18.3%	16.1%	17.1%	19.8%	21.4%	24.5%	30.6%			
	PHT Mean time in ED		200	227	206	210	230	235	266	235	205	217	229	239	250	274	266	280	277	298			
	RBCH Mean Time in ED		200	211	217	226	219	259	258	222	206	223	228	250	280	297	278	294	297	304			
	Patients >12hrs from DTA to admission		0	0	0	0	7	8	3	1	0	0	0	0	0	0	5	16	21	34			
	Patients >6hrs in dept			1833	1454	1540	1488	2126	2052	698	1072	1674	2110	2735	3656	4349	3679	4258	3980	4071			
	ED attendance Growth (YTD)	*vs 20/21*										94.3%	17.0%	56.1%	45.8%	37.4%	33.2%	31.5%	31.5%	31.5%			
		vs 19/20		-26.0%	-23.2%	-15.7%	-21.2%	-21.8%	-22.6%	-31.4%	-21.1%	-3.0%	-15.0%	9.0%	0.9%	1.7%	2.3%	2.8%	2.5%	2.8%			
SWAST SCAST	Ambulance handover growth (YTD)	*vs 20/21*										43.0%	35.7%	22.9%	14.6%	9.8%	6.1%	2.7%	1.0%	2.7%			
		vs 19/20				-6.7%	-7.5%	-7.0%	-4.7%	-11.9%	-4.4%	7.8%	8.8%	8.9%	7.3%	1.7%	2.4%	-0.4%	-2.6%	-0.4%			
	Ambulance handover 30-60mins breaches			313	228	249	213	261	296	126	190	227	264	341	411	330	290	213	262	281			
	Ambulance handover >60mins breaches			56	52	48	57	103	203	12	20	42	67	117	168	238	203	127	175	164			
Patient Flow	Emergency admissions growth (YTD)	*vs 20/21*										33.2%	17.0%	2.2%	26.7%	21.1%	17.0%	14.4%	13.1%	14.4%			
		vs 19/20		-11.9%	-10.5%	-12.1%	-15.4%	-16.4%	-13.1%	-19.3%	-13.4%	-16.2%	-15.0%	-15.1%	-1.4%	-2.2%	-2.9%	-4.1%	-5.5%	-4.1%			
	Bed Occupancy		85%		85.9%	86.0%	85.4%	85.2%	87.4%	84.6%	82.3%	85.1%	90.5%	90.3%	89.7%	92.5%	90.3%	92.4%	92.4%	91.3%			
	Stranded patients:																						
	Length of stay 7 days				380	394	385	311	443	311	347	338	374	390	407	483	467	475	514	500			
	Length of stay 14 days				197	214	219	155	242	155	184	178	195	216	233	296	294	295	328	318			
	Length of stay 21 days		108		108	126	132	86	144	86	105	103	115	132	148	198	198	202	224	224			
	Non-elective admissions				6089	6279	5673	6034	5231	6034	6130	6355	6463	6366	6486	6119	5972	6291	5852	5621			
	> 1 day non-elective admissions				3796	3932	3554	3686	3521	3686	3737	3873	4025	3885	4108	3950	3756	4009	3727	3575			
	Same Day Emergency Care (SDEC)				2291	2346	2118	2344	1710	2344	2387	2481	2437	2478	2374	2166	2211	2275	2123	2044			
	Conversion rate (admitted from ED)		30%		34.40%	36.10%	38.30%	36.90%	42.30%	36.90%	37.00%	33.90%	32.50%	30.40%	29.90%	29.00%	28.30%	30.10%	29.90%	32.70%			

Quality - SAFE

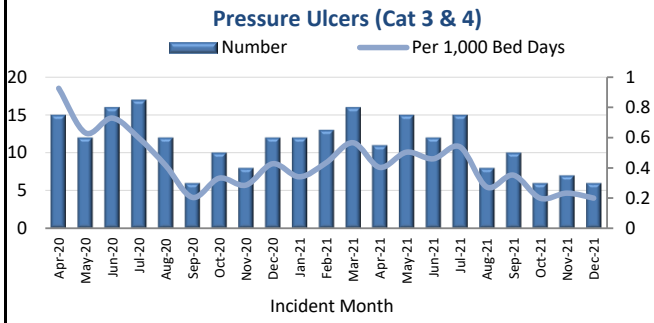
Commentary on high level board position

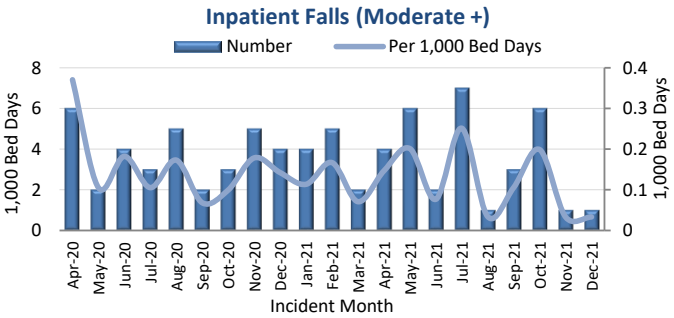
- Six cat 3's reported this month. Two incidents are mixed aetiology, moisture & pressure. Three incidents relate to pre-exisitng damage deteriorating during admission and one category 3 developed during admission.
- One fall moderate harm event this month, patient suffered a # neck of femur following an unwitnessed fall.
- Three (3) new Serious Incidents reported in month (December 21). Full report on learning from completed scoping meeting and investigations included in CMO report to Quality Committee and Board.
- One (1) new Never events reported in month. YTD figure still remains below 20/21 figure.
- Number of patient safety incidents reported to NRLS appears to remain below 20/21. The Risk team are currently reviewing NRLS coding and upload records for 19/20 and 20/21 in order to validate.

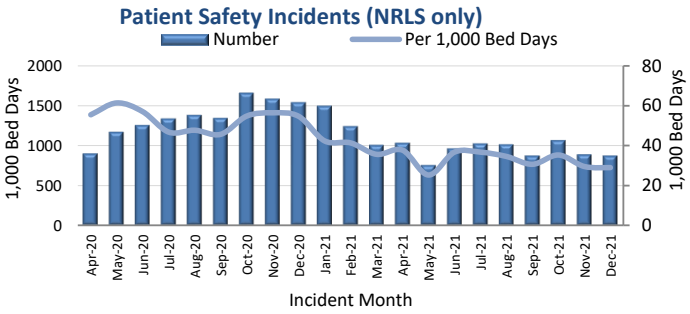
High level Board Performance Indicators

		21/22 YTD	20/21 YTD	Variance
Presure Ulcers (Cat 3 & 4)	Number	90	108	-18
	Per 1,000 Bed Days	0.35	0.47	-0.12
Inpatient Falls (Moderate +)	Number	31	34	-3
	Per 1,000 Bed Days	0.12	0.15	-0.03
Medication Incidents (Moderate +)	Number	22	24	-2
	Per 1,000 Bed Days	0.08	0.10	-0.02
Patient Safety Incidents (NRLS only)	Number	8,468	12,140	-3672
	Per 1,000 Bed Days	32.68	52.74	-20.06
Hospital Associated Infections	MRSA	1	0	1
These are difficult to compare to 20/21	MSSA	33	37	-4
in terms of pure numbers.	C Diff	57	39	18
See Cover Sheet for more info.	E. coli	66	48	18

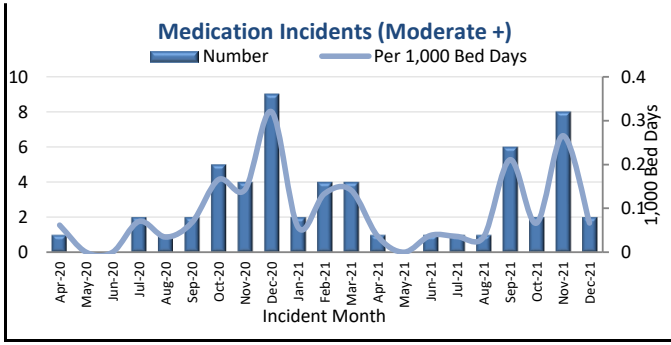
High Level Trust Performance

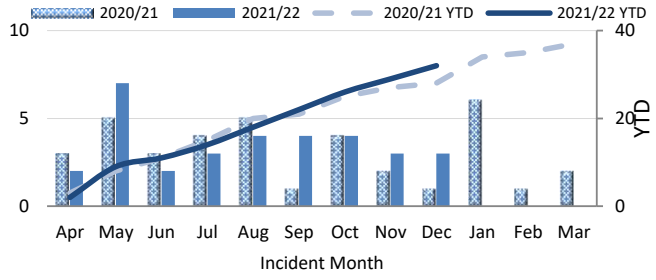


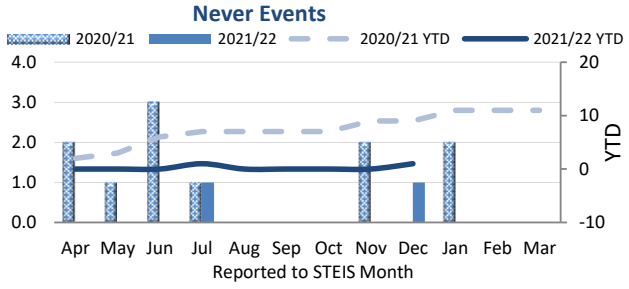




0 (Nov 21) MRSA 0 (Dec 21) | 4 (Nov 21) MSSA 4 (Dec 21) | 6 (Nov 21) C Diff 4 (Dec 21) | 7 (Nov 21) E. coli 9 (Dec 21)







Quality - RESPONSIVE

Commentary on high level board position

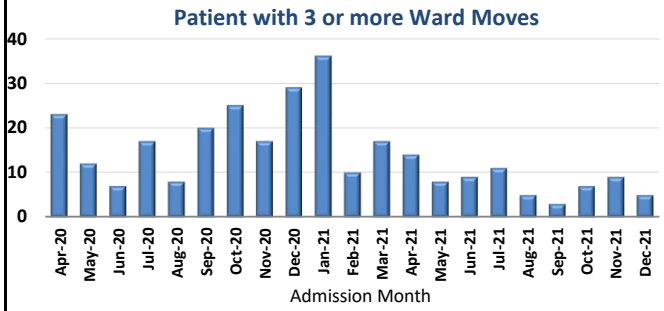
- eNA compliance of the initial assessment completion within 6hrs of admission remains a challenge for admitting areas with complaince remaining static. Membership has been decided for an eNA task & finsh group, with the aim of reviewing the risk assessments and compliance requirements.

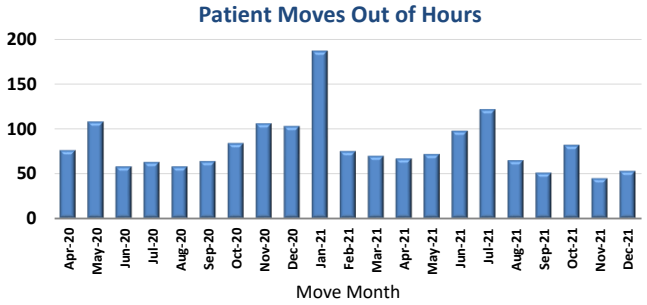
- The trust continues to strive to keep out-of-hours patient moves to a minimum. With Covid-19 cases rising there has been a need to move patients more than we would like in order to maintain good infection prevention and control practice.

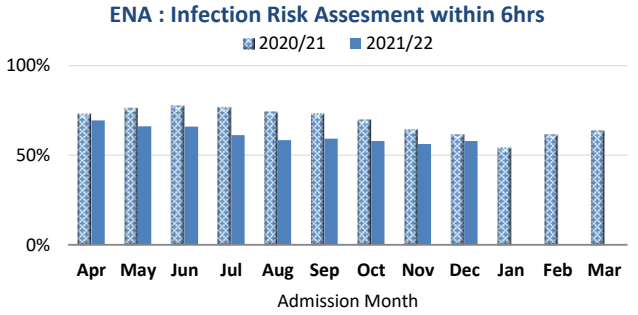
High level Board Performance Indicators

	21/22 YTD	20/21 YTD	Variance
Patient with 3+ Ward Moves (Non-Clinically Justified Only)	71	158	-87
Patient Moves Out of Hours (Non-Clinically Justified Only)	655	720	-65
Mixed Sex Acc. Breaches Suspended Apr20 - Sep21	8	N/A	N/A
ENA Risk Assessment			
Falls	57.4%	60.5%	-3.1%
Infection	61.5%	73.4%	-11.9%
MUST	61.7%	63.8%	-2.1%
Waterlow	57.8%	60.2%	-2.4%

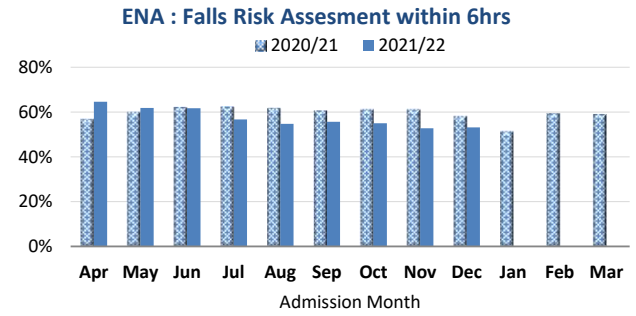
High Level Trust Performance

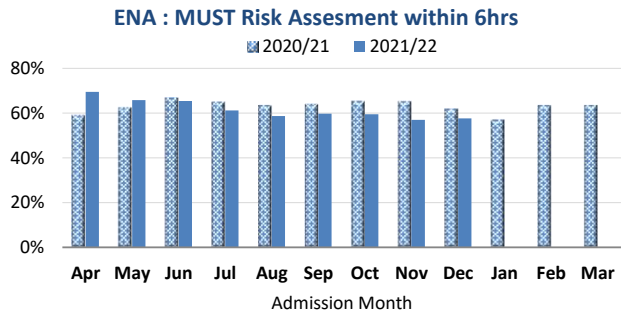


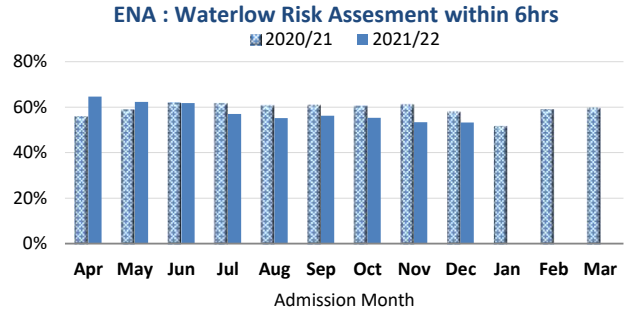




52.8% (Nov 21) Falls 53.2% (Dec 21) | 56.2% (Nov 21) Infection 58.0% (Dec 21) | 56.9% (Nov 21) MUST 57.6% (Dec 21) | 53.3% (Nov 21) Waterlow 53.2% (Dec 21)







Quality - EFFECTIVE AND MORTALITY

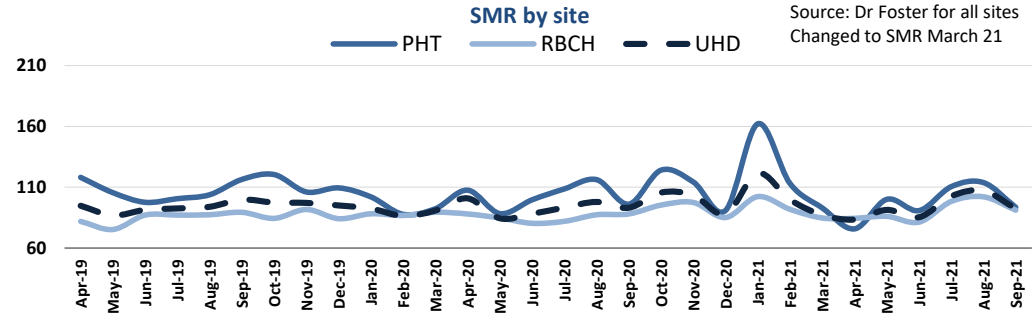
Commentary on high level board position

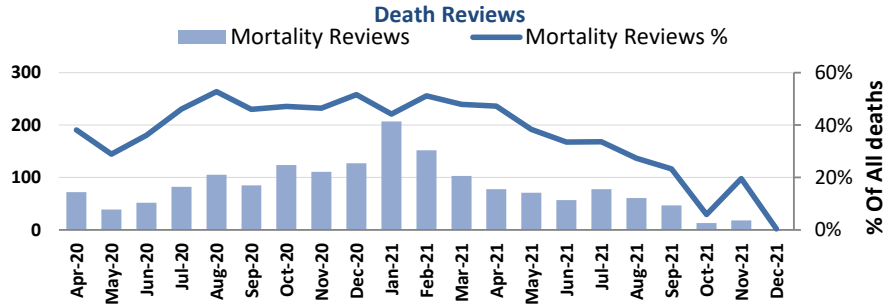
- Please see separate CMO paper regarding Mortality
- An audit of Mortality governance processes started in November 21. The audit will focus on the effective implementation of M&M meetings across the Care groups and the dissemination of learning from completed mortality reviews.
- A project to roll out a new learning from deaths process across UHD has restarted in November. The aim of the project is to implement a single IT system across UHD for the verification of death, mortuary admisssion process, Medical examiner scrutiny and completion of consultant led mortality case note reviews for all inpatient deaths.

High level Board Performance Indicators

		21/22	20/21	Variance
SMR (Source: Dr Foster for all sites)	Latest (Sep-21 - UHD)	92.4	93.2	
Patient Deaths	YTD	1637	1629	8
Death Reviews	Number	423	670	N/A
Note: 3 month review turnaround target	Percentage	28%	44%	
Deaths within 36hrs of Admission		274	277	-3
Deaths within readmission spell		126	120	6
Patient readmitted within 5 days				

High Level Trust Performance

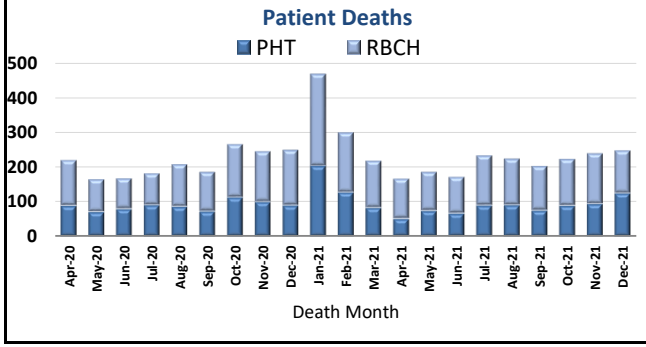


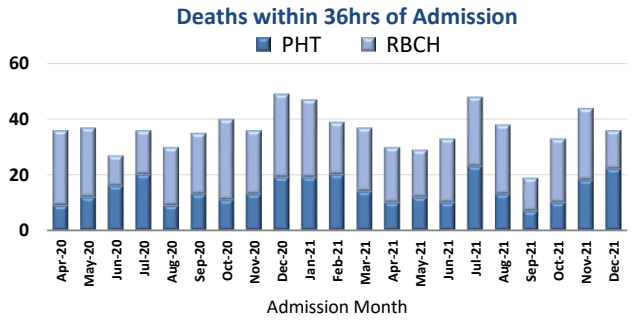


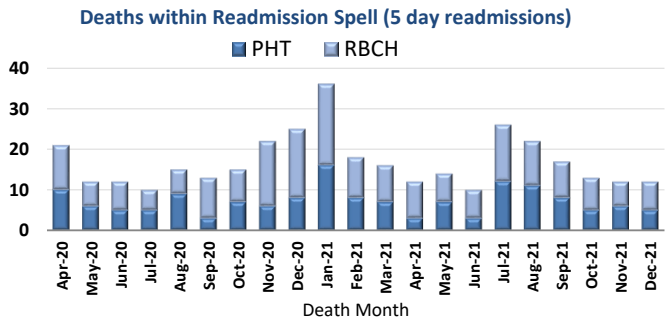
107.1 (Aug 21) | SMR | 92.4 (Sept 21)

238 (Nov 21) | Patient Deaths | 248 (Dec 21)

27.4% (Aug 21) | Deaths Reviewed | 23.3% (Sep 21)







Quality - CARING

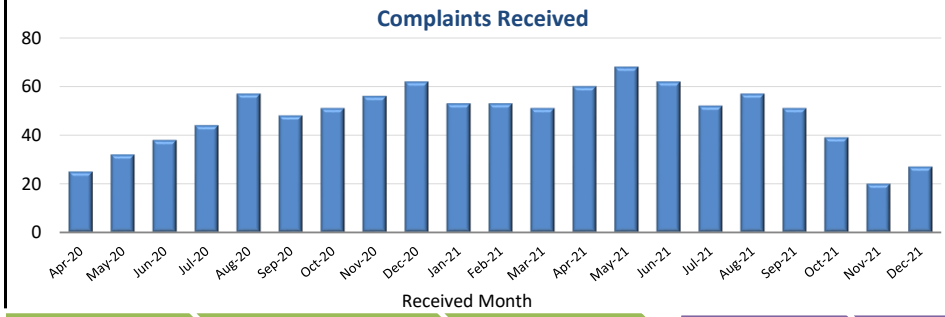
Commentary on high level board position

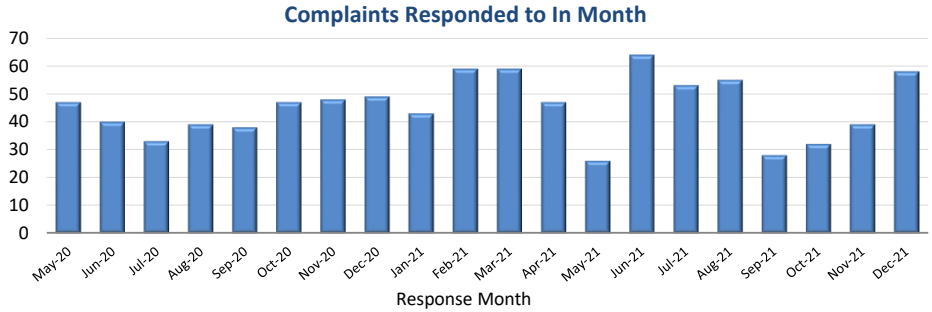
- The Trust continues to achieve good response rates for FFT and the % of patients who report that care is good/very good has increased for the third consecutive month.
- Trust records show that 27 complaints were received during December. However, this is only part of the picture. During the last two months, the patient experience team have focused on promoting early resolution of complaints as an integral part of the new UHD complaints model. However, due to gaps in the workforce, some of this data has not been accurately recorded and this may account for the lower numbers. This data will be corrected for next month.
- The number of complaints responded to in month has significantly improved over the last four months and the backlog of open complaints has reduced. Work will continue to drive the backlog down to more reasonable levels.
- **Key themes from PALS & complaints:** long waits in ED; inability to get through to departments/wards and poor communicationl;staff attitude.

High level Board Performance Indicators

	21/22 YTD	20/21 YTD	Variance
Complaints Received	436	413	23
Complaint Response Compliance	TBC		
Complaint Response in month	402	388	14
Section 42's	25	26	-1
Reported quarterly			
Friends & Family Test	88%	91%	-3%
New guidelines from June 2020			

High Level Trust Performance

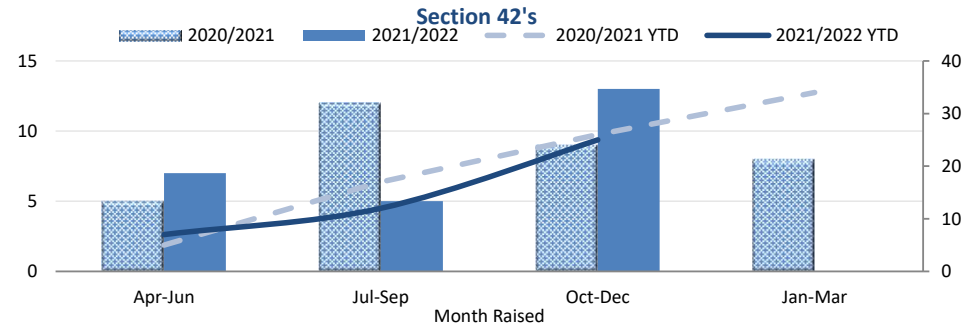


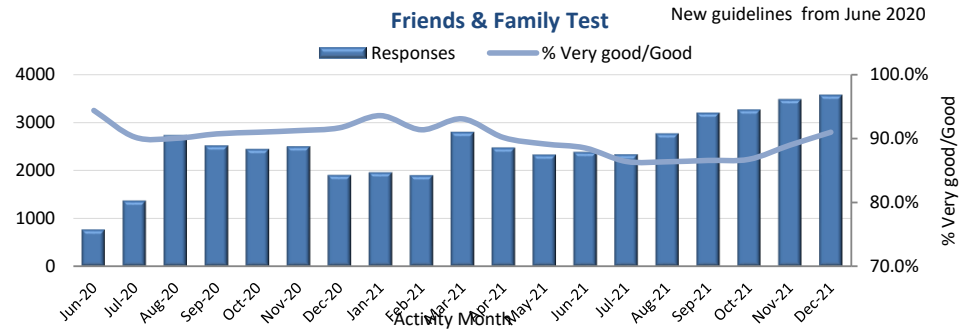


20 (Nov 21) | Complaints Received | 27 (Dec 21)

39 (Nov 21) | Complaint Responses | 58 (Dec 21)

89.0% (Nov 21) | FFT % V.Good/Good | 91.0% (Dec 21)





Quality - WELL LED

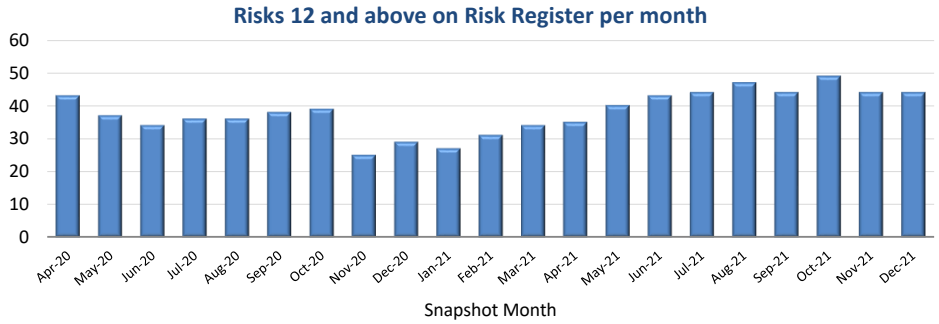
Commentary on high level board position

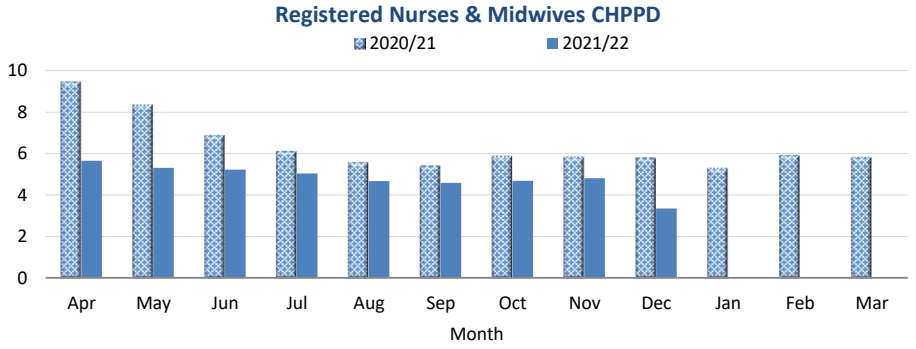
- Risk register update (as at 10/1/2022) provided in TMB, Audit Committee and Board report
- Heat map risk reports provided to Finance and Performance Committee, Workforce Committee and Operations and Performance Group .
- Specific Heat map risk reports provided to Health and Safety Group and Infection Prevention and Finance and Performance Committee,
- In the context of Covid-19 and the national nurse vacancy picture, safe staffing continues to be a challenge for the Trust. Robust process's for monitoring staffing with senior oversight are in place with the majority of red flags mitigated. CHPPD has dropped in 21/22 due to the national challenges. The national median for Registered nurses and Midwives is 4.7 which placing the Trust on par with peer organisations. It is important to note the significant difference between 2020 and 2021 is linked to historical pre merger data process'.

High level Board Performance Indicators

	21/22 YTD	20/21 YTD	Variance
Risks 12 and above on Register	44	29	15
Red Flags Raised* *criteria now aligned across UHD	1009	298	711
Registered Nurses & Midwives CHPPD	4.8	6.4	-1.6
Patient Safety Alerts Outstanding	0	0	0

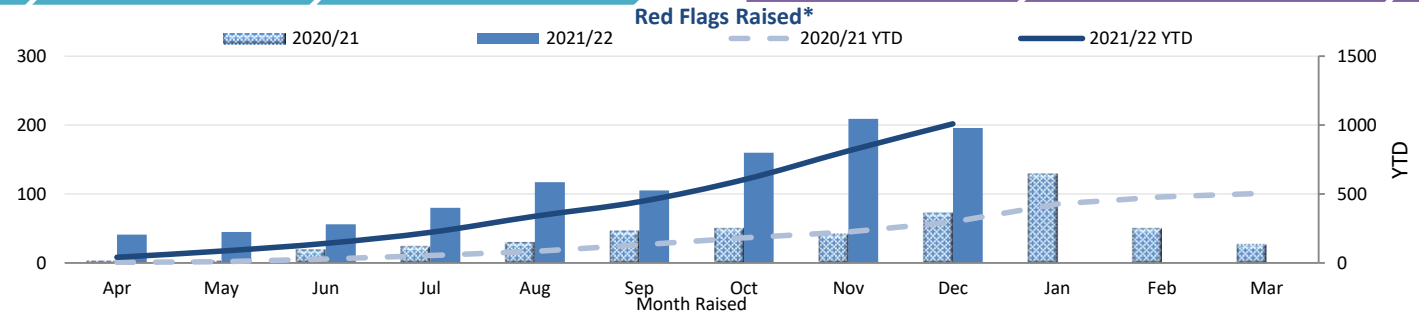
- **High Level Trust Performance**





44 (Nov 21) > Risks 12+ > 44 (Dec 21)

4.81 (Nov 21) > RN & RM CHPPD > 3.34 (Dec 21)



Workforce

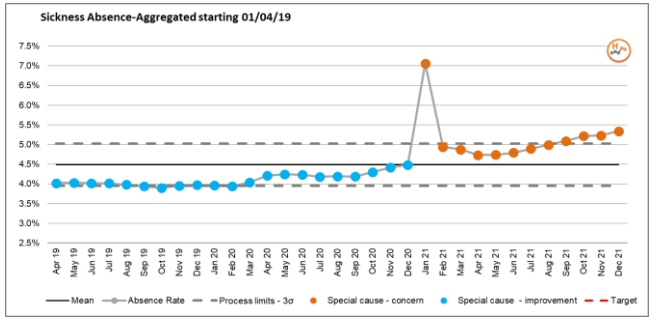
Commentary on high level board position

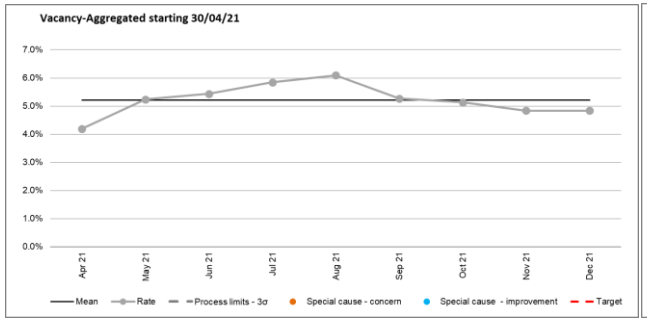
UHD turnover has risen slightly to 12.8% actual this month and is tracking at 12.0% year to date.
Vacancy Rate is showing at 5.2%, an increase of 0.4% on last month. This reflects the increase we have seen in the number of staff leaving the trust. Work continues to refine our data analysis and establishment processing.
Overall Sickness Overall Sickness levels have again increased this month noting added pressure felt on the operations across the site and the impact felt from the Omicron variant. Sickness aligned to Covid has seen a rise from 0.20% to 0.29%.
Medical & Dental appraisal levels have fallen by 9% this month, but overall are tracking higher than last year by 2.7%.
Value based appraisal levels are up slightly again this month by 0.2%. but are still tracking low year to date.
Statutory and Mandatory training compliance continues strong despite continuing disruption to training due to operational pressures.
Temporary Staffing: Volume of requests for temporary staffing is high across all staff groups and specialties; fill rates are lower than previous months for Clinical and Health Care support staff

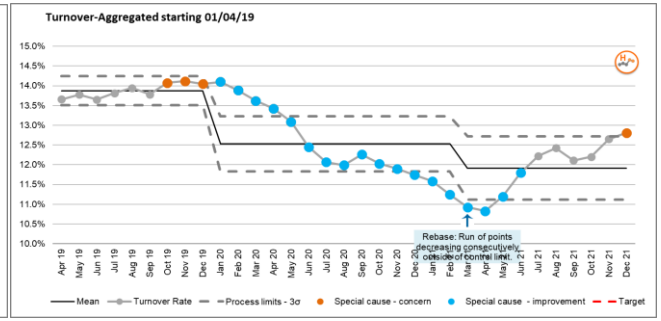
High level Board Performance Indicators

		21/22 YTD	20/21 YTD	Variance
Turnover		12.0%	12.3%	-0.3%
Vacancy		5.2%		N/A
Sickness Rate		5.0%	4.5%	0.5%
Appraisals	Values Based	34.5%	42.1%	-7.6%
	Medical & Dental	57.3%	54.6%	2.7%
Statutory and Mandatory Training		87.3%	86.7%	0.6%

High Level Trust Performance





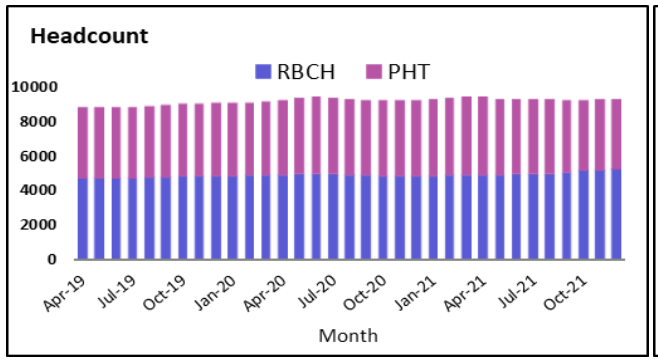


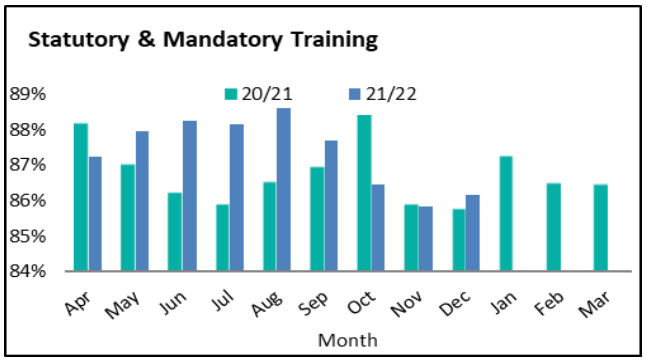
63.1% (Nov21) | Appraisals (Medical) | 54.1% (Dec21)

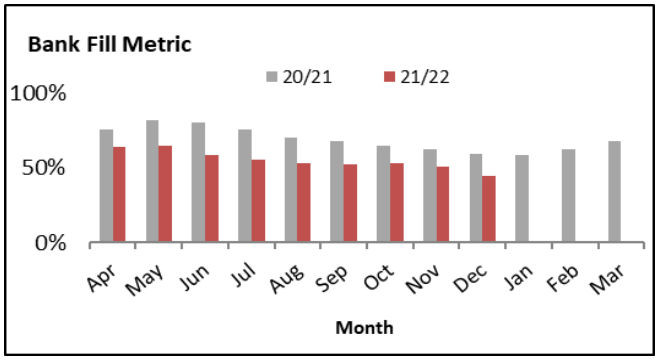
58.2% (Nov21) | Appraisals (Values) | 58.4% (Dec21)

12.6 (Nov21) | Turnover | 12.8% (Dec21)

5.2% (Nov21) | Sickness | 5.3% (Dec21)







Emergency

Commentary on high level board position

UHD continues to experience challenges in our Emergency Departments. Attendance numbers continue to reduce with an average of 37 less per day compared to December 2019, and 30 less per day than in November. There was improved performance of achieving initial assessment within the standard, and an increase in the ratio of patients seen by a clinician within 60 mins of arrival. Mean time slightly deteriorated on the RBH site, with patients wafting in the department more than 12 hours also worsening.

Daily Ambulance activity is similar to November but significantly lower than the same period in 2019 (c30 per day as an average). Ambulance delays were consistent with November with 164 waiting over 60 minutes (175 November). The Trust have been advised by SWAST that in in with national guidance Ambulance crews will no longer support 'cohorting' patients in corridors from January 11th, and the implications of this are being worked through.

Overall admissions are slightly lower than November, with an average of 95 at RBH and 88 at Poole. Patients with no criteria to reside in hospital beds remains high impacting the efficiency of flow on both sites, manifesting itself as increased escalation and crowding in both Emergency Departments.

In January the ECIST review and support plan will be shared with the ED teams and with the Trust Management Group to develop the programme of work required to support improvement.

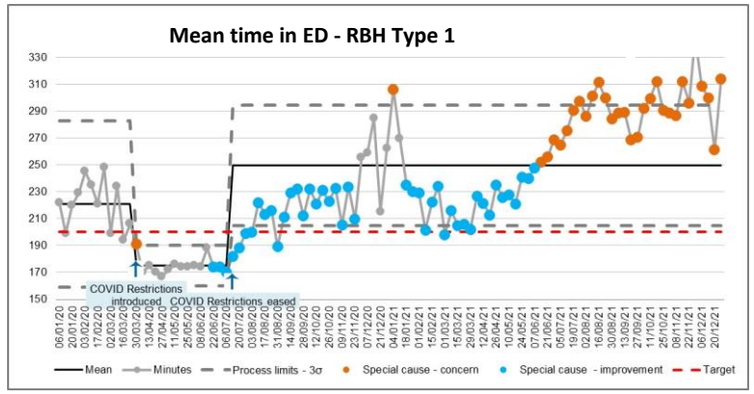
High level Board Performance Indicators

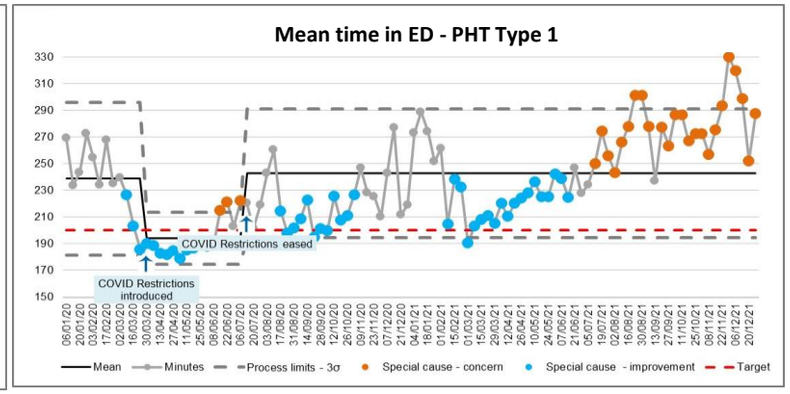
Type 1 ED	Standard	Merged Trust
Emergency Dept		
Arrival time to initial assessment	15	4
Clinician seen <60 mins		30.6%
PHT Mean time in ED	200	298
RBCH Mean Time in ED	200	304
Patients >12hrs from DTA to admission	0	34
Patients > 12hrs in dept		418
YTD ED attendance Growth vs 20/21 (vs 19/20)		31.5% (2.8%)
Ambulance Handover		
YTD Ambulance handover Growth vs 20/21 (vs 19/20)		2.7% (-0.4%)
Ambulance handover 30-60mins breaches		281
Ambulance handover >60mins breaches		164
Emergency Admissions		
YTD Emergency admissions growth vs 20/21 (vs 19/20)		14.4% (-4.1%)

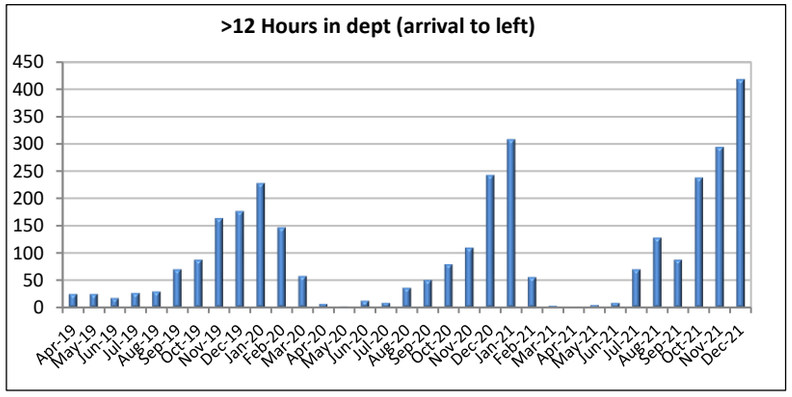
4 mins Nov-21 → Mean time to initial assessment → 4 mins Dec-21

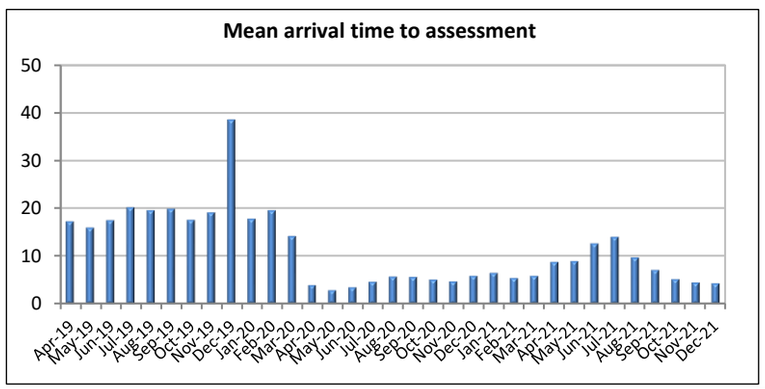
288 mins Nov-21 → Mean time in Dept. RBH & PHT → 301 mins Dec-21

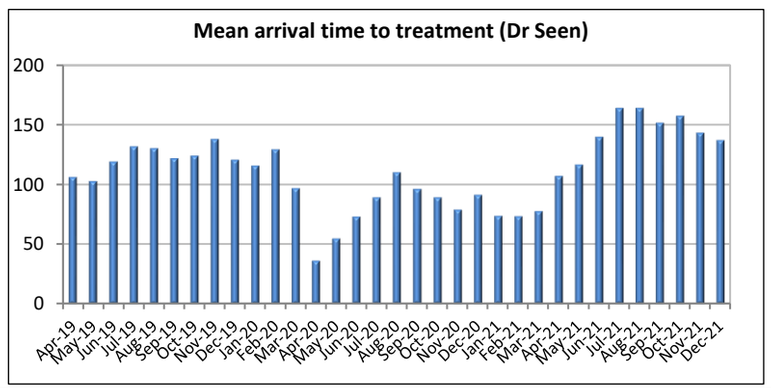
High Level Trust Performance

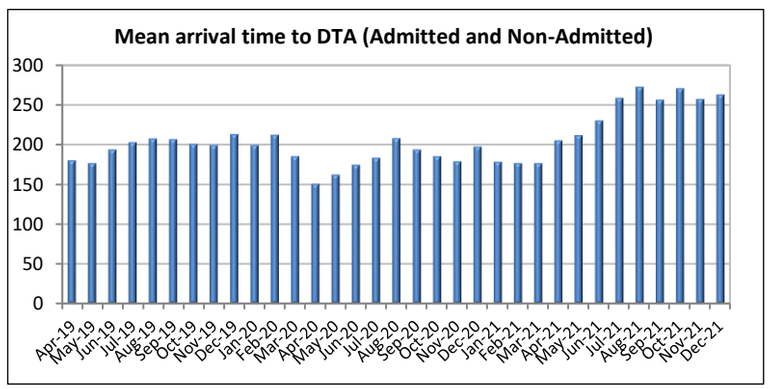












Patient Flow

Commentary on high level board position

Patient Flow

Bed occupancy has reduced in December compared to previous month, 91.3% against 92.4% in November. The improvement can be attributed to a high discharge rate during the Christmas period. However, it is still remains above the 85% Standard. The figure also includes escalation capacity and the Trust was fully escalated during this period. Escalation beds were required due to infection control outbreaks and an increase in covid admissions which impacted on available green capacity.

The ED conversion rate increased in month by 2.8% to 32.7% which is also above the specified standard.

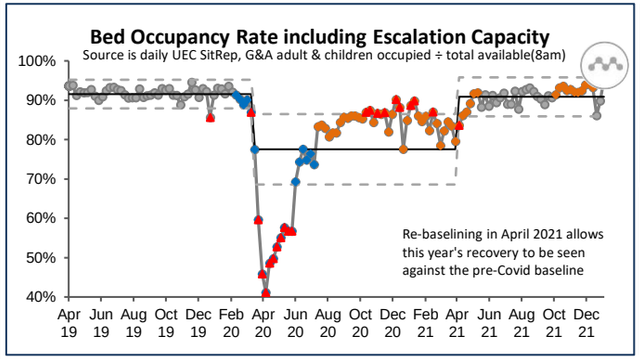
Adult occupied bed days reduced in month by 280 days with a minor reduction in net admissions against discharges (37 less admissions).

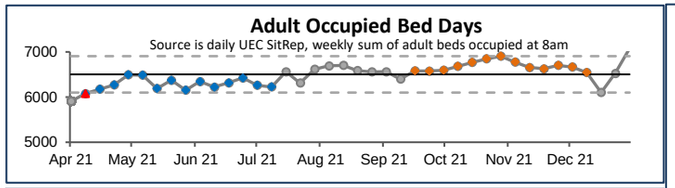
The mean bed wait for patients reduced significantly in December to 169 mins compared to 219 mins the previous month.

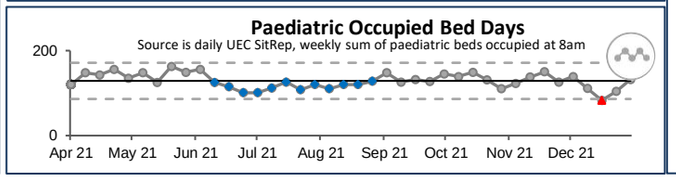
High level Board Performance Indicators & Benchmarking

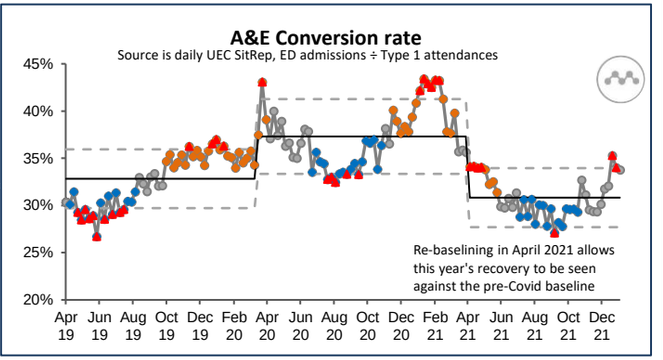
December 2021	Standard	Merged Trust
Patient Flow		
Bed Occupancy		
(incl. escalation in capacity)	85%	91.3%
(excl. escalation in capacity)		92.9%
Occupied Bed Days		29,182
Admissions v Discharges		6,317 v 6,354
Net admissions	<= 0	-37
Non-elective admissions		5,621
> 1 day non-elective admissions		3,575
Same Day Emergency Care (SDEC)		2,044
Conversion rate (admitted from ED)	30%	32.7%
Mean bed wait: minutes *w/c 3 Jan*		169.4

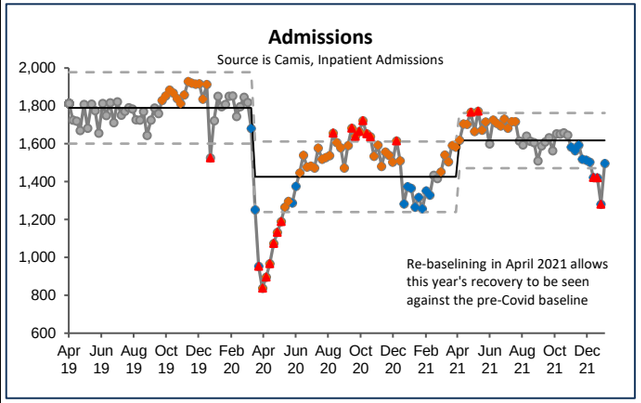
High Level Trust Performance (weekly)

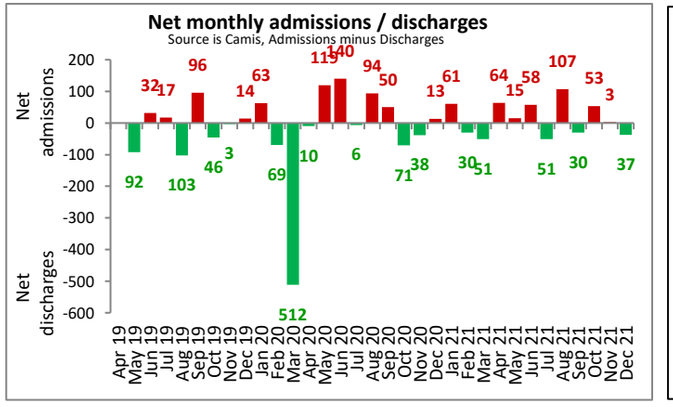


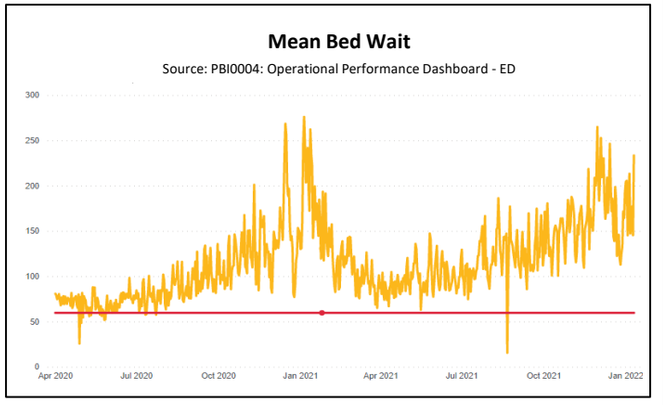












Length of Stay and Discharges

Commentary on high level board position

Patient Flow

The average number of beds per day occupied by patients with a length of stay>7days has slightly reduced in month (-14 patients). The number of patients with a length of stay over 21 days remained at 224 and the proportion of this cohort of patients increased by 1% and remains above pre pandemic levels. The overall increased stay for stranded patients remains above the standard and continues to cause operational challenges to managing flow and has a detrimental impact on the national UEC metrics.

The number of patients who are ready to leave/have no reason to reside (MRTL/NRTL) has decreased with an average of 166 patients waiting in month compared to 174 in November. The position improved with the introduction of block booked beds being provided in the community. The overall proportion of NRTR patients worsened in month to 23% (increase of 1%). Internal processes account for 17% of the patients no longer meeting the criteria to reside (CTR), an improvement of 7% on the previous month. Data completeness in relation to whether a patient has C2R has marginally dropped to the 78% mark. Further work is needed to improve this position.

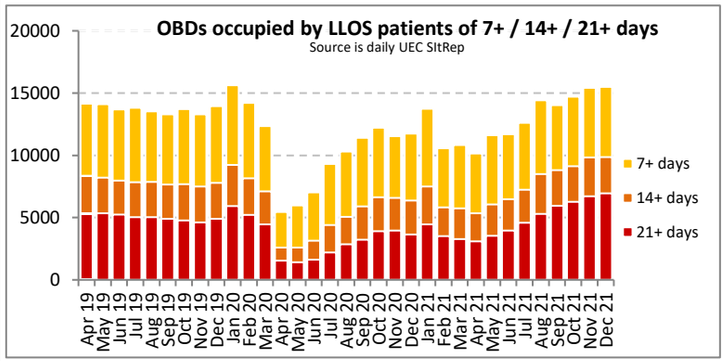
High level Board Performance Indicators & Benchmarking

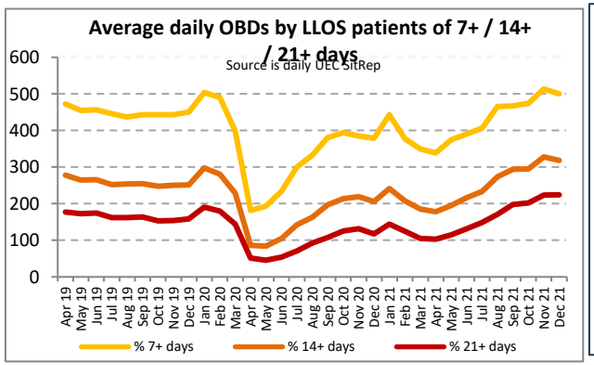
December 2021	Standard		Merged Trust	
Length of Stay and Discharges				
Stranded patients:				
Length of stay 7 days		*42%*	500	*53.1%*
Length of stay 14 days		*21%*	318	*33.8%*
Length of stay 21 days	108	*12%*	224	*23.8%*

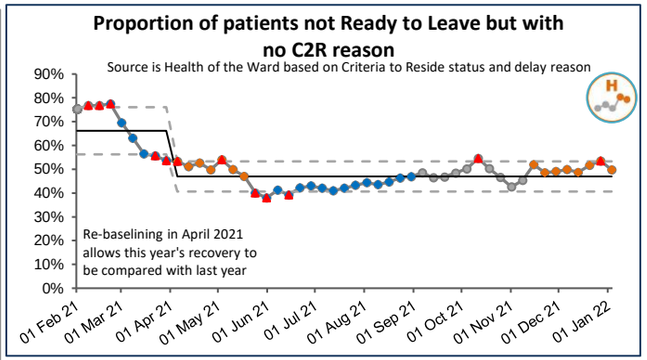
Criteria to Reside (excludes Ready to Leave)	Physiology	5%
	Function	11%
	Treatment	25%
	Recovery	8%
	Not Recorded	**51%**

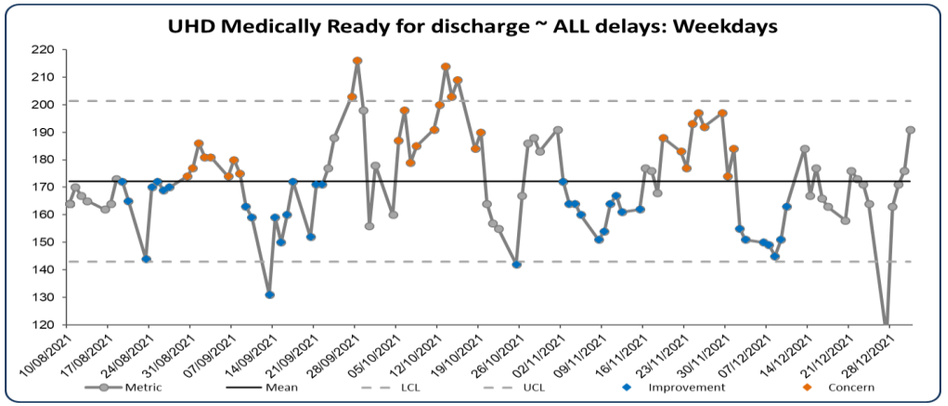
Proportion of patients who are Ready to Leave 23%

High Level Trust Performance (weekly)









Escalation Report

Dec-21

Trauma Orthopaedics : 18% compliance achieved against fractured neck of femur target of 95% of clinically appropriate patients to surgery within 36hrs.

Activity | Response

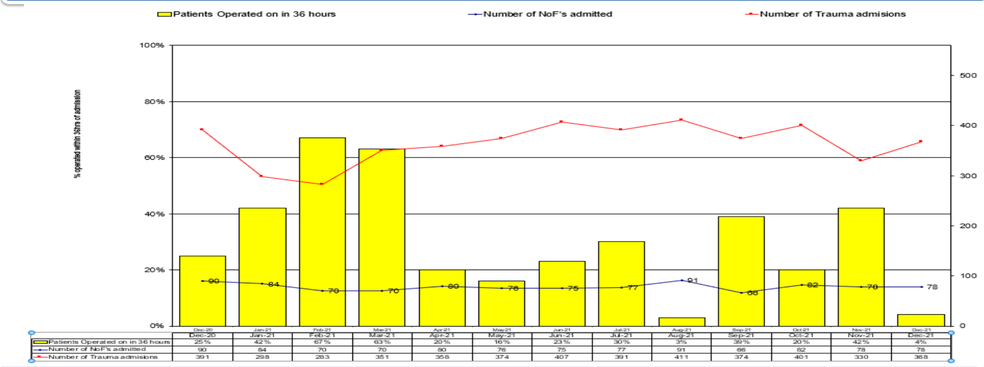
Definition of Trauma Quality Targets & Compliance Achieved

NHFD Best Practice Tariff Target: 85% of fractured neck of femur (NOF) patients to be operated on within 36 hours of admission.
Dec 2021 Compliance: 4%
CCG 2018-19 Quality Target: 95% of fractured neck of femur (NOF) patients to be operated on within 36 hours of admission or of being clinically appropriate for surgery, increasing to 95% by March 2019 (internal target remains at 95% on a monthly basis).
Dec 2021 Compliance: 18%
Internal Target: 95% of other trauma patients to theatre within 48 hours of admission or being deemed fit for surgery.
Dec 2021 Compliance: 85%

Breakdown of Breach Reasons and Waiting Times

NoF Breach Reasons	No. of pts
Patients not fit pre-op & needed optimising	10
Patients on anti coagulants	1
Other NoF/trauma patients prioritised	53
Loss of weekend capacity due to theatre staffing	0
Awaiting x-ray/scan availability	0
Required medical review pre-op	0
Equipment failure	0
Awaiting specialist surgeon	5
Total breached NoFs	69

Demand on Trauma Directorate during December 2021



	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Patients Operated on in 36 hours	25%	42%	67%	63%	20%	16%	23%	30%	9%	39%	20%	42%	4%
Number of NoF's admitted	90	84	70	70	80	76	75	77	91	66	82	78	78
Number of Trauma admisions	391	298	283	351	358	374	407	391	411	374	401	330	368

Escalation Activity in November 2021

December proved to be a challenging month for the trauma service with 368 admissions including 78 patients with a fractured neck of femur (# NOF) and 13 with a femoral shaft #. The performance figures in December deteriorated having started the month in a poor position with 11 patients with a # NoF outstanding, patients admitted at the start of the month with a # NoF did not go to theatre until the 4th December which has a knock on effect on going throughout the month. Multiple days of high admissions of #NOF patients, 11 in one 2 day period and 10 in another 2 days. Achieving the 36 hour target was also impacted with the loss of theatre lists over the Christmas and New Year bank holiday periods.

The service spent the majority of the month in stage 2 of escalation moving into stage 3 for a 5 days and stage 1 for 3 days, though after the Christmas period the service moved to high stage 2 with 44 patients awaiting surgery having admitted 7 NoFs on Christmas day and with urgent trauma cases clinically prioritised throughout the month (loss of theatre lists over the bank holiday period) leading to difficulty in recovering perform recover performance.

Mitigations and Reset

Application of national clinical guidelines: Major trauma, #NOF, Spinal, discharge, flow.
Bi weekly Trauma Steering Board in place to review opportunity and blocks to safety, productivity and efficiency. Remedial action plan created and action log in place.
Fracture clinic capacity increased to 550 per week, all patients are reviewed and receive telephone consultations where appropriate.
Virtual fracture clinic capacity increased to provide same day access.
Bed base, reduction in core capacity to provide Blue Covid capcity and Critical Care capacity
No change in the average daily NOF admissions leading to backlog of patients awaiting surgery.
Daily trauma operational huddle in place
Availability of timely fracture clinic reviews, both face to face and via telephone. additional sessions planned January
Recruitment under way for consultant posts to support Derwent 3rd theatre.
Trauma Ambulatory Care Unit (TOACU) opened at the end of July 80% admission avoidance rate improving to 90%. service impacted over holiday period as capacity used for inpatient capacity for 3 days.

Complexity of Case Load

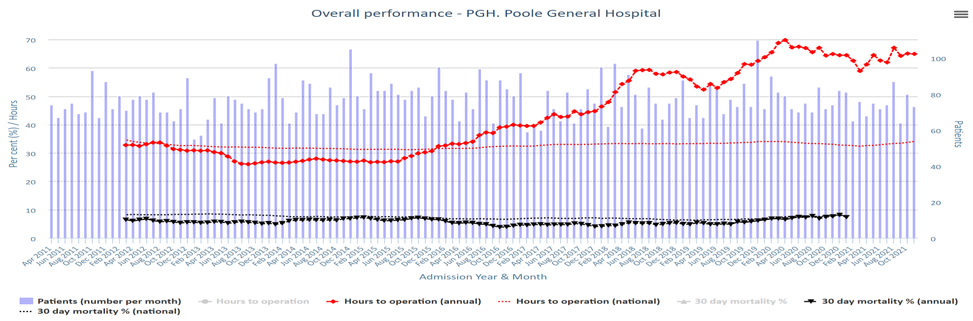
Soft Tissue	No. of pts
Patients requiring returns to theatre	7
Additional theatre slots required	13
Complex Surgery	**No. of pts**
Total Hip Replacements for NoFs	10
Revisions carried out	0

A high number of complex patients in month with 10 # NoF patients had a THR for their fracture, and 8 of 13 patients admitted with a femoral shaft fracture required surgery

The service records on the NHFD all femoral fractures over the age of 60, and the most recent facilities audit for the NHFD focused on femoral shaft fractures.

7 patients required 2 or more trips to theatre this month, equating to an additional 13 theatre visits, which is approximately 4 theatre sessions (of multiple trips to theatre) if 3 soft tissue cases are done on a session.

Neck of Femur QSPC Focus



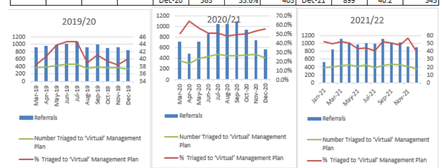
Name	Code	Number of cases submitted	Surgery on day of, or day after, admission	Surgery supervised by consultant surgeon and anaesthetist	General anaesthetic	General anaesthetic and nerve block (of all GA)	Spinal anaesthetic	Spinal anaesthetic and nerve block (of all SA)	Proportion of arthroplasties which are cemented	Eligible displaced intracapsular fractures treated with THR	Trochanteric fractures (excl. reverse oblique) treated with SHS	Subtrochanteric fractures treated with an IM nail
Poole General Hospital	PGH	921	21.7	8.2	81.6	52.9	18.3	24.4	97.7	26.4	49.0	88.5
Queen Elizabeth Hospital, Edbaston	QEB	867	59.0	99.8	71.9	0.0	23.2	0.0	57.7	19.6	56.1	87.8
Norfolk and Norwich Hospital	NOR	842	71.6	66.3	71.3	0.0	28.9	0.0	99.1	14.2	72.6	92.3
Leicester Royal Infirmary	LER	821	64.8	68.2	23.3	79.5	77.5	55.7	98.7	19.8	81.7	90.6
University Hospital of North Staffordshire	STO	763	65.7	51.1	84.9	27.1	21.8	15.7	85.8	38.2	79.1	92.2

December Update on virtual fracture clinic

2019/20 Month	Referrals	% Triaged to 'Virtual' Management Plan	Number Triaged to 'Virtual' Management Plan
Mar-19	924	38.4	355
Apr-19	953	40.6	387
May-19	972	43.7	425
Jun-19	1012	44.6	451
Jul-19	1064	44.6	467
Aug-19	926	38.9	352
Sep-19	988	41.1	375
Oct-19	899	39.4	365
Nov-19	924	38.4	355
Dec-19	832	40.2	332

2020/21 Month	Referrals	% Triaged to 'Virtual' Management Plan	Number Triaged to 'Virtual' Management Plan
Jan-20	860	40.2	314
Feb-20	889	39	365
Mar-20	716	50.4%	361
Apr-20	484	63.6%	308
May-20	716	55.9%	400
Jun-20	861	50.8%	438
Jul-20	1040	51.1%	473
Aug-20	1038	47.8%	448
Sep-20	1100	49.3%	452
Oct-20	934	50.3%	467
Nov-20	743	53.2%	478
Dec-20	563	55.6%	403

2020/21 Month	Referrals	% Triaged to 'Virtual' Management Plan	Number Triaged to 'Virtual' Management Plan
Jan-21	518	52.5	383
Feb-21	852	50	400
Mar-21	1117	52.1	438
Apr-21	1039	50.6	452
May-21	972	43.7	425
Jun-21	1012	44.6	451
Jul-21	988	41	375
Aug-21	1117	52.1	438
Sep-21	1040	51.1	473
Oct-21	1038	47.8	448
Nov-21	928	56.8	425
Dec-21	899	40.2	345



In comparison to 2019 activity there has been an increase in patients managed virtually, with up to 64% of all referrals managed as such. Over the comparable months there has been an over all increase to 55% versus 40% in 2019. This has undoubtably helped to mitigate demands on face to face fracture clinics and remains a huge success.

Author John West

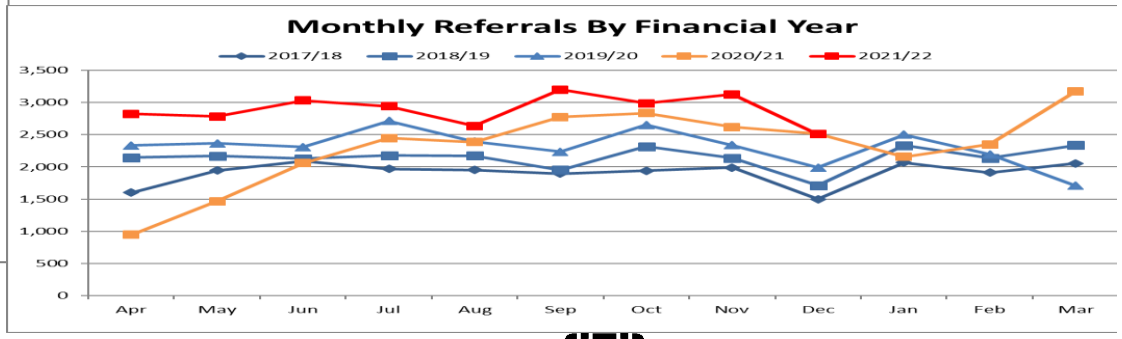
Cancer - Actual November 2021 and Forecast December 2021

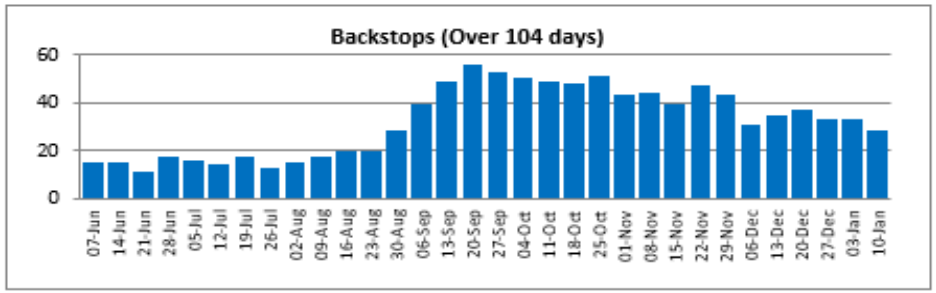
Commentary on high level board position

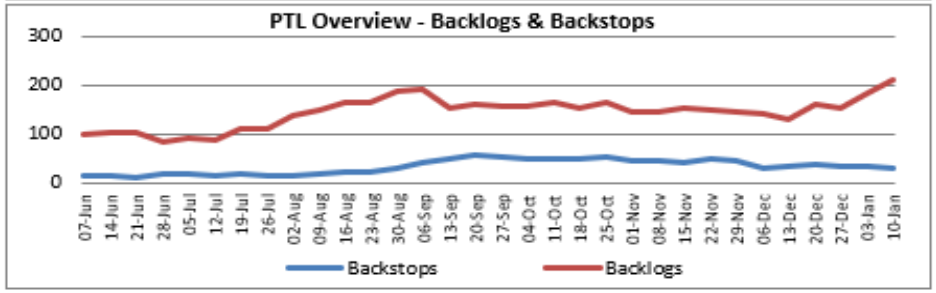
The Trust continued to receive a significant increase in referral numbers in November (16% increase compared to same period last year) and a 14% increase against the planned trajectory. The tumour sites seeing the highest increases were colorectal (30%), lung (24%), skin (27%), and haematology (39%). The total number on the UHD PTL in November remained above 3600 which was considerably larger than previous years with UHD having the 12th highest PTL nationally. The number of patients on a fast track pathway continue to challenge all performance standards. However, of the 30 trusts with the largest PTL's nationally, UHD has the 2nd lowest % of backstop patients (lowest reported position since August 2021), even with the current challenges. 28-day FDS in November dropped to below the 75% threshold, reporting 66.4%. 1st OPA capacity was the main breach reason (56%). Sites that are most challenged are breast, colorectal, gynae and urology. Data completeness in November against this standard was above the target of 95% (95.1%). The Trust has consistently achieved the 31-day standard between April – November 2021 and is also expected to be achieved in December. The Trust also achieved all 3 subsequent treatment KPI's in November with similar performance expected in December. Although the 62-day performance in November was below the 85% threshold (71.%), this is above the current national average of 68.3%. In November, the total number of 1st treatments for patients on a 62-day pathway was 22 above number reported in the same period last year.

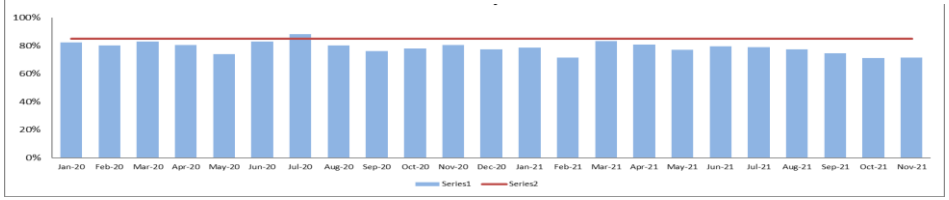
High level Board Performance Indicators & Benchmarking

Cancer Standards	Standard	UHD Nov-21	Predicted Dec-21
31 day standard	96%	96.8%	96.6%
62 day standard	85%	71.4%	66.8%
28 day faster diagnosis standard	75%	66.4%	62.9%

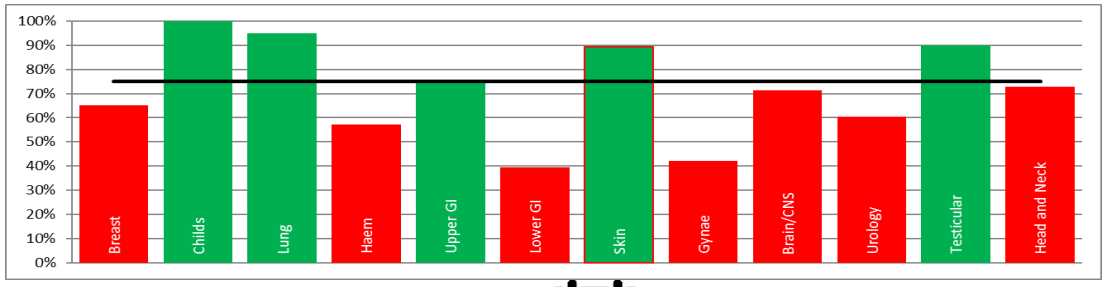




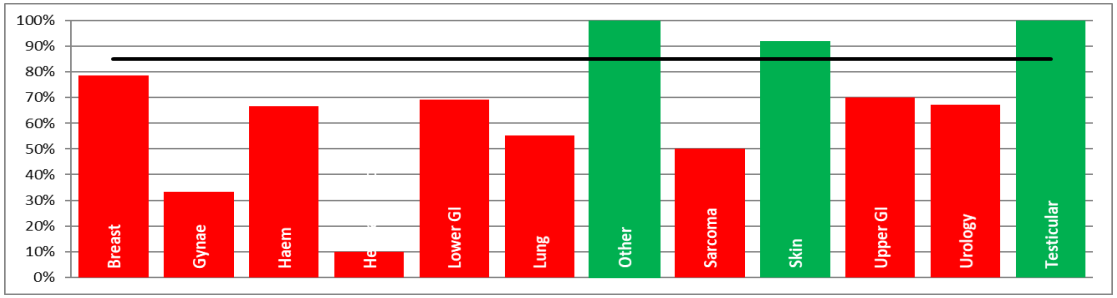




Target 75% | **28** | **UHD: November 2021: 66.4%**



Target 85% | **62** | **UHD: November 2021: 71.4%**



Elective & Theatres

Commentary on high level Board position

18 Weeks Referral to Treatment
At the end of December 2021, the Trust's 18 week RTT performance is **61.6%** (92% standard).

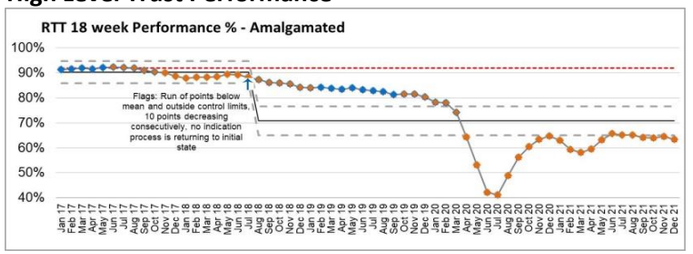
- 2,968 patients were waiting over 52 weeks for treatment, a decrease of 354 compared to November The percentage of the waiting list now over 52 weeks has also reduced to **5.6%** .
- 952 patients are waiting over 78 weeks, a reduction since November whilst 273 patients are waiting over 104 weeks, an increase of 25 since the previous month.
- Specialty level improvement trajectories are in place and governed by the Care Groups with oversight of delivery through the Operational Performance Group
- The overall **waiting list size** has grown in 21/22 for multifactorial reasons, including: reduced capacity during the pandemic; transfer of routine waiting lists/activity from Dorset Healthcare University NHS FT and Dorset County Hospital NHS FT to the Trust as part of the system recovery plan; and the impact of workforce challenges in a number of areas.
- Our waiting list validation programme is continuing across our RTT, follow up and planned waiting lists.
- **99.97%** of patient referrals have been allocated a clinical prioritisation code (P code) with fewer than 5 not yet recorded on the patient administration system (PAS).

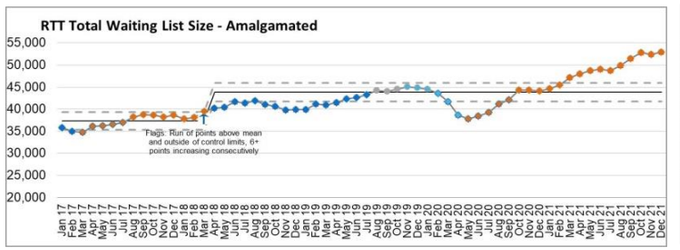
Theatre utilisation The current theatre (main) utilisation rate has **decreased by 1%** since last month.
Trauma The percentage of patients with a fractured neck of femur treated within 36 hours of admission (4%) has deteriorated substantially since last month (42% November 21).

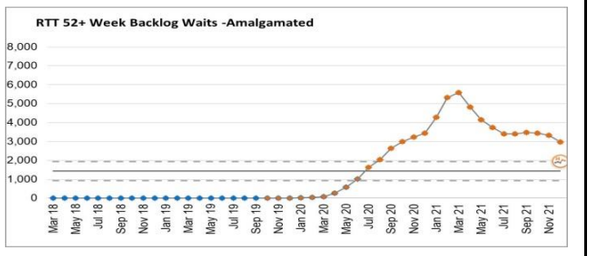
High level Board Performance Indicators & Benchmarking

	Standard	Merged Trust	% of pathways with a DTA
Referral To Treatment			
18 week performance %	92%	61.6%	
Waiting list size	51,491	52,972	23%
Waiting List size variance compared to Sep 2021 %	0%	2.9%	
No. patients waiting 26+ weeks		12,904	38%
No. patients waiting 40+ weeks		5,374	54%
No. patients waiting 52+ weeks (and % of waiting list)	5.6%	2,968	65%
No. patients waiting 78+ weeks		952	74%
No. patients waiting 104+ weeks		273	89%
Average Wait weeks	8.5	19.5	
% of Admitted pathways with a P code		99.97%	
Theatre metrics			
Theatre utilisation - main	80%	70%	
Theatre utilisation - DC	85%	61%	
NOFs (Within 36hrs of admission - NHFD)	85%	4%	

High Level Trust Performance

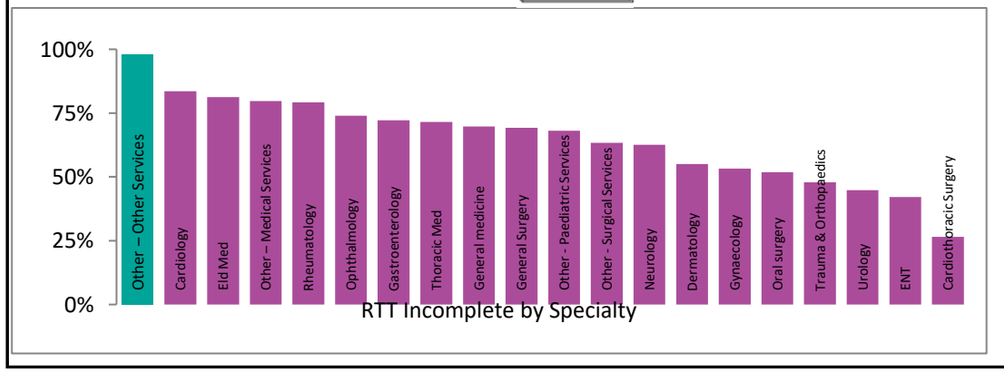


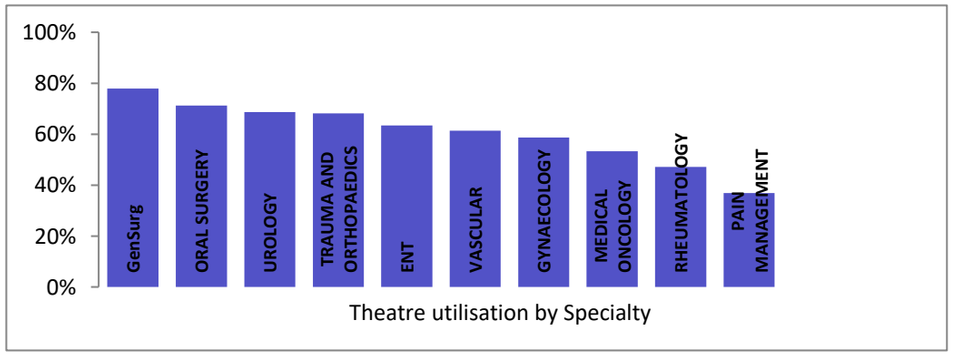




RTT Incomplete 61.6% <18weeks 18 WEEKS (Last month 64.0%) Target 92%

Theatre Utilisation 68% (Last month 69%)





Referral to Treatment (RTT)

What is driving under performance?

92% of all patient should be seen and treated within 18 weeks of referral.
61.6% of all patients were seen and treated within 18 weeks at the close of December 2021.
The overall waiting list (denominator) was **52,984** which is higher than previous months and 2.9% above the September 2021 waiting list of 51,491.

2,968 RTT waits exceeded 52 weeks, which is an improved position and aligned with the Trust's operational plan trajectory for Sept 2021-March 2022.

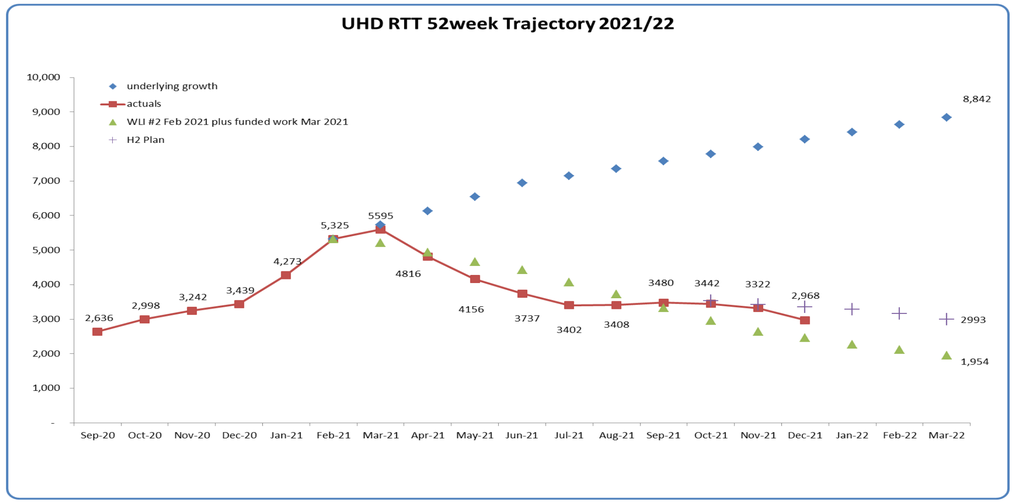
December 2021 (compared with previous month)

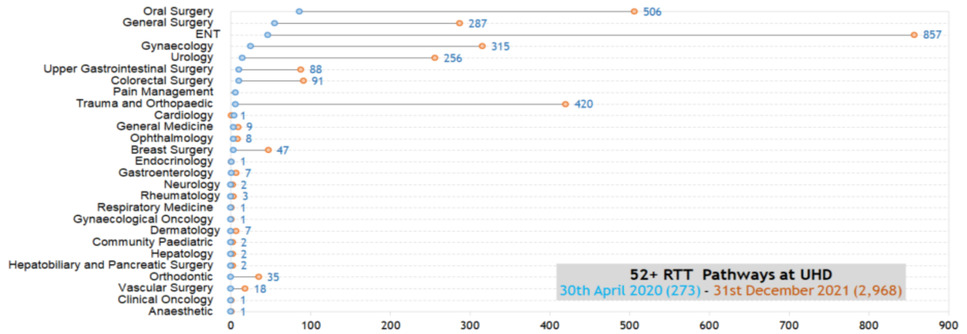
32,657 decrease < 18 weeks
12,904 increase > 26 weeks
5,374 decrease > 40 weeks
2,968 decrease > 52weeks
952 decrease > 78 weeks
273 increase > 104 weeks

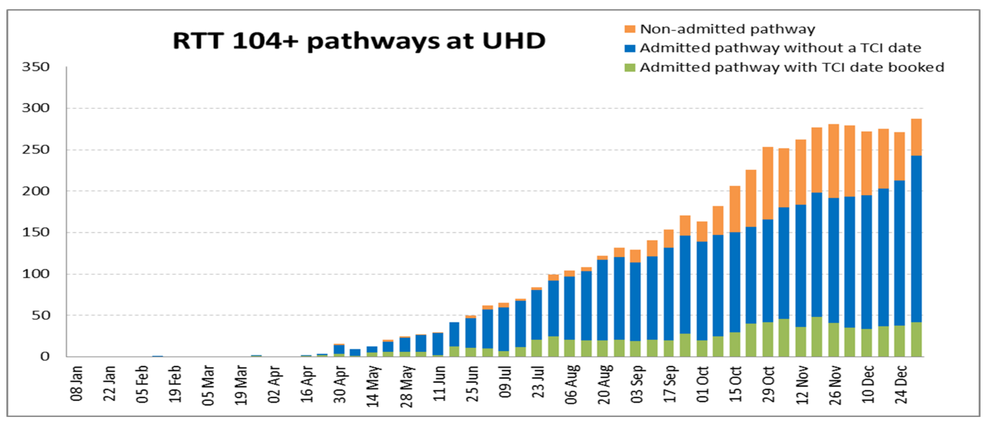
During December maintaining recovery of elective activity has remained a challenge alongside our continued focus on responding to COVID activity, managing an increase in non-elective demand, adhering to national guidelines on social/physical distancing, shielding and self isolation (patients and staff) and management of workforce capacity shortfalls in a number of areas. This has led to a reduction in routine elective activity including outpatient appointments and surgical procedures compared to 2019/20. Independent sector providers continue to provide capacity to support recovery of elective waits.

Non admitted and Admitted Performance
In addition to the above further reasons for under performance in 18 week patient pathways are:

- Royal College guidelines on the numbers of patients that can be safely seen during COVID -19 pandemic leading to many patients being deferred for both outpatient appointments and routine elective surgery
- Patients choosing not to attend hospital due to concerns about COVID-19, including patients choosing to wait until the pandemic is over or they have been fully vaccinated. Patients' concerns about time away from work or family commitments has also influenced their decisions.
- National requirements regarding testing, PPE and infection control processes restrict a full recovery of activity in many specialties.
- Clinical prioritisation of urgent and cancer pathways reducing routine capacity / activity
- Workforce has been redeployed to support the response to managing COVID-19, notably to support critical care
- Surgical/theatre capacity has been diverted to respond to an increase in Trauma activity.







What actions have been taken to improve performance ?

An Elective Operational Performance, Assurance and Delivery (OPAD) programme is in place to oversee improvements in performance, activity and reducing the number of patients waiting a long time for treatment. The OPAD programme accounts to the Chief Operating Officer through the Trust Operational and Performance Group.

The OPAD programme has a number of workstreams to support continuous improvements with the main programmes of work being:

- Validation & clinical prioritisation of all waiting lists commenced in April; Extension of the digital enabled validation programme includes neurology services in December 21.
- Delivery of the Single PAS project to support merged teams to manage single UHD waiting lists.
- Standard operating procedures which support the trust's Access Policy are being developed alongside moving to a single PAS and the merger of teams to increased standardisation and reduce variation.
- Opening of the 'Think Big' Outpatient centre at Beales in Poole to help tackle our waiting lists and bring diagnostic services closer to the community, as part of the Dorset 'Health Village' approach.
- Establishing 52+ week wait improvement trajectories and deploying demand and capacity tools to support management /tracking of improvements
- Continued improvements in business intelligence to support and monitor recovery.
- The operating model for the surgical admissions team is under review to enable best use of this essential resource.
- Mutual aid arrangements across the Dorset ICS are in place to reduce patient waits. Additional capacity using local independent sector providers and/or Insourcing companies has also been optimised.
- Two Trust-wide improvement programmes have also commenced:
  - Theatre improvement programme: value and efficiency
  - Outpatient Enabling Excellence and Transformation programmes

104 week-waiters improvement plan
To support a reduction in the Trust of people waiting over 104 weeks, local recovery plans are in place and additional monitoring and tracking of improvement has been established.

Health Inequalities
The Trust continues to support work to tackle health inequalities through the Dorset ICS Health Inequalities in Elective Care Programme. The programme is in the intervention design stage for two cohorts of patients waiting elective care i) People waiting times > 18 weeks and from deprived communities ii) People on Orthopaedic waiting lists. Currently a process of re-identification of patients to identify named patients in these cohorts is taking place. Patients in these cohorts will then be contacted to support them to access community services that will enable them to wait well. For example, community groups, exercise and weight loss programmes, support with shopping or transport or stop smoking services/advice.

Executive Lead Mark Mould | Trustwide Lead | Author Judith May

Outpatients & Diagnostics

Commentary on high level board position

Outpatients

- GP Referrals down 4% on last month
- Patient cancellations are high and have increased to 7.1% an increase of 2.2% on last month.
- Non Face-to-Face attendances - performing above the national standard
- An outpatients improvement programme is focussing on a 'back to basics' review of processes to ensure best practice in Outpatients
- Aligned to this will be delivery of the key requirements identified in the Sept 2021-March 2022 planning guidance (12% advice and guidance, 2% patient initiated follow-up and maintaining at least 25% remote delivery of outpatient attendances)

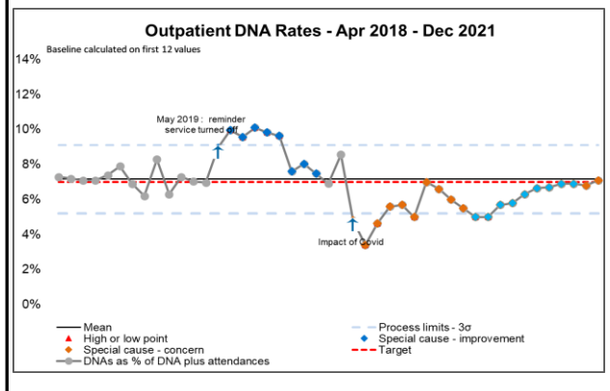
Diagnostics

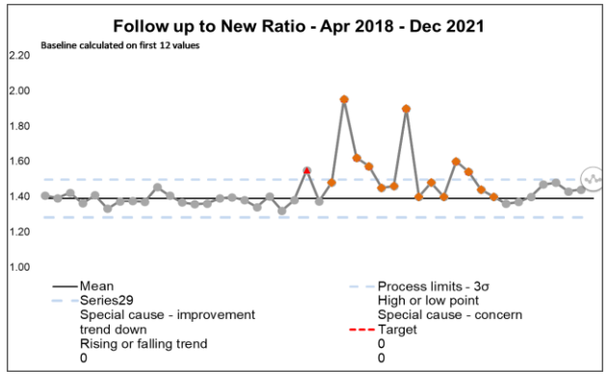
- Decrease against October position from 94.4% to 92.8% of all diagnostics tests required within 6 weeks
- Endoscopy position has slipped from 75.8% in October to 72.7% in November
- Echocardiography has slipped from 86.4% in October to 62.2% in November
- Neurophysiology has improved from 99.7% in October to 100% in November
- Radiology continue meeting the 99% target now at 99.4% for November

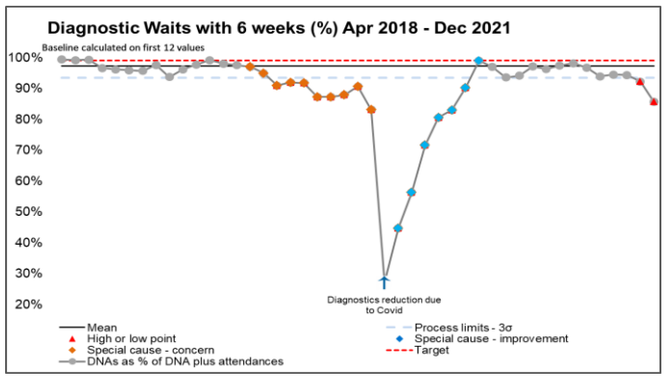
High level Board Performance Indicators & Benchmarking

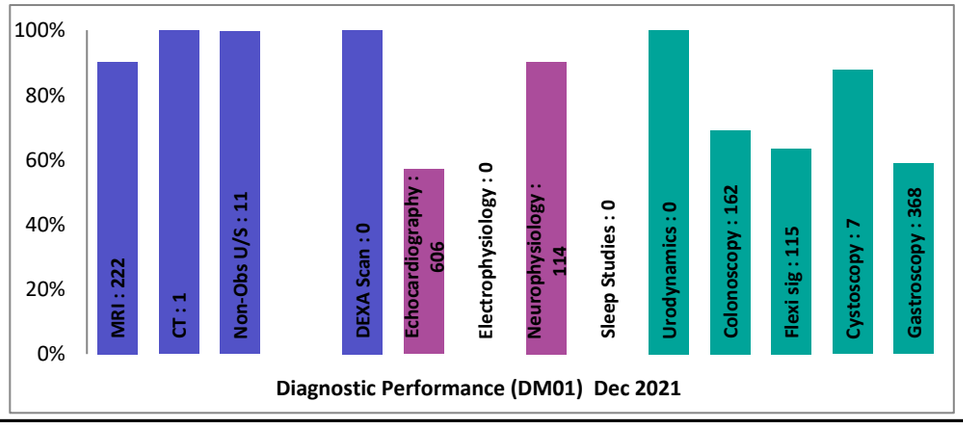
		Standard	Values	Merged Trust
Referral Rates				
GP Referral Rate year on year	*(values 20/21 v 21/22)*	-0.5%	71202 / 95614	34.3%
	(values 19/20 v 21/22)		106481 / 95614	-10.2%
Total Referrals Rate year on year	*(values 20/21 v 21/22)*	-0.5%	129310 / 169647	31.2%
	(values 19/20 v 21/22)		177752 / 169647	-4.6%
Outpatient metrics				
Overdue Follow Up Appointments				16,393
Follow-Up Ratio		1.91		1.49
% DNA Rate	*(New & Flup Atts / Total DNAs)*	5%	30056 / 2282	7.1%
Patient cancellation rate	*(New & Flup Atts / Total Pat Canx)*		30056 / 4882	14.0%
reduction in face to face attendances				
% telemed/video attendances	*(Total Atts / Total Non F-F)*	25%	30056 / 8354	27.8%
Diagnostic Performance (DM01)				
% of >6 week performance	*(Total / 6+ Weeks)*	1%	11220 / 1606	14.3%

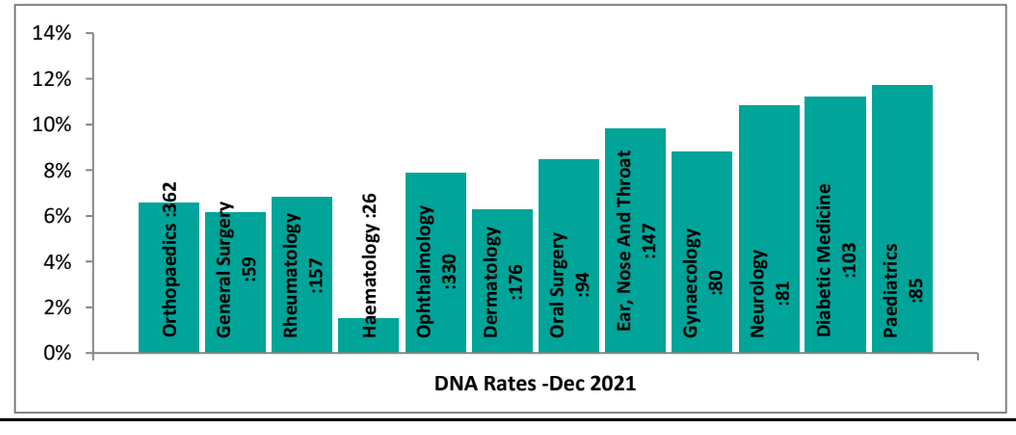
High Level Trust Performance











SCREENING PROGRAMMES

Commentary on High Level Board Position

Bowel Cancer Screening

Invitation Backlog Recovery

Invitation backlog recovery achieved in May 2021.

The National Team have produced guidance to support programmes to adjust the invitation rate to enable the smoothing of peaks in invitations created during recovery through higher than normal levels of inviting. The current performance standard is +/- 6 weeks from invitation due date, the new guidance will allow for up to + 14 weeks. Additional flexibility with this standard will enable the programme to manage spikes in demand in 2023.

Dorset Plan to be agreed at Programme Board in January 2022.

Age Extension

Age extension was launched in May 2021 with invitations to 56 year olds and the bowel scope cohort. The team are preparing to invite 58 year olds in 2022/23 as part of the phased roll out and submitted plans to Commissioners in December 2021.

Key Performance Standards

*** Uptake Standard** (*Number of subjects aged 60 to 74 who adequately participated in screening within 6 months of the invitation)*:

The average uptake rate is 75% since January 2021 (acceptable performance = >52%; achievable performance = >60%).

*** SSP Clinic Wait Standard** (*Proportion of patients with an abnormal FIT result offered an appointment with a Specialist Screening Practitioner (SSP) within 14 days):*

The clinic wait standard has been maintained at 100% for the last 18 months via virtual clinics (acceptable performance = 95%; achievable performance = 98%). Discussions are now taking place to restart some face to face clinics where need demands.

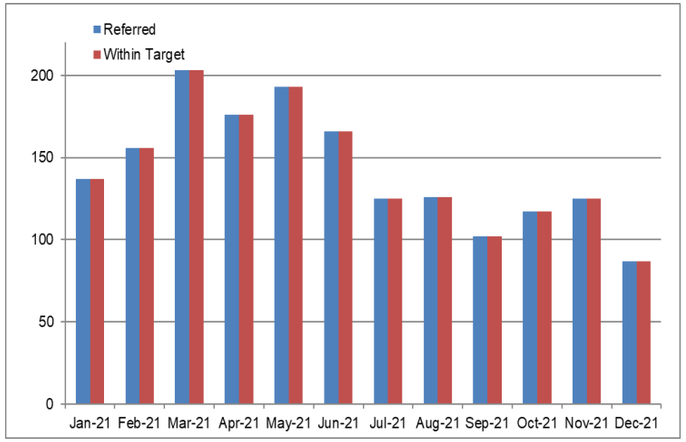
*** Diagnostic Wait Standard** *(Proportion of patients with an abnormal FIT result whose first offered diagnostic test date falls within 14 days of their SSP appointment)*:

Diagnostic wait performance has been above the achievable standard of 95% between April and December 2021 (acceptable performance = 90%; achievable performance = 95%). There was a drop in performance to 93% in September due to colonoscopy and CTC capacity . However, this is still above the programme achievable standard. In December diagnostic wait performance was achieved at 99%.

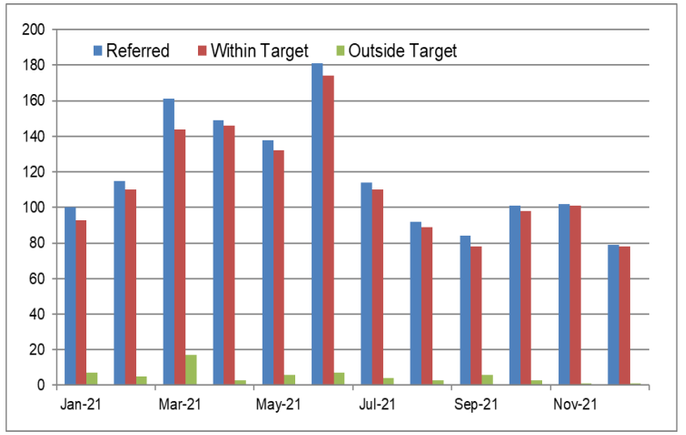
High Level Board Performance Indicators

Bowel Screening Standard	Target	Trust December Performance
SSP Clinic Wait Standard (14 days)	95%	100%
Diagnostic Wait Standard (14 days)	90%	99%

Clinic Wait Standard



Diagnostic Wait Standard



SCREENING PROGRAMMES

Commentary on high level board position

Breast Screening

KPI's are being met with the exception of the Round length.

Significant staffing issues have forced a temporary revision of the recovery plan. There are not enough staff to continue at the current pace. The reduction is approximately 25%.

If the reduction continues at this rate the recovery would not take place until Autumn 2022 in the worst case scenario.

Locum Radiologist, bank staff and overtime continue to bolster capacity.

High level Board Performance Indicators & Benchmarking

Breast Screening	Standard	Merged Trust
Screening to Normal Results within 14 days	95.00%	99.00%
assessment appointment within 3 weeks	95.00%	99.00%
Round Length within 36 months	90.00%	34.00%
Longest Wait time (Months)	36	42

Maternity

Commentary

Midwifery staffing has remained challenging in December, due to workforce gaps and the impact of Covid. Some maternity services needed to be reduced for a short period of time (such as home birth service) to mitigate the risk and maintain safety.

An Implemtation plan to move to a new maternity digital system is planned for February which will enable women to have a personailsed care .

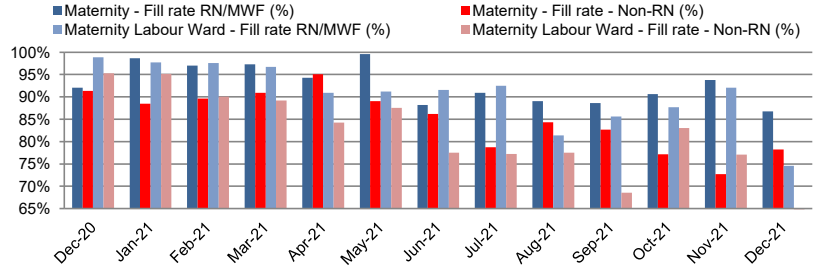
Delays in induction of labour is currently on our risk register - a working party commenced to improve our service with updating information to service users.

Continuity of care project plan will be prsented to the board to support implementation.

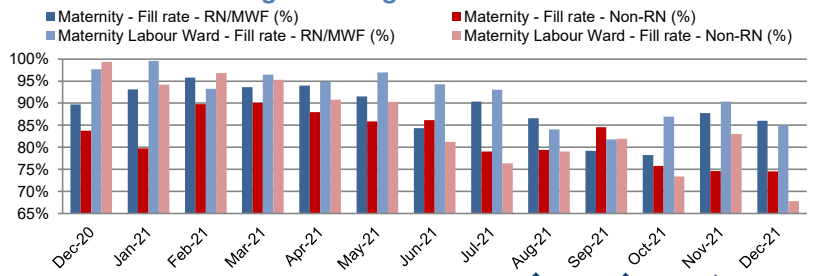
CQC Maternity Ratings	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Good	Requires Improvement	Good	Outstanding	Good	Outstanding

Screening incidences		2	
Serious Incidents Reported		0	
HSIB Cases Reported		0	
HSIB / NHSR /CQC Concerns		No	
Coroner Reg 28		No	
Maternity Safety Support Programme		No	
FFT Maternity User Response	Good / Very Good	90%	
	Poor / Very Poor	5.40%	
	Neither	1.60%	
	Don't Know	3%	

Day average staff fill rate



Night average staff fill rate



Training Compliance PROMPT Dec 2021

	Number Compliant December 2020 to date	Number of Headcount Staff @ December 2021	Percentage Compliant
Midwives Band 5	13	18	72.2%
Midwives Band 6	119	168	68.7%
Midwives Band 7	20	30	66.6%
Midwiifery Managers, Matrons &Other Band 8+	5	7	71.4%
Consultant Obstetricians	13	17	76.4%
Obstetric Trainees (Doctors)	17	25	68%
Obstetric Anaesthetics	11	27	40.7
HCAs/MCAs/MSWs	31	78	39.7%
ODP	8	13	61.5%

Maternity

Severe Incidents (0)

HSIB Referal case (0)

Screening Incidents (2)

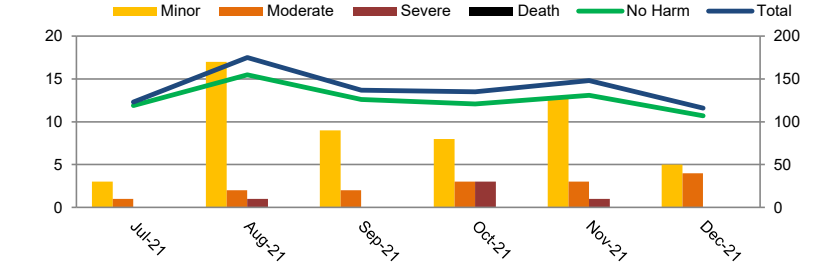
Perinatal Mortuary Review Panel (1 case reviewed)

Learning

Screening and Fetal Medicine team to consider to generically offering PAPP-A as a single screening test if patients decline chromosomal screening.

PMRT- Patient feedback regarding external entrance to Spring Suite is unwelcoming, including position of trade bins to the entrance and parking spaces. Spring charity to support improvements.

Datix Incidents



No Harm	119	155	126	121	131	107
Minor	3	17	9	8	13	5
Moderate	1	2	2	3	3	4
Severe	0	1	0	3	1	0
Death	0	0	0	0	0	0
Total	123	175	137	135	148	116

Learning from incidents

Learning from obstretric and a gastric cancer patient review

Recommendations

- Education of Obstetric and Midwifery staff regarding rarer causes of vomiting and weight loss in pregnancy and when to refer to gastroenterology services
- Consideration of endoscopic ultrasound at an earlier stage in cases of unclear diagnosis.
- Updating of Trust Protocol for the Management of Hyperemesis Gravidarum to give additional guidance on identifying alternative causes of nausea and vomiting in pregnancy, with appropriate referral pathways
- Open communication with patients regarding possible diagnoses and diagnostic uncertainty.

FINANCE

FINANCIAL INDICATORS	Year to date Budget £'000	Actual £'000	Variance £'000	Forecast Variance £'000
Control Total Surplus/ (Deficit)	1,425	1,470	45	528
Capital Programme	43,111	32,297	10,814	12,860
Closing Cash Balance	72,010	75,376	3,366	10,216
Public Sector Payment Policy	95%	91%	-4%	0

Commentary

The Trust set a breakeven budget for the second half of the year (the 'H2' period to 31 March) supported by the continuation of national top-up funding and funding to cover specific COVID costs. The national financial framework during this period includes an Elective Recovery Fund (ERF) to support the necessary increases in capacity to see and treat those patients still awaiting planned care. This is accounted for on a monthly basis, reported as a variance against both expenditure and income budgets. The full year deficit budget of £528,000 reflected the shortfall in ERF income received in the H1 planning period however this has now been fully funded through ERF+ resulting in a forecast breakeven position for the financial year ending 31 March 2022.

At the end of December, the Trust is reporting a £45,000 variance ahead of plan due to the phasing of ERF+ funding. Additional expenditure of £11.178 million has been incurred in the Trusts elective recovery programme and, pending national validation, income has been matched in full. Within this aggregate position, the Surgical Care Group report an adverse variance of £1.436 million, mainly due to CIP performance, additional medical staffing costs and partially offset by reduced activity particularly within Orthopaedics; the Medical Care Group report an adverse variance of £157,000, mainly due to an over achievement in cardiac private patient income together with the cessation of Bowel Scope and Bowel Cancer screening services; and the Specialties Care Group report a favourable variance of £1.093 million principally due to vacancies within Pathology and Pharmacy.

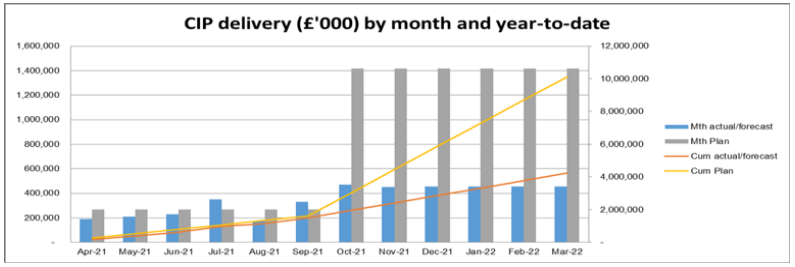
Cost savings of £2.869 million have been achieved to date against a target of £5.870 million, representing an under achievement of £3.001 million. Full year savings of £4.241 million have currently been identified of which 80% is non-recurrent. The refreshed H2 budget includes a significant increase in the savings requirement to £10.124 million for the full year, which if not achieved recurrently will result in further and considerable pressure on future years budgets. Currently the Trust is forecasting to deliver a shortfall of £5.884 million and a recurrent shortfall of £9.267 million.

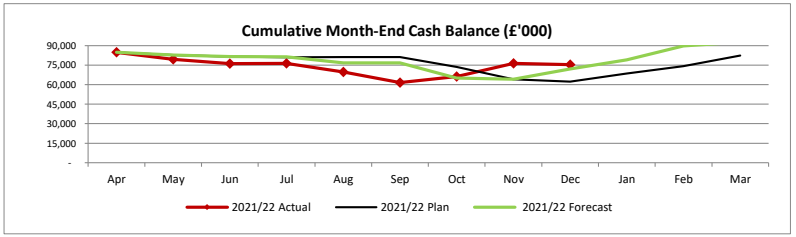
The Trust has set a very challenging capital programme for the year, with many priority schemes deferred due to the restrictive capital allocation for the Dorset Integrated Care System. This presents a considerable risk for the Trust and requires very careful ongoing management. As at 31 December capital spend is £32.297 million, being £10.814 million behind plan. This largely relates to underspends in the Maternity Children Emergency Centre and the Theatres Programme (STP Wave 1).

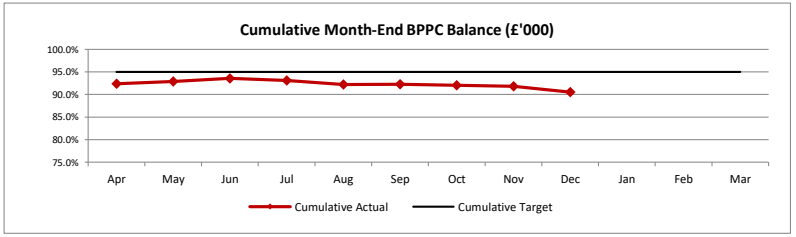
The Trust is currently holding a consolidated cash balance of £75.376 million, which is fully committed in support of the medium-term strategic reconfiguration programme.

REVENUE	Year to date Budget £'000	Actual £'000	Variance £'000
Surgical	(99,536)	(100,972)	(1,436)
Medical	(121,598)	(121,755)	(157)
Specialties	(129,191)	(128,098)	1,093
Operations	(19,681)	(19,034)	647
Corporate	(47,996)	(47,729)	266
Trust-wide	418,683	418,906	223
Surplus/ (Deficit)	**681**	**1,319**	**638**
Consolidated Entities	225	310	85
Surplus/ (Deficit) after consolidation	**906**	**1,629**	**723**
Other Adjustments	519	(159)	(678)
Control Total Surplus/ (Deficit)	**1,425**	**1,470**	**45**

CAPITAL	Year to date Budget £'000	Actual £'000	Variance £'000
Estates	12,725	14,217	(1,493)
IT	1,458	1,474	(16)
Medical Equipment	1,987	3,590	(1,604)
Donated Assets	783	1,588	(804)
Strategic Capital	26,159	11,428	14,731
Total	**43,111**	**32,297**	**10,814**





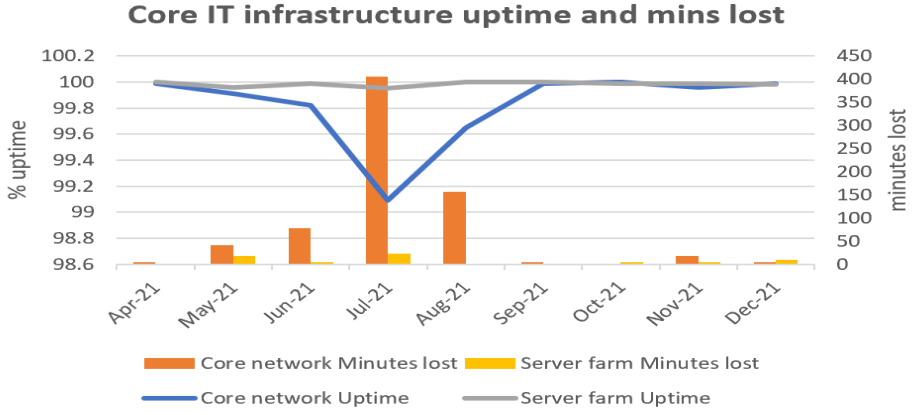


Informatics - Jan 2022

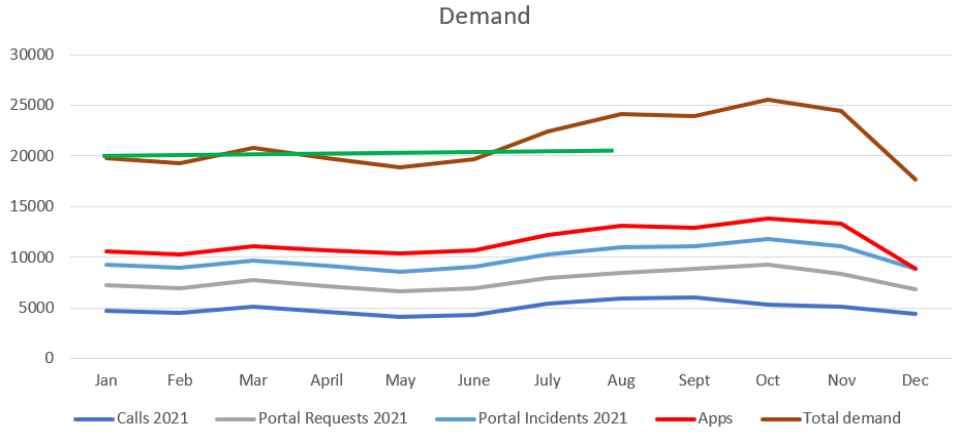
Overall Commentary: Graph 1: Sustained high performance of core infrastructure uptime**. Graph2:** understandable reduction in demand over the Christmas period. **Table 5:** Our Cyber programme has now reduced the unprotected servers to less than 2%. **Graph 6:** The steep acceleration of the number of Information Assets that are now compliant to the DSPT continues (green line)**. Graph 8:** DCR use continues to grow with more than 61,000 records accessed in Nov which was sustained in Dec (even with a shorter month). Other highlights: **Single Sign On:** Over 5700 users now live and 73 applications profiled.

Business As Usual/Service Management

Graph 1: core Infrastructure availability



Graph 2: Service Desk demand



Projects/Developments/Security/IG

Table 3: flow of Informatics projects since Nov 2018. c 150 closed projects per year.

Informatics Projects since November 2018						
Project Type	**Pending Approval**	**Not Started**	**Deferred**	**In Progress**	**Completed**	**Total**
eForm/Automation Project	2	13	15	36	173	237
Infrastructure Mandatory	0	20	0	4	5	29
Projects	1	48	18	94	271	431
Service Improvement Projects	0	0	0	0	3	3
Grand Totals	**3**	**81**	**33**	**134**	**452**	**700**

Table 4: Project Totals and Escalation

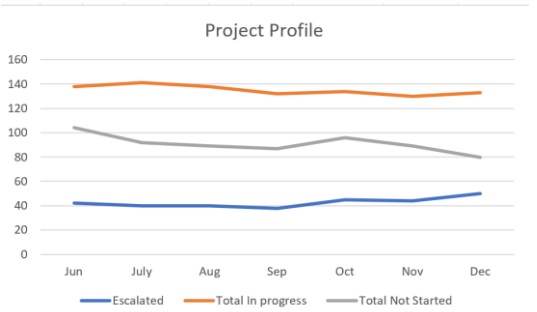


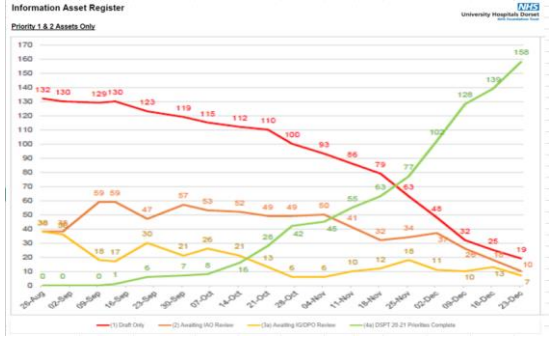
Table 5: Cyber Security - Obsolete system

	% Supported	% Obsolete	% Mitigated	% Unprotected
Windows Desktops	97.9%	2.1%	0.0%	2.1%
Windows Servers	71.0%	29.0%	27.8%	1.2%

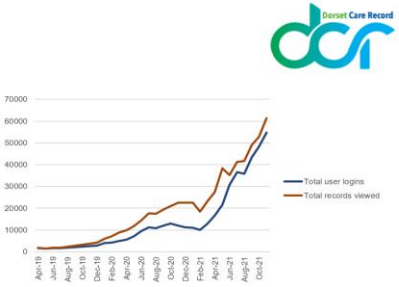
Table 7: FOI compliance

	Total rec'd	Compliance
August	50	82%
September	39	87%
October	36	64%
November	50	72%

Graph 6: Information Assets



Graph 8: DCR growth



University Hospitals Dorset
NHS Foundation Trust

COUNCIL OF GOERNORS PART 1 – COVER SHEET

Meeting Date: 27 January 2022

Agenda item: 4.4

Subject:	2021/22 External Audit Plan

Prepared by:	Rob Andrews
Presented by:	Jon Brown

Purpose of paper:	The paper is for noting.
Background:	Audit Plan The Audit plan sets out the significant risks and audit approach for the 2021/22 audit, including the approach to new value for money regime.
Key points for members:	
Options and decisions required:	N/A
Recommendations:	N/A
Next steps:	N/A

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	N/A
BAF/Corporate Risk Register: (if applicable)	N/A
CQC Reference:	N/A

Committees/Meetings at which the paper has been submitted:	**Date**
Audit Committee	20/01/2022

KPMG

Audit Plan 2021/22

University Hospitals Dorset NHS Foundation Trust

20 January 2022

rob.andrews@kpmg.co.uk

Contents	Page

Introduction

To the Audit Committee of University Hospitals Dorset NHS Foundation Trust

We are pleased to have the opportunity to meet with you on 20 January 2022 to discuss our audit of the consolidated financial statements of University Hospitals Dorset NHS Foundation Trust ('the Trust'), as at and for the year ending 31 March 2022.

This report outlines our risk assessment and planned audit approach. At page 19 we include our enhanced VFM risk assessment as required by the Code of Audit practice, we have not identified any significant risks that there are significant weaknesses in your arrangements.

As a large Foundation Trust with revenues over £500m, the Trust audit is within the scope of potential review of the FRC's Audit Quality Review team. This triggers additional an increased level of audit response at KPMG and this additional work has been reflected in our audit fee on page 25.

We provide this report to you in advance of the meeting to allow you sufficient time to consider the key matters and formulate your questions.

The engagement team

Jonathan Brown is the engagement partner on the audit and has over 20 years of public sector audit experience. This is Jon's second year working on your audit.

Rob Andrews and Mohini Katoch will be the managers responsible for the audit and will be responsible for overseeing the delivery of our audit.

Other key members of the engagement team include Nimish Aggarwal who will be the in-charge for the audit and coordinate our on site fieldwork.

Yours sincerely,

Jonathan Brown

How we deliver audit quality

Audit quality is at the core of everything we do at KPMG and we believe that it is not just about reaching the right opinion, but how we reach that opinion that is also important.

We define 'audit quality' as being the outcome when audits are:

- **Executed consistently**, in line with the requirements and intent of **applicable professional standards** within a strong **system of quality controls**; and
- All of our related activities are undertaken in an environment of the utmost level of **objectivity**, **independence**, **ethics** and **integrity**.

Restrictions on distribution

This report is intended solely for the information of those charged with governance of University Hospitals Dorset NHS Foundation Trust and the report is provided on the basis that it should not be distributed to other parties; that it will not be quoted or referred to, in whole or in part, without our prior written consent; and that we accept no responsibility to any third party in relation to it.

Our audit

Focusing our audit on your risks

We have commenced our audit planning and identified the following risks that we will focus on:

Risk	Risk change	
Financial Statements		
Valuation of land and buildings	● Stable	Page 9
Expenditure recognition	● Stable	Page 10
Management override of control	● Stable	Page 11
Other Audit Risks		
IFRS 16 transition	▲ Increased	Page 12

Professional standards require us to make a rebuttable presumption that the fraud risk from revenue recognition is a significant risk, we have rebutted this risk for Trust this year, please see page 13 for details.

Scope

Materiality
£15.5m

Page 5

Reporting threshold
£300k

Page 5

Value for money commentary

We are required to provide a public commentary on the arrangements in place for ensuring value for money is achieved at the Trust and do this via our Auditor's Annual Report. This is required to be published on the Trust's website and include a commentary on our view of the appropriateness of the Trust's arrangements against each of the three specified domains of value for money: financial sustainability; governance; and improving economy, efficiency and effectiveness.

We have set out the methodology to be followed in undertaking our risk assessment procedures on page 17-20 and will provide a copy of our risk assessment to the next Audit Committee.

Materiality (Group and Trust)

15.5m
Materiality

Total group revenue

£693m

(2020/21: £318m)

Total trust revenue

£690m

(2020/21: £316m)

Group materiality

£15.5m

2.25% of revenue

(2020/21: £4.7m, 1.5% of revenue)

Trust materiality

£15.4m

(2020/21: £4.7m, 1.5% of revenue)

£300k (Group and Trust)

Misstatements reported to the Audit Committee (2020/21: £235k)

Group: £11.6m
Trust: £11.5m

Procedure designed to detect individual errors at this level (2020/21: £3.5m)

£15.5m
£15.4m

Materiality for the financial statements as a whole (2020/21: £4.7m)

Our materiality levels

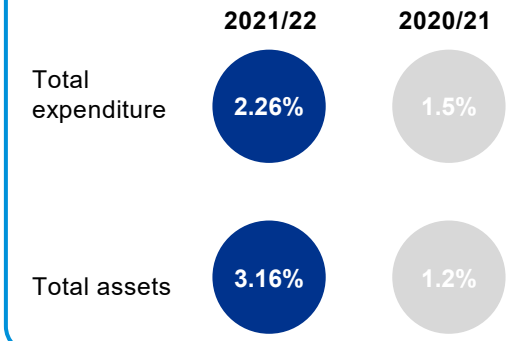
Please note, the prior year Trust was a 6 month period, so the revenue and associated materiality levels were much reduced compared to a full period.

We determined materiality for the Trust's financial statements at a level which could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements. We used a benchmark of revenue which we consider to be appropriate as it reflects the scale of the Trust's services and we consider this most clearly reflects the interests of usersof the Trust's accounts. We assessed the underlying risk indicators, such as industry, operations, size, profile and history of issues, and have set our materiality level at 2.25%, which is within our 1-3% range for unlisted entities. The previous years was capped at 1.5% due to higher risk from first year of integration.

To respond to aggregation risk from individually immaterial misstatements, we design our procedures to detect misstatements at a lower level of materiality set at £11.6m. We also adjust this level further downwards for items that may be of specific interest to users for qualitative reasons, such as directors' remuneration and losses and special payments.

Please note, the reporting threshold is capped at £300k, which is our reporting threshold to the DHSC Group Auditor, the NAO.

Group materiality vs other metrics



Covid-19 - audit implications

Scepticism Challenge

The table below identifies the specific areas of our audit that are expected to be affected by the COVID-19 pandemic, and how our audit differs from the prior year. We will continue to update this risk assessment throughout the year as the pandemic and the government response continues to evolve. We will provide updates to the Committee should it become necessary to amend our risk assessment.

Planned scope and timing Page 16	– As a result of Covid-19 the changes to the funding arrangements have been extended for the 2021/22 financial year. For H1 (April to September 2021) NHS providers were provided with funding via system allocations based on the 2020/21 CCG outturns adjusted for known pressures and efficiency assumptions, with block funding arrangements between providers and key commissioners. For H2 (October 2021 to March 2022) these arrangements were extended, with additional efficiency assumptions added into the guidance. There continues to be the possibility of further changes to the nature and form of funding for 2021/22 at the time of developing our audit plan. We will consider the impact of the funding arrangements as part of our value for money conclusion. – As part of this the Trust needs to deliver a budgeted position as part of the Dorset Integrated Care System (ICS) position. For 2021/22 control totals have been set at an ICS level and so there may be additional pressures or incentives for management to manage its financial performance to support the ICS in achieving its overall control total position. We will understand the forecast position of the ICS and consider any funding changes made during the year to consider whether there is additional risk associated with these.
Materiality Page 5	– We have not considered it necessary to revise our materiality approach in order to normalise the level of funding. We have however revised our benchmark up from last year when a lower value was selected for the first year as a merged Trust.
Estimates Page 14	– As with last year there may be additional indicators of possible impairment of the Trust's fixed assets as a result of Covid-19, for example if capital spend was incurred to provide additional capacity that is not anticipated to be fully utilised going forwards. Similarly, Covid-19 may mean that the Trust should reassess the assumptions made in determining the design of a modern equivalent asset for specialised assets, for example in response to enhanced infection control expectations. This may be offset by increasing build and labour costs in the construction market, used within valuations. – We will evaluate the methods, assumptions and data used to derive the estimates for Land and Buildings Valuation to obtain evidence that they are appropriate in the context of the financial reporting framework and are, when appropriate, based on conditions and events at the measurement date. We will consider whether management has appropriately addressed the increased estimation uncertainty when setting the estimate. – We will evaluate whether sufficient disclosure has been provided of the sources of estimation uncertainty and how estimates have been set within the Trust's accounting policies.
Obtaining sufficient appropriate audit evidence	– We anticipate that a significant part of our fieldwork will continue to be undertaken remotely for our 2021/22 audit, We will apply the lessons learned from the remote delivery of our 2020/21 audit to help ensure that this is delivered as smoothly as possible. As with the 2020/21 audit we may need additional time from management to ensure we are able to collect sufficient and appropriate audit evidence to support our opinion or may need to design alternative procedures if audit evidence cannot be accessed remotely.

Significant risks and other areas of audit focus

Risk-based

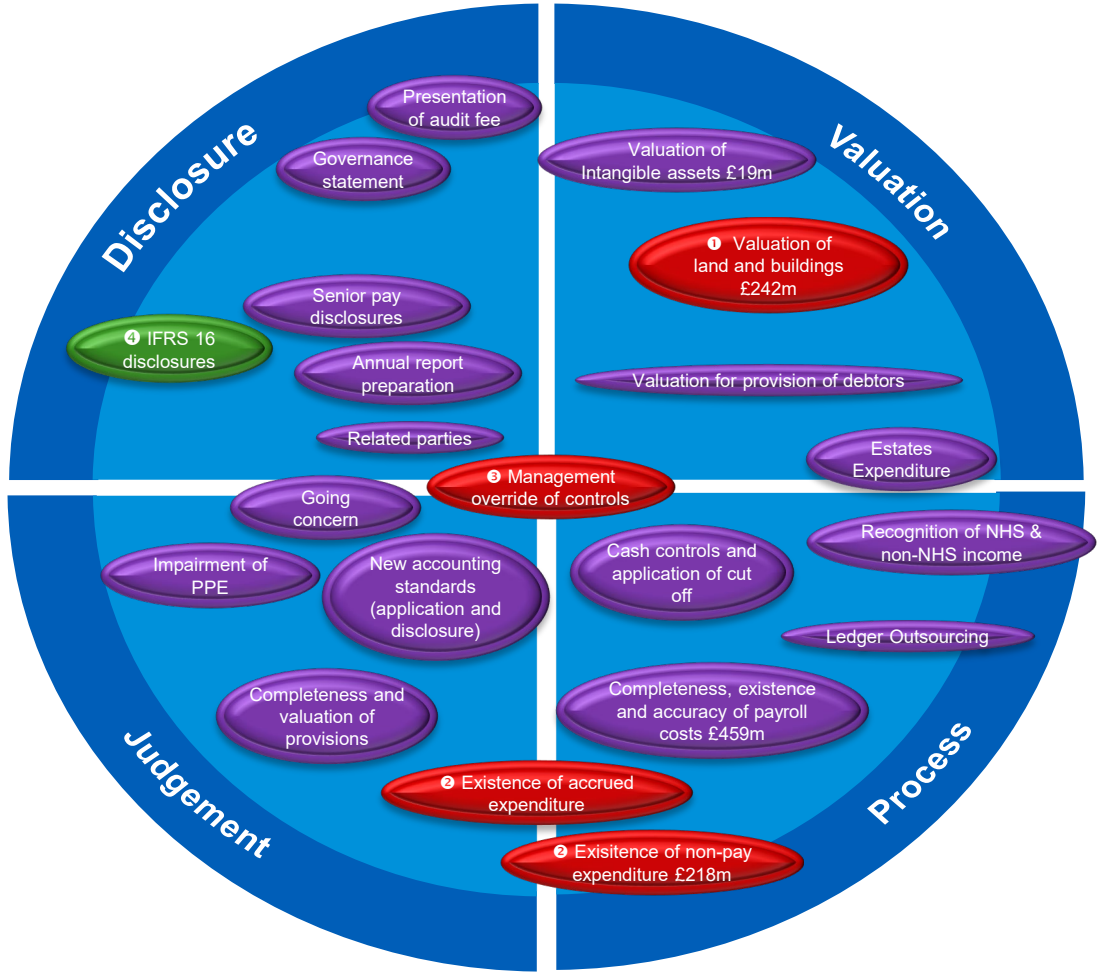
Our risk assessment draws upon our historic knowledge of the business, the industry and the wider economic environment in which University Hospitals Dorset NHS Foundation Trust operates.

We also use our regular meetings with senior management to update our understanding and take input from review of your Board papers and internal audit reports.

The risk map records those significant opinion risk and other audit risks (and where appropriate the balance included for these within your prior year financial statements).

Audit risk key:

- Significant risks
- Other audit risk
- Other audit area



Significant risks and other areas of audit focus

Understanding

Our risk assessment draws upon our historical knowledge of the Trust, the sector and the wider economic environment in which the Trust operates.

We also use our regular meetings with senior management to update our understanding and take input from local audit teams and internal audit reports.

Audit Risk

H	Higher
M	Moderate
L	Low

Year on year movement

▲	Increased
◄►	Same
▼	Decreased
↗	New

Relevant factors affecting our risk assessment

Significant risks		Size	Complexity	External scrutiny	Susceptibility to fraud/error
1	Valuation of land and buildings	H ◄►	H ◄►	M ◄►	H ◄►
2	Fraud risk from expenditure recognition	H ◄►	M ◄►	M ◄►	H ◄►
4	Management override of controls	H ◄►	M ◄►	H ◄►	H ◄►
Other audit risk					
4	IFRS 16 transition	L ↗	M ↗	M ↗	M ↗

The above risks represent risks applicable to the Trust and the Group audit. Please see page 15 for risks on the Charity audit.

Audit risks and our audit approach

Scepticism Challenge

Valuation of land and buildings

Significant audit risk

The risk

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 value of the Trust's land and buildings at 31 March 2021 was £243m, of which £240m are valued as specialised assets at depreciated replacement cost. The trust also has significant buildings works currently underway which may need to be considered depending on completion date.

The Trust is due to undertake a desktop revaluation of its land and buildings up to 31 March 2022.

Both the predecessor entities had undergone a full revaluation of its land and buildings in 2020 and the specialised assets were valued at depreciated replacement cost.

Planned response

We will perform the following procedures designed to specifically address the significant risk associated with the valuation:

- We will critically assess the independence, objectivity and expertise of Cushman & Wakefield, the valuers used in developing the valuation of the Trust's properties at 31 March 2022;
- We will inspect the instructions issued to the valuers for the valuation of land and buildings to verify they are appropriate to produce a valuation consistent with the requirements of the Group Accounting Manual;
- We will compare the accuracy of the data provided to the valuers for the development of the valuation to underlying information, such as floor plans, and to previous valuations, challenging management where variances are identified;
- We will critically assess the design and implementation of controls in place for management to review the valuation and the appropriateness of assumptions used;
- We will consider the carrying value of the land and buildings; including any material movements from the previous revaluations. We will challenge key assumptions within the valuation, including the use of relevant indices and any changes to the underlying assumptions on the modern equivalent asset, as part of our judgement;
- We will review how the buildings under construction have been considered for the Land & Buildings valuation, depending on status;
- We will perform inquiries of the valuers in order to verify the methodology that was used in preparing the valuation and whether it was consistent with the requirements of the RICS Red Book and the GAM;
- We will agree the calculations performed of the movements in value of land and buildings and verify that these have been accurately accounted for in line with the requirements of the GAM; and
- We will read and evaluate, by reference to the GAM, the adequacy of the disclosures concerning the key judgements and degree of estimation involved in arriving at the valuation.

Audit risks and our audit approach

Fraud risk from expenditure recognition - Existence

Significant audit risk

The risk

As the Trust is expected to deliver it's budgeted financial position as part of the system control total, there is a risk that non-pay expenditure, excluding depreciation, may be manipulated in order to meet that position.

The nature of funding in the Dorset system is such that the Trust is currently forecasting to meet its budgeted position, with the potential for additional funding later in the year. This can create an incentive or opportunity for management to overstate the level of current year expenditure for the benefit of future financial performance.

We consider this would be most likely occur through overstating accruals and expenditure around the period end, rather than being a risk throughout the period, for example to bring forward expenditure from 2022-23 to mitigate future financial pressures.

Due to the uncertain nature of NHS funding for the year and for 2022-23 we will need to keep this area of the audit under close scrutiny.

Planned response

We will perform the following procedures in order to respond to the significant risk identified:

- We will assess the design and implementation and operating effectiveness of process level controls for the purchase ordering of goods and services and the accrual of information at the end of the year based on those that have been receipted;
- We will assess the design and implementation of controls for developing manual expenditure accruals at the end of the year to verify that they have been completely and accurately recorded;
- We will inspect a sample of expenditure invoices and cash payments, in the period prior to and following 31 March 2022, to determine whether expenditure has been recognised in the correct accounting period;
- We will select a sample of year end accruals and inspect evidence to support the value of the accrual made, for example the actual amount paid after year end in order to assess whether the accrual exists and has been accurately recorded.
- We will inspect journals posted as part of the year end close procedures that increase the level of expenditure recorded in order to critically assess whether there was an appropriate basis for posting the journal and the value can be agreed to supporting evidence; and
- We will also compare the items that were accrued and provided for as at 31 March 2021 to those accrued and provided for at 31 March 2022 in order to assess whether any additional items of expenditure accrued have been not been accrued at 31 March 2021, or accrued at a significantly higher value without supporting evidence.
-

Audit risks and our audit approach

Scepticism Challenge

Management override of controls

Significant audit risk

The risk

Professional standards require us to communicate the fraud risk from management override of controls as significant.

Management is in a unique position to perpetrate fraud because of their ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively.

We have not identified any specific additional risks of management override relating to this audit.

Planned response

Our audit methodology incorporates the risk of management override as a default significant risk. In line with our methodology, we will test the operating effectiveness of controls over journal entries and post closing adjustments.

- We will assess the design and implementation of the controls in place for the approval of manual journals posted to the general ledger to ensure that they are appropriate.
- We will analyse all journals through the year and focus our testing on those with a higher risk, such as journals impacting revenue or expenditure recognition.
- We will assess the appropriateness of changes compared to the prior year to the methods and underlying assumptions used to prepare accounting estimates.
- We will review the appropriateness of the accounting for significant transactions that are outside the Trust's normal course of business, or are otherwise unusual.
- We will assess the controls in place for the identification of related party relationships and test the completeness of the related parties identified. We will verify that these have been appropriately disclosed within the financial statements.

Audit risks and our audit approach

Scepticism Challenge

IFRS 16 Implementation

Other audit risk

The delayed adoption of IFRS16 has been confirmed as taking place from 1 April 2022. Whilst full implementation will not be required in the 2021/22 financial statements the impact of the new standard will be required to be reported as per IAS 8 in a note to the financial statements. Due to the complexity of this standard there is a risk that this disclosure is not correctly prepared.

The main source of this risk is that lease terms and lease payments are inappropriately determined. This is a particular risk for arrangements which are not subject to a formal contract such as property agreements with NHS Property Services without an agreed contract or term.

Other risks include that the discount rate used to measure the lease liability is inappropriately determined or that a lease liability is not appropriately remeasured when reassessment is required.

Linked to the above there is a potential risk that lease payments are not completely and accurately recorded, are not recorded in the correct accounting period or have not occurred.

Planned response

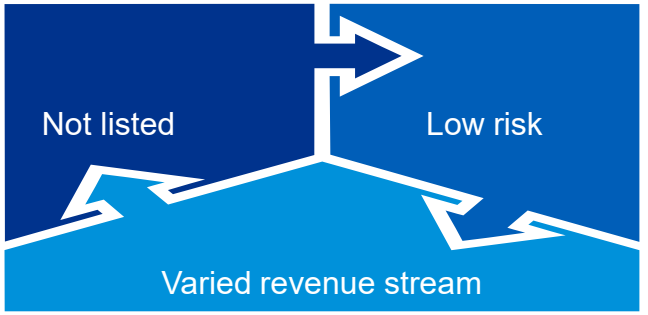
- We will evaluate the Trust's process for reviewing current arrangements and contracts to ascertain whether there is a lease falling within the remit of the standard;
- We will test the completeness and accuracy of the data collected by the Trust and used as part of the preparation of the disclosure note;
- We will critically assess the key decisions made about material contracts such as property leases;
- We will review the discount rate used in the calculation of the lease liability and confirm that the rate used is either the HM Treasury rate as per the GAM or the rate implicit within the lease payments for that specific arrangement;
- We will reperform the calculation of the lease liability and right of use asset for a sample of leases;
- We will critically assess the disclosure proposed for compliance with the requirements of the GAM.

Audit standards driven risks

Scepticism Challenge

Professional standards require us to make a rebuttable presumption that the fraud risk from revenue recognition is a significant risk.

The majority of the Trusts revenue is through block contract arrangements with the commissioner where there is limited opportunity to fraudulently misstate misstate revenue due to simple recognition criteria. The revenue outside of the block contract is low value, high volume and deemed limited incentive to manipulate, therefore, we have rebutted the presumed revenue risk.



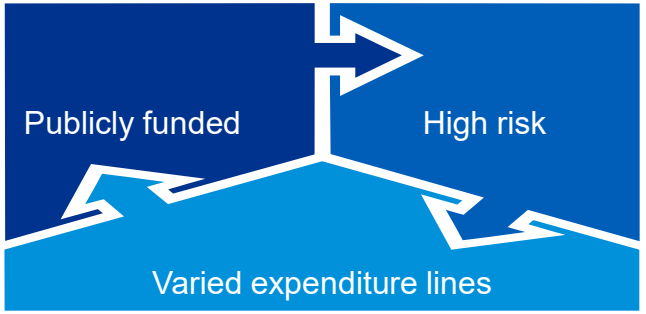
Professional standards require us include a risk that management have overridden controls.

For every external audit, the auditors are required to include a risk that presumes management have overridden controls. We have included this risk within our work, outlined on page 11.

Required in every audit – no judgement applied.

Practice Note 10 suggests that auditors should consider a rebuttable presumption that there is a fraud risk associated with expenditure recognition.

We have highlighted within our audit risk assessment our focus on your key items of expenditure (non-payroll costs), see page 10. We will report on our work completed on these as part of our final report to the Audit Committee.



Other significant matters relating to our audit approach

Scepticism Challenge

Disclosure of significant estimates and judgements

We have included here the disclosures of significant estimates and judgements from the prior year annual report and our assessment of the level of optimism included within the valuation as well as our assessment of the quality of disclosure made about the estimation uncertainty within the estimate:

Estimates and judgements	Balance £m	Assessment of balance	Assessment of disclosure	Further comments
Valuation of land and buildings (estimate)	242	Cautious / Neutral / Optimistic	Needs improvement / Neutral / Best practice	We will consider the appropriateness of the valuation of land and buildings. The previous year the Trust completed a desktop valuation and is planning to do so again. The estimate was deemed to be neutral in 2021 Our work will focus on the fair value this year, and any decisions made over the booking of market movements to the book value. KPMG found this to be a balanced valuation in the previous year and appropriate.

Subsidiary audits

No surprises Dialogue

Entity	Reporting framework	Materiality	Significant risks
University Hospitals Dorset NHS Charity *Note – we will be auditing Poole Charity for the March 2022 year end.*	We will carry out an audit of the charity pursuant to International Auditing Standards and issue an opinion in accordance with the Charities Act and Charity Commission SORP.	£75,000 (3% of £3m combined charity income at 2021 levels). We will revise this based on actual revenue.	Our audit methodology incorporates the risk of management override of controls as a default significant risk. Our methodology considers journals, unusual transactions and any estimates/judgements made by management. Professional standards require us to make a rebuttable presumption that the fraud risk from revenue recognition is a significant risk and due to the nature of the revenue we have rebutted the fraud risk associates with recognition of income. This is consistent to our treatment of the RBCH and Poole Charity audits in 2021 We have identified the following key areas of risk: • Management override of controls

Audit cycle and timetable

Timeliness

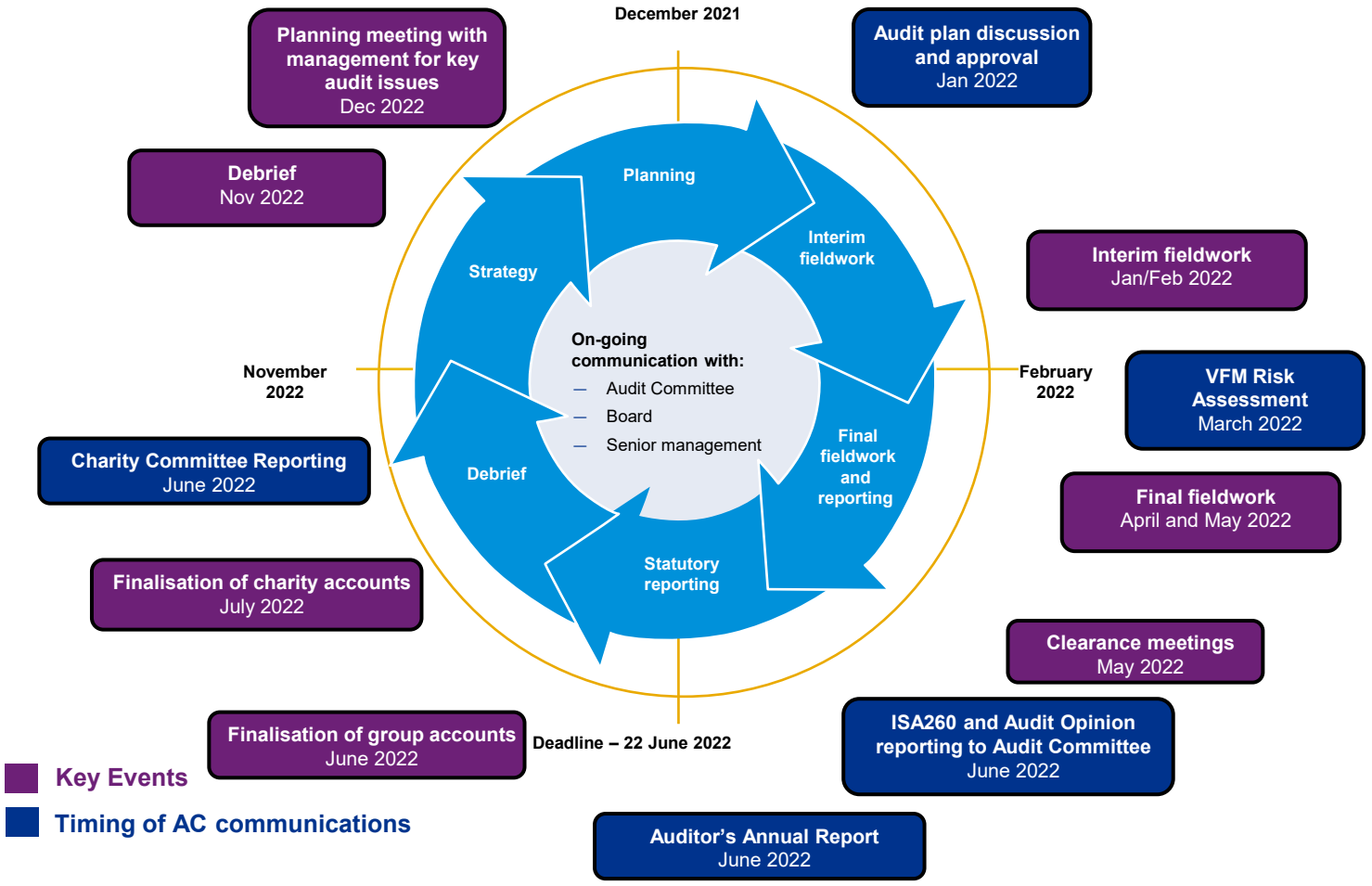
Our 2021/22 schedule

Covid-19

As we move towards a future hybrid working model we can flex our audit between onsite and remote. We have discussed with your finance team and plan to work remotely for the bulk of our work.

An increasing amount of our audit procedures are able to be performed remotely and therefore we do not anticipate that remote working will prevent us from being able to complete our audit.

There will be some areas of the audit for which we require access to audit information that may be held in hard copy. We will work with management to identify this proactively and plan for how it can be provided.



Value for money

Value for money arrangements

Scepticism Challenge

For 2021/22 our value for money reporting requirements have been uncharged and as last year follow the guidance in the Audit Code of Practice.

While our responsibility to conclude on significant weaknesses in value for money arrangements is unchanged, for 2021/22 the NAO guidance has been updated to reflect auditor feedback on the initial year of the new approach.

The main output remains a narrative on each of the three domains, summarising the work performed, any significant weaknesses and any recommendations for improvement.

We have set out the key methodology and reporting requirements on this slide and provided an overview of the process and reporting on the following page.

Risk assessment processes

Our responsibility remains to assess whether there are any significant weaknesses in the Trust's arrangements to secure value for money. Our risk assessment will continue to consider whether there are any significant risks that the Trust does not have appropriate arrangements in place.

In undertaking our risk assessment we will be required to obtain an understanding of the key processes the Trust has in place to ensure this, including financial management, risk management and partnership working arrangements. We will complete this through review of the Trust's documentation in these areas and performing inquiries of management as well as reviewing reports, such as internal audit assessments.

Reporting

As with the prior year our approach to value for money reporting aligns to the NAO guidance and includes:

- A summary of our commentary on the arrangements in place against each of the three value for money criteria, setting out our view of the arrangements in place compared to industry standards;
- A summary of any further work undertaken against identified significant risks and the findings from this work; and
- Recommendations raised as a result of any significant weaknesses identified and follow up of previous recommendations.

The Trust will be required to publish the commentary on its website at the same time as publishing its annual report online.

Value for money criteria

Financial sustainability

How the body manages its resources to ensure it can continue to deliver its services.

Governance

How the body ensures that it makes informed decisions and property manages its risks.

Improving economy, efficiency and effectiveness

How the body uses information about its costs and performance to improve the way it manages and delivers its services.

Value for money arrangements

Scepticism Challenge

Approach we take to completing our work to form and report our conclusion:

Process

Understanding the Trust's arrangements

- Financial statements planning
- Internal reports, e.g. IA
- Inquiries with mgmt
- External reports, e.g. regulators
- Assessment of key processes
- Annual report

Evaluation of Trust's value for money arrangements

- Targeted follow up of identified value for money significant risks
- Continual update of risk assessment

Value for money conclusion and reporting

- Conclusion whether significant weaknesses exist

Outputs

Risk assessment to Audit Committee

Our risk assessment will provide a summary of the procedures undertaken and our findings against each of the three value for money domains.

This will conclude on whether we have identified any significant risks that the Trust does not have appropriate arrangements in place to achieve VFM.

Value for money assessment

We will report by exception as to whether we have identified any significant weaknesses in arrangements.

Public commentary

Our draft public commentary will be prepared for the Audit Committee alongside our annual report on the accounts.

Public commentary

The commentary is required to be published alongside the annual report.

November | December | January | February | March | April | May | June | July

Value for money arrangements

Scepticism Challenge

Management will complete our self assessment questionnaire that sets out the management view of each of the key lines of enquiry

We continue to review this assessment and the supporting evidence to finalise our risk assessment.

Risk assessment

We have started our review of the Trust's policies and procedures to inform our VFM risk assessment. To assist with this, management are in progress of completing a questionnaire providing the Trust's self-assessment against a number of key areas, including:

- Financial planning;
- Financial sustainability;
- Delivery of cost improvements;
- Risk management;
- Internal control and policies;
- Budget monitoring;
- Arrangements for major decisions;
- Non-financial performance;
- Partnership working;
- Monitoring of service providers; and
- Covid-19 controls.

Once we have completed our initial review, we will identify any areas that indicate a significant risk to our VFM conclusion and carry out further work to inform our overall judgement. Our detailed risk assessment will be reported to the Committee separately in March.

Appendices

Mandatory communications

Dialogue

Management's responsibilities (and, where appropriate, those charged with governance)	Prepare financial statements in accordance with the applicable financial reporting framework that are free from material misstatement, whether due to fraud or error. Provide the auditor with access to all information relevant to the preparation of the financial statements, additional information requested and unrestricted access to persons within the entity.
Auditor's responsibilities	Our engagement letter dated 26 January 2021 communicates our responsibilities to form and express an opinion on the financial statements that have been prepared by management with the oversight of those charged with governance. The audit of the financial statements does not relieve management or those charged with governance of their responsibilities.
Auditor's responsibilities - Fraud	This report communicates how we plan to identify, assess and obtain sufficient appropriate evidence regarding the risks of material misstatement of the financial statements due to fraud and to implement appropriate responses to fraud or suspected fraud identified during the audit.
Auditor's responsibilities – Other information	Our engagement letter dated 26 January 2021 communicates our responsibilities with respect to other information in documents containing audited financial statements. We will report to you on material inconsistencies and misstatements in other information.
Auditor's responsibilities – value for money	Our value for money methodology slide on page 18 sets out our responsibilities for reporting on the Trust's arrangements for securing economy, efficiency and effectiveness. We have set out on this page the methodology that will be followed in order to reach our risk assessment, as part of which we will conclude as to whether there are any risks which may suggest a significant weakness.
Independence	Our independence confirmation on page 25 discloses matters relating to our independence and objectivity including any relationships that may bear on the firm's independence and the integrity and objectivity of the audit engagement partner and audit staff.

Appendix two

Audit team and rotation

Continuity Specialists Experience

Your audit team has been drawn from our specialist healthcare audit department and is led by key members of staff who will be supported by auditors and specialists as necessary to complete our work. We also ensure that we consider rotation of your audit partner and firm.

Jonathan Brown is the partner responsible for our audit. He will lead our audit work, attend the Audit Committee and be responsible for the opinions that we issue.

Rob Andrews is the senior manager, with shared responsibility for our audit. He will co-ordinate our audit work, attend the Audit Committee and ensure we are co-ordinated across our accounts and VFM.

Mohini Katoch is the manager with shared responsibility for our audit. She will co-ordinate our on stie audit work using her 3 years experience of the UHD and previous trust audits, working closely with the audit team and reviewing their work.

To comply with professional standard we need to ensure that you appropriately rotate your external audit partner. There are no other members of your team which we will need to consider this requirement for:

This will be Jon's 2nd year as your engagement lead. He was also the engagement partner on the audit of predecessor entities i.e. RBCH NHS FT for 4 years and Poole NHS FT for 2 years.

Appendix three

Fees

Audit fee

The table below summarises our agreed fees for the year ending 31 March 2022. The fees quoted are exclusive of VAT.

Entity	2021/22	2020/21
Poole Financial Statements *(6 months)*	-	£49,500
RBCH Financial Statements *(6 months)*	-	£50,000
UHD Financial statements *(6 months)*	£85,000	£66,000
Core audit related fees	**£85,000**	**£165,500**
Merger disclosures (one off charge)	-	£2,000
Impact of new VFM rules (recurring)	£10,000	£9,000
IFRS 16 transition (one off charge)	£5,000	-
Change of Scope – AQR (recurring)	£8,000	-
Total audit related fees	**£108,000**	**£176,500**
RBCH Charity (now UDH)	£6,000	£4,000
Poole Charity	Not required	£5,000
Group total audit fees	**£114,000**	**£185,500**

Our fee is as agreed with the Finance Director. The 2020/21 fee was slit between the 6 month periods for the previous Trusts and the first 6 months of UHD audit.

The 2021/22 fee as first full year period of £108k, which is £13k higher than originally proposed, due to the one off charge of IFRS 16 and movement of the Trust into AQR scope.

Billing arrangements

Fees will be billed in accordance with a billing schedule to be agreed with management.

Basis of fee information

In line with our standard terms and conditions the fee is based on the following assumptions:

- The Group's audit evidence files are completed to an appropriate standard (we will liaise with management separately on this);
- Draft statutory accounts are presented to us for audit subject to audit and tax adjustments;
- Supporting schedules to figures in the accounts are supplied; A trial balance together with reconciled control accounts are presented to us;
- All deadlines agreed with us are met;
- We find no weaknesses in controls that cause us to significantly extend procedures beyond those planned;
- Management will be available to us as necessary throughout the audit process; and
- There will be no changes in deadlines or reporting requirements.

We will provide a list of schedules to be prepared by management stating the due dates together with pro-formas as necessary. Our ability to deliver the services outlined to the agreed timetable and fee will depend on these schedules being available on the due dates in the agreed form and content.

If there are any variations to the above plan, we will discuss them with you and agree any additional fees before costs are incurred wherever possible.

Appendix four

Confirmation of Independence

We confirm that, in our professional judgement, KPMG LLP is independent within the meaning of regulatory and professional requirements and that the objectivity of the Partner and audit staff is not impaired.

To the Audit Committee members

Assessment of our objectivity and independence as auditor of the University Hospitals Dorset NHS Foundation Trust

Professional ethical standards require us to provide to you at the planning stage of the audit a written disclosure of relationships (including the provision of non-audit services) that bear on KPMG LLP's objectivity and independence, the threats to KPMG LLP's independence that these create, any safeguards that have been put in place and why they address such threats, together with any other information necessary to enable KPMG LLP's objectivity and independence to be assessed.

This letter is intended to comply with this requirement and facilitate a subsequent discussion with you on audit independence and addresses:

- General procedures to safeguard independence and objectivity;
- Independence and objectivity considerations relating to the provision of non-audit services; and
- Independence and objectivity considerations relating to other matters.

General procedures to safeguard independence and objectivity

KPMG LLP is committed to being and being seen to be independent. As part of our ethics and independence policies, all KPMG LLP partners and staff annually confirm their compliance with our ethics and independence policies and procedures including in particular that they have no prohibited shareholdings. Our ethics and independence policies and procedures are fully consistent with the requirements of the FRC Ethical Standard.

As a result we have underlying safeguards in place to maintain independence through:

- Instilling professional values
- Communications
- Internal accountability
- Risk management
- Independent reviews.

We are satisfied that our general procedures support our independence and objectivity.

Independence and objectivity considerations relating to the provision of non-audit services

Summary of non-audit services

Facts and matters related to the provision of non-audit services and the safeguards put in place that bear upon our independence and objectivity, are set out in the following table

Description of scope	Threats to independence	Safeguards applied	Value of service and basis of fee
None completed so far, Quality accounts assurance has been descoped.	N/a	N/a	N/a

Appendix four

Confirmation of Independence

We have considered the fees charged by us to the Trust and Charity for professional services provided by us during the reporting period. Total fees charged by us can be analysed as follows:

	2021/22 (to date)	2020/21
	£'000	£'000
Audit of Trust	108	77
Audit of charity	6	9
Total audit	**114**	**89**
Other Assurance Services	-	-
Total non-audit services	-	-
Total Fees	**114**	**185**

Fee ratio

The anticipated ratio of non-audit fees to audit fees for the year at the time of planning is 0:1.

We do not consider that the total non-audit fees create a self-interest threat since the absolute level of fees is not significant to our firm as a whole.

Contingent fees

Under the FRC's Revised Ethical Standard, no new contingent fees for non-audit or audit related services for an audited entity, its UK Trust undertaking and any worldwide controlled undertaking can be entered into after 15 March 2020. We confirm that no new contingent fees for such services have been entered into for University Hospitals Dorset since that date and that no contingent fee amounts remain outstanding from previously provided non-audit services.

Application of the FRC Ethical Standard 2019

We communicated to you previously the effect of the application of the FRC Ethical Standard 2019. That standard became effective for the first period commencing on or after 15 March 2020, except for the restrictions on non-audit and additional services that became effective immediately at that date, subject to grandfathering provisions.

We confirm that as at 15 March 2020 we were not providing any non-audit or additional services that required to be grandfathered.

Confirmation of audit independence

We confirm that as of the date of this letter, in our professional judgement, KPMG LLP is independent within the meaning of regulatory and professional requirements and the objectivity of the partner and audit staff is not impaired.

This report is intended solely for the information of the Audit and Compliance Committee and should not be used for any other purposes.

We would be very happy to discuss the matters identified above (or any other matters relating to our objectivity and independence) should you wish to do so.

Yours faithfully

KPMG LLP

Appendix five

Covid-19 financial reporting implications

Based on our understanding of your business, your financial reporting could be significantly affected by the Covid-19 pandemic in the following areas. We are committed to continuing to deliver a quality audit that adapts to respond to new and changing risks, including those outlined below. Those risks that we consider to be audit focus areas are set out on page 14.

Area	Covid-19 impact	Area	Covid-19 impact
Going concern	At the time of drafting our plan there is not yet certainty as to how funding for 2022-23 will operate. The Trust will need to complete an assessment of the continuation of the services provided by the Trust and ensure that sufficient disclosure is included within the annual report and accounting policies setting out the basis for adopting the going concern basis of preparation.	**Revenue**	Funding arrangements for 2021/22 have been amended, with block contracts agreed for the period. Contributions for additional costs incurred should be considered as revenue and accounted for gross of any additional costs.
Leases	As Covid-19 has required a reconfiguration of services and ongoing service provision will continue to be considered at a system level by the ICS this may impact on the Trust's leases. As the Trust begins to prepare for IFRS 16 it will need to consider whether this impacts on the lives of its leases and the future commitments.	**Asset values**	There remains a high degree of uncertainty associated with the valuation of land and buildings following the lockdown restrictions implemented. These could lead to significant changes in the valuation of the Trust's estate at 31 March 2022. Revised operating processes within the Trust's sites as a result of Covid-19 may require the Trust to re-assess assumptions that it has made in developing the modern equivalent asset valuation for the site. Where capital investments were made to support and enhance services during Covid-19 this may require impairment if it is not anticipated that it will be utilised for long term service provision.
Valuation of receivables	Where Trusts have significant non-NHS receivable balances, such as local authorities, there may be an increased risk relating to the recoverability of receivable balances.	**Certain disclosures**	Will need more detail and be more complex to prepare, particularly those relating to significant judgements and sources of estimation uncertainty – e.g. impairment, expected credit losses, asset fair values, financial instruments and going concern.

Appendix six

Responsibility in relation to fraud

We are required to consider fraud and the impact that this has on our audit approach. We will update our risk assessment throughout the audit process and adapt our approach accordingly.

Management responsibilities	KPMG's identification of fraud risk factors	KPMG's response to identified fraud risk factors	KPMG's identified fraud risk factors
Adopt sound accounting policies. With oversight from those charged with governance, establish and maintain internal control, including controls to prevent, deter and detect fraud. Establish proper tone/culture/ethics. Require periodic confirmation by employees of their responsibilities. Take appropriate action in response to actual, suspected or alleged fraud. Disclose to Audit Committee and auditors: — Any significant deficiencies in internal controls; and — Any fraud involving those with a significant role in internal controls	Review of accounting policies. Results of analytical procedures. Procedures to identify fraud risk factors. Discussion amongst engagement personnel. Enquiries of management, Audit Committee, and others. Evaluate broad programmes and controls that prevent, deter, and detect fraud.	Accounting policy assessment. Evaluate design of mitigating controls. Test effectiveness of controls. Address management override of controls. Perform substantive audit procedures. Evaluate all audit evidence. Communicate to Audit Committee and management.	Whilst we consider the risk of fraud to be low around University Hospitals Dorset and its associated entities, we will monitor the following areas throughout the year and adapt our audit approach accordingly. — Revenue recognition; — Purchasing; — Management override of controls; and — Manipulation of results to achieve targets and expectations of stakeholders.

Appendix seven

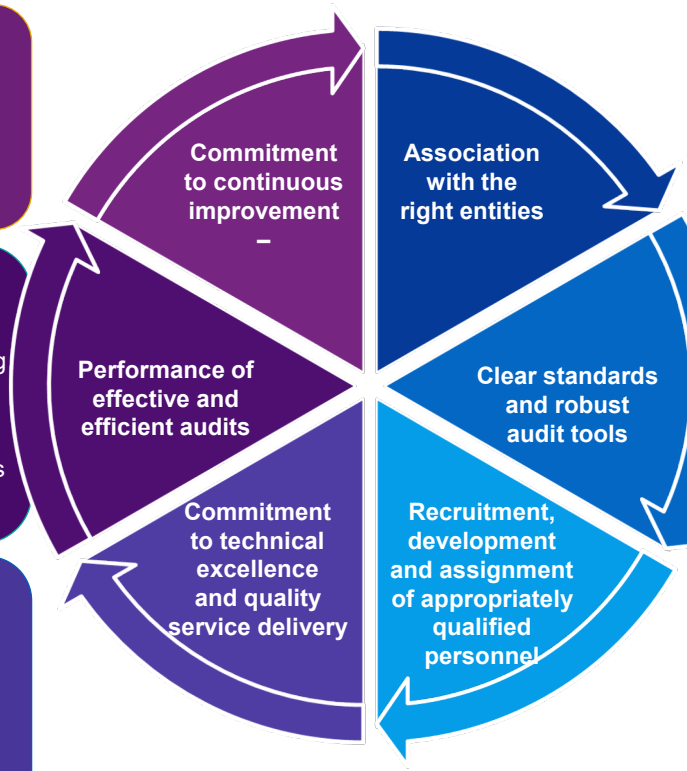
KPMG's Audit Quality

Audit quality is at the core of everything we do at KPMG and we believe that it is not just about reaching the right opinion, but how we reach that opinion. To ensure that every partner and employee concentrates on the fundamental skills and behaviours required to deliver an appropriate and independent opinion, we have developed our global Audit Quality Framework

- Comprehensive effective monitoring processes
- Significant investment in technology to achieve consistency and enhance audits
- Obtain feedback from key stakeholders
- Evaluate and appropriately respond to feedback and findings

- Professional judgement and scepticism
- Direction, supervision and review
- Ongoing mentoring and on the job coaching, including the second line of defence model
- Critical assessment of audit evidence
- Appropriately supported and documented conclusions
- Insightful, open and honest two way communications

- Technical training and support
- Accreditation and licensing
- Access to specialist networks
- Consultation processes
- Business understanding and industry knowledge
- Capacity to deliver valued insights



- Select clients within risk tolerance
- Manage audit responses to risk
- Robust client and engagement acceptance and continuance processes
- Client portfolio management

- KPMG Audit and Risk Management Manuals
- Audit technology tools, templates and guidance
- KPMG Clara incorporating monitoring capabilities at engagement level
- Independence policies

- Recruitment, promotion, retention
- Development of core competencies, skills and personal qualities
- Recognition and reward for quality work
- Capacity and resource management
- Assignment of team members and specialists

Appendix eight

KPMG Clara workflow implementation

How will your audit experience change?

At KPMG, we know that the business landscape is continually changing - with new markets and business models, technological developments, and increasingly more complex regulatory requirements. KPMG is committed to being at the forefront of change, helping to lead the future of the audit, both in the UK and globally. In particular, we have a focus on driving audit quality.

In response to this continual change, we have refreshed the KPMG audit methodology alongside the development of the KPMG Clara workflow, which is the single biggest software deployment in the history of our firm. This new automated workflow uses cutting edge technology enabling us to further enhance audit quality and bring global consistency to all KPMG audits.

KCw sits on our KPMG Clara smart audit platform alongside other audit technology solutions, including powerful data analytics to analyse transactions, predictive analytics to help us challenge areas of judgement and estimation, bots to audit your bots and AI capabilities to read documents.

The transition to KCw is internal to KPMG and will have minimal impact on both the Audit Committee and the LLP, however, the change will facilitate technological development of our audits in the future. We have noted below the key differences you will see through the audit process as a result of the change in our methodology and workflow.

Risk assessment

The refreshed approach to risk assessment will provide our engagement team with a **deeper understanding of your business and related risks, driving more precise, risk-based audit procedures**.

Timing

This increased focus on risk assessment means we can **bring forward** some of our audit procedures – and avoid your busiest time. As such, you may see **changes in the timing** of our audit procedures.

Information requests

There may be increased use of **data analytics and related technologies.** We may therefore ask for more and different kinds of data than we have in the past. We will continue to work collaboratively with your finance and IT personnel to safely and securely extract and transfer data.

Controls reliance

There may be more **controls testing** as there is a clearer link between effective controls and the tailored substantive testing that is undertaken.

Consistency

There will be a **higher degree of prescription** and **more direction** around which procedures should

be performed, which will help drive **more consistent audits** across the UK and around the world.

The refreshed methodology will **reduce optionality** and allow the audit team to **focus on higher judgmental matters**.

Sample sizes

There may be changes in **sample sizes** across different procedures. A more targeted control response may allow us to **reduce sample sizes** in substantive testing **if controls are operating effectively**.

University Hospitals Dorset
NHS Foundation Trust

COUNCIL OF GOVERNORS PART 1 – COVER SHEET

Meeting Date: 27 January 2022

Agenda item: 4.5

Subject:	UHD FT Board Assurance Framework (BAF)

Prepared by:	Joanne Sims, Associate Director Quality, Governance and Risk
Presented by:	Paula Shobbrook, Chief Nursing Officer

Purpose of paper:	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.
Background:	The 2021/22 BAF for UHD was presented to the Board of Directors and approved at its meeting in June 2021. In accordance with the UHD FT Risk Management Strategy the Board Assurance Framework for UHD FT will be reviewed quarterly at the Audit Committee and Quality Committee and 6 monthly by the Board of Directors This report provides the end of Q2 2021/22 position of the Board Assurance Framework for UHD FT.
Key points for members:	For information
Options and decisions required:	For information
Recommendations:	For information
Next steps:	

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	All
BAF/Corporate Risk Register: (if applicable)	BAF
CQC Reference:	Well Led

Principle objective	Specific Objective	Executive Director Lead	Risk Lead	Risk Register Ref	Risk Title / Description	Q1 Risk Rating	Q2 Risk Rating	Last Update	Monitoring Group	Target Risk Rating	
To be a great place to work, by creating a positive and open and inclusive culture, and supporting and developing staff across the Trust, so that they are able to realise their potential and give of their best.	1.1 To To engage with staff at all levels to ensure we maintain focus and realise the Health, Wellbeing and Covid-recovery needs and priorities of all our people, investing in appropriate provision of holistic interventions and resources.	Chief People Officer (KA)	Carla Jones Deputy Director of Workforce & Organisational Development, Deborah Matthews Director of Improvement and OD	1493	Absence, Burnout and PTSD - Risk of medium and long-term impact of Covid 19 on the health and wellbeing of the workforce due to burnout and PTSD which may potentially lead to high levels of sickness absence and the requirement for significant sustained support	S(4) x L (3) = 12 Moderate Risk	S(4) x L (3) = 12 Moderate Risk	[08/11/2021] Demand for Occupational Health services remains high and staff continue to experience increased waiting times for OH Nurse appointments, impacting on the length of time some staff remain absent from work as they await OH Nurse input to support them in their return. A service review has been undertaken and a business case to uplift the OH nursing and consultant establishment is progressing through the authorisation process. The Wellbeing service continues to work within capacity providing 1:1 psychological support and counselling. However, longer waiting times are now being experienced for Steps2Wellbeing. This is impacting on staff who are unable to work and awaiting specialist 1:1 therapy (for mental health disorders such as PTSD) and resulting in some staff going off sick and being off sick for longer time periods as they are unable to continue without the needed therapy/support. These waiting times are likely to increase if winter pressures impact more on staff mental health. Collaborative and innovative solutions are required and we are working with the ICS, Steps2Wellbeing and partner providers to address these delays. All other mitigations continue.	• Workforce Strategy Committee	S(2) x L(2) = 4 Low Risk	
	1.4 To deliver the trust's People Strategy by developing effective and responsive People services, policies and practices for each stage of the employee cycle. This will include workforce planning, recruitment and retention, training and education, employee relations, temporary workforce and workforce systems.	Chief People Officer (KA)	Carla Jones Deputy Director of Workforce & Organisational Development, Louise Hamilton-Welsh, Head of HR Strategy	1492	Resourcing Pressures - Staffing. Risk of significant resourcing pressures in the remainder of the Covid 19 pandemic and recovery period due to limited number of trained front line staff, likely increase in turnover as soon as the pandemic eases and limited pipeline of new recruits which is also impacted by the uncertainty around retaining EU employees and continuing to recruit from the EU.	S(4) x L (3) = 12 Moderate Risk	S(4) x L (3) = 12 Moderate Risk	[08/11/2021] Detailed vacancy data derived from cleansed ESR and budgeted establishment sources will shortly be available at ward level which will help to improve the overview. In addition to normal contact points, we have introduced a regular meeting with clinical leads to flag and escalate any operational resourcing issues. Recruitment activity remains very high with no signs of the challenging market conditions improving at this stage and we continue to be creative in our approach, for example all of the Medical Support Workers through the Myanmar Refugee programme have now commenced work. Demand for consultant recruitment continues to be high.[	• Workforce Strategy Committee	S(2) x L(2) = 4 Low Risk	
To ensure that all resources are used efficiently to establish financially and environmentally sustainable services and deliver key operational standards and targets.	2.1 Agree and deliver a sustainable budget, including Cost Improvement Programme (CIP) and merger savings programme	Chief Finance Officer (PP)	Peter Papworth	1584	Financial Control Total 2021/22 - Trust at risk of failing to achieve the required break-even outturn position, resulting in a revenue deficit and an unplanned reduction in cash available to support the capital programme	S(4) x L (3) = 12 Moderate Risk	S(4) x L (3) = 12 Moderate Risk	[05/11/2021] The Finance & Performance Committee reviewed the risk and agreed for the risk to remain the same. It was noted that the risk may be increased due to the challenges surrounding the H2 allocation.	• Finance and Performance Committee	S(3) x L(2) = 6 Low Risk	
		Chief Finance Officer (PP)	Peter Papworth	1585	ICS Financial Control Total 2021/22 - ICS at risk of failing to achieve the required break-even outturn position, resulting in a revenue deficit and an unplanned reduction in cash available to support the capital programme	S(4) x L (3) = 12 Moderate Risk	S(4) x L (3) = 12 Moderate Risk	[05/11/2021] The Finance & Performance Committee reviewed the risk and agreed for the risk to remain the same. It was noted that the risk may be increased due to the challenges surrounding the H2 allocation.	• Finance and Performance Committee	S(3) x L(2) = 6 Low Risk	

		Chief Finance Officer (PP)	Peter Papworth	1594	Capital Programme Affordability (CDEL) - Risk that the agreed capital programme will not be affordable within the ICS capital allocation (CDEL) resulting in operational and quality/safety risks and a delay in the reconfiguration critical path.	S(4) x L (3) = 12 Moderate Risk	S(4) x L (3) = 12 Moderate Risk	[05/11/2021] The Finance & Performance Committee reviewed the risk and agreed for the risk to remain the same.	• Finance and Performance Committee	S(3) x L(2) = 6 Low Risk	
		Chief Finance Officer (PP)	Peter Papworth	1595	Medium Term Financial Sustainability -Risk that the Trust will fail to deliver a financial break-even position resulting in regulatory intervention, an unplanned reduction in cash and the inability to afford the agreed 6 year capital programme.	S(4) x L4)=16 High Risk	S(4) x L4)=16 High Risk	[05/11/2021] The Finance & Performance Committee reviewed the risk and agreed for the risk to remain the same.	• Finance and Performance Committee	S(3) x L(2) = 6 Low Risk	
	2.2 To deliver a Covid restoration programme that returns waiting times and waiting patient numbers towards the national standards, for elective, cancer, diagnostics and emergency care	Chief Nursing Officer (PS)	Paul Bolton	1383	Given the nature of the novel coronavirus, there is a risk that patients and/or staff could contract hospital acquired covid-19 infection as a result of inadequate or insufficient infection prevention and control processes and procedures, which may not be known due to evidence base available at the time of the pandemic	S(4) x L (2) = 8 Moderate Risk	S(4) x L (2) = 8 Moderate Risk	[14/10/2021] Update by Deputy CNO MH: This risk remains there continues to be community transmission of Covid-19 and significant changes to the controls within the community i.e. optional mask wearing. UHD Guidance on facemasks for all in hospitals settings remain as does social distancing. Risks assessments reviewed for high risk ward areas and reviewed by Matrons and Ventilation group. Co2 Monitoring increased. Updates in staff risk assessments. The organisation continues to have its controls (as listed) in place and oversight i.e. IPC Cell, IPC group and attendance at Dorset Wide IPC ICS cell and review of BAF. Covid1-19 booster programme has also started within UHD in Oct 2021. Fit testing task and finish group reviewing process/policy. Outbreak PIR learning and action plan in place. Outbreak process in place and learning shared. Regular communication on IPC & regular review of epicell data Continued monitoring and oversight by Head of IPC	Quality Committee, Infection prevention and control group	S(4) x L (2) = 8 Moderate Risk	
		Chief Operating Officer (MM),	May, Judith - Associate Director of Operational Performance, Assurance & Delivery	1342	The inability to provide the appropriate level of services for patients during the COVID-19 outbreak - There is potential for this outbreak to create a surge in activity with resultant pressure on existing services. Risk to personal health if staff contract Covid-19 Risk to the organisation relating to staffing gaps (medical, nursing, AHP, ancillary) due to social isolation requirements and sickness. Risk of Covid-19 positive patients presenting to main hospital services causing risk from spread of infection Risk of delays to patient care in ED due to staff/beds being required for suspected Covid-19 patient testing and care of multiple or frequent patient presentations. Risk of insufficient isolation beds for	S(5) x L(3)=15 High Risk	S(4) x L(4)=16 High Risk	[09/11/2021] Covid inpatients have increased and now over national planning requirement of 5% inpatient beds, alongside increased case incidence in the community. Current epicell modelling indicates this may continue to increase. Also impacting on ITU capacity with sustained high demand across Covid and non covid, as well as on a small number of electives. Some staffing impact with increased isolation/absence. Tactical Group and related huddles/cells supporting Covid/operational planning continue. Risk score increased and continue to monitor closely.	Quality Committee, Infection prevention and control group	S(3) x L(2) = 6 Low Risk	

	To deliver a Covid restoration programme that returns waiting times and waiting patient numbers towards the national standards, for elective, cancer, diagnostics and emergency care	Chief Operating Officer (COO)	Judith May	1074	Risks to regulatory performance compliance, patient delay and dissatisfaction if RTT related targets for 2020/21 are not met There is a risk that there will be patient harm from delayed pathways, NHSI/E regulatory challenges and premium expenditure requirements if the RTT related targets for 2020/21 are not met, namely: 1) Total waiting list to be no greater than Jan 2020 2) No 52 week waiters 3) RTT delivers to agreed operational plan trajectory for 2020/21 4) Recognise RTT standard is 92% (national NHS constitution target) and should be delivered where possible	S(4) x L(5)=20 High Risk	S(4) x L(5)=20 High Risk	13/10/2021] Risk remains the same as previous months, controls and action plans in place. Numbers of patients waiting over 52 weeks continue to decrease but as a percentage of the waiting list they represent 6.8%. >108week-waiters continue to rise.	• Finance and Performance Committee	S(2) x L(2) = 4 Low Risk	
	To deliver a Covid restoration programme that returns waiting times and waiting patient numbers towards the national standards, for elective, **cancer**, diagnostics and emergency care	Chief Operating Officer (COO)	Alison Ashmore	1386	Cancer waits - Risk of patient harm from delayed pathways, risk to compliance with CWT standards. Risk may be increased if unable to recruit and retention of key clinical staff (oncologist and histopathologists) in particular in sub specialisation areas that rely on a single handed practitioner.	S(4)xL(4) = 16 , Moderate Risk	S(4) x L (3) = 12 Moderate Risk	[26/10/2021] To downgrade the score . All RCA's carried out on 104 day pathways are stating no harm – so whilst we continue to fail the KPI –patients are not coming to harm. The Trust is aware though that in some cases treatment options are decreased due to timings on the pathway –this will be raised at the next DCP co-ordinating group and clinical advisory board for info	• Finance and Performance Committee	S(2) x L(2) = 4 Low Risk	
	To deliver a Covid restoration programme that returns waiting times and waiting patient numbers towards the national standards, for elective, cancer, **diagnostics** and emergency care	Chief Operating Officer (COO)	Alex Lister	1348	Covid related pause to Dorset Bowel Cancer Screening Programme and potential diagnostic delay	S(4) x L (3) = 12 Moderate Risk	S(4) x L (2) = 8 Moderate Risk	[09/11/2021] Backlog recovery has been delivered and the programme is achieving all KPIs as of 09/11/2021. Age extension rolled out as planned in May 2021. The number of screening subjects in the 'invited not screened' group has reduced further to 17,000. Neither the Commissioners or the Southern Hub are concerned about this number. The remaining risk is that a high proportion of this cohort return kits in a short time scale and increase	Finance and Performance	S(2) x L(3) = 6 Low Risk	
		Chief Operating Officer (COO)	Tanner, Mandy - Radiology General Manager	1574	Breast screening backlog - There is currently a significant backlog with 20,000 women waiting for breast screening in Dorset and just 3.9% of women eligible are being offered screening. If this continues women will present later with breast cancer as 7-10% of every 1000 patients screened have cancer detected early. The earlier the condition is found the better the prognosis and the less likely the patient is to need major surgery and treatments such as chemotherapy	S(4) x L(4)=16 High Risk	S(4) x L(4)=16 High Risk	[04/11/2021] Advertising for 2 band 6 Radiographers and a band 7 advanced practitioner. Will shortly advertise for another band 4 mammography associate. Continue to use overtime routinely to cope with workload. Compliance with standard of 90% eligible patients offered screening remains poor (<5%), risk to recovery of service remains the same	Finance and Performance	S(2) x L(2) = 4 Low Risk	

	To deliver a Covid restoration programme that returns waiting times and waiting patient numbers towards the national standards, for elective, cancer, diagnostics and **emergency care**	Chief Operating Officer (MM)	Alex Lister	1429	Ambulance handover delays - If we cannot assess and move patients into ED clinical areas from the Ambulance queues within 15 minutes then there is a risk of harm to patients in the queue or community. See attached PDSA documents. There is also a risk to organisational performance standards and reputation	S(5) x L(3)=16 High Risk ,	S(5) x L(3)=16 High Risk ,	14/10/2021] Ambulance handover delays >30/60 mins improved in September but remained at the significantly higher levels seen since July/August. We benchmark lower than a number of South West providers, however, remain at levels well above our standards. We work closely with SWAST both at specific times of pressure and with regular senior huddles to continually assess/implement our ambulance handover/cohorting protocols as well as cross site diverts where safe and appropriate. Score remains unchanged	Finance and Performance Committee	S(3) x L(1) =3, Very Low Risk	
		Chief Nursing Officer (PS), Chief Operating Officer (MM)	Leanne Aggas	1430	Emergency Department Workforce - Post COVID-19. Whilst there is a requirement to maintain compliance within current COVID pathways within ED services then there will be a nursing vacancy gap of 50 WTE (Total establishment 160 WTE proposed 104 WTE Funded). There is a potential risk to patient safety, finance and performance This will result in high usage of agency staff posing a performance/ finance and safety risk.	S(4) x L (3) = 12 Moderate Risk	S(4) x L (3) = 12 Moderate Risk	[11/10/2021] Risk remains unchanged - current template review and staffing trajectory planned for 14.10.2021	Finance and Performance Committee	S(3) x L(1) =3, Very Low Risk	
	2.3 To continue to deliver efficiency and productivity opportunities using Getting it Right First Time (GIRFT) and Model Hospital benchmarking data, in the context of the Covid-19 response. This includes resetting services in ways to reduce unwarranted variation in our clinical and non-clinical services both across sites and between services	Chief Medical Officer (AOD)	Rushforth, Helen - Head of Productivity and Efficiency	1416	GIRFT and Model Hospital Risk of not achieving efficiency and productivity opportunities identified through the Getting it Right First Time (GIRFT) programme and Model Hospital metrics resulting in continued unwarranted variation, reduced productivity and higher cost of service provision.	S(3) x L (3) = 9 Moderate Risk	S(3) x L (4) = 12 Moderate Risk	[04/11/2021] Reviewed and risk increased to reflect challenges in responding to identified variation due to operational pressures	Finance and Performance Committee	S(3) x L(2) = 4 Low Risk	
	2.4 To agree and publish the multi-year Green Plan, to measure, and reduce our carbon footprint, improve air quality and make more sustainable use of resources as part of a multi-year sustainability strategy. This is to be developed by the Trust and agreed by the Board by July 2021 and progress reported to the Board by March 2022	Chief Strategy and Transformation Officer (RR)	Davies, Edwin - Associate Director Capital and Estates	1446	Sustainability Strategy If we do not deliver the Trust's Sustainability Strategy there is a risk that the Trust will not either measure or reduce it's carbon footprint	S(2) x L(2) = 4 Low Risk	S(2) x L(2) = 4 Low Risk	12/8/21 Sustainability Plan approved and in place, ongoing performance to be measured	Sustainability Committee	S(2) x L(2) = 4 Low Risk	
To continually improve the quality of care so that services are safe, compassionate timely, and responsive, achieving consistently good outcomes and an excellent patient experience	3.1 To deliver 4 priority clinical Quality Improvement (QI) programmes to improve: • Fluid management for inpatients As well as supporting clinical and non-clinical QI work across the Trust.	Chief Medical Officer (AOD), Chief Nursing Officer (PS)	Dr D Tiwari	1473	Safe Fluid management - If we are not able to safely prescribe and administer appropriate fluids, in the correct volumes and accurately monitor fluid balance and patient physiology there is significant risk to patient safety	S(3)x L(4) = 12 , Moderate Risk	S(3)x L(4) = 12 , Moderate Risk	[04/11/2021] The QI project group is continuing to meet The updated IV fluid prescription chart is being rolled out currently Audit required at an interval to assess impact	Quality Committee, Quality Goverance Group	S(2) x L(2) = 4 Low Risk	

	To deliver 4 priority clinical Quality Improvement (QI) programmes to improve: • Escalation of deteriorating patients As well as supporting clinical and non-clinical QI work across the Trust.	Chief Medical Officer (AOD), Chief Nursing Officer (PS)	Chief Medical Officer	1605	Managing the deteriorating patient - if the Trust is unable to develop a unified policy and process for the monitoring, escalation and management of a deteriorating patient then there is a risk to patient safety and patient outcomes.	S (4) x L (3) = 12 Moderate Risk	S (4) x L (3) = 12 Moderate Risk	[08/11/2021] QI workstream initiated with 8 sub groups within this focussed on policies, communication and staffing All work groups established and some well advanced in their work Aligning trust policies and structures for responding to deteriorating patients not complete although resus training has now been aligned	Quality Committee, Quality Goverance Group	S (3) x L (3) = 9 Moderate Risk	
	To deliver 4 priority clinical Quality Improvement (QI) programmes to improve: • Urgent IV access As well as supporting clinical and non-clinical QI work across the Trust.	Chief Medical Officer (AOD), Chief Nursing Officer (PS)	Dr D Morgan, Dr Holloway, Dr Spake	1598	If staff are not sufficiently trained or experienced to manage, escalate and/or ensure IV access for patients then risk to patient safety and outcomes.	S (3) x L (3) = 9 Moderate Risk	S (3) x L (3) = 9 Moderate Risk	30/10/21 QI project in progress	Quality Committee, Quality Goverance Group	S (2) x L (2) = 4 Low risk	
	To deliver 4 priority clinical Quality Improvement (QI) programmes to improve: • Safety checklists for procedures As well as supporting clinical and non-clinical QI work across the Trust.	Chief Medical Officer (AOD), Chief Nursing Officer (PS)	Joanne Sims, Dr Holloway	1599	If unable to embed culture for use of safety checklist process for all interventional procedures undertaken across UHD then risk of never events occuring with potential harm to patients and regulatory action from CQC. Risk that variable application across UHD and lack of standardardisation across sites for same specialities, including staff training, will impact on compliance and culture .	S (4) x L (3) = 12 Moderate Risk	S (4) x L (3) = 12 Moderate Risk	[11/10/2021] QI Group have completed audit of staff views on use of safety checklists across UHD. Survey results being used to consider next steps including human factors training and key safety culture messages. List of all checklists in use across UHD collected (60+). Group now to compare against WHO checklist minimum standards and establish smaller T&F groups to create new UHD checklists and SOPs by speciality.	Quality Committee, Quality Goverance Group	S (3) x L (2) = 6 Low Risk	
	To deliver 4 priority clinical Quality Improvement (QI) programmes as well as supporting clinical and non-clinical QI work across the Trust.	Chief Nursing Officer (PS)	Paul Bolton	1463	Prevention of healthcare associated gram negative blood stream infections. There is a potentially avoidable risk of patient harm for those patients who contract hospital acquired gram negative infections.	S(2)xL(3) = 6 , Low Risk	S(2)xL(3) = 6 , Low Risk	[28/06/2021] Current rising rate of HCAI cases across UK and SW. QI group set up in SW to review the learning planned in the next few months. No further changes required.	• Infection Control Group	S(2) x L(2) = 4 Low Risk	

		Chief Nursing Officer (PS)	Paul Bolton	1383	Given the nature of the novel coronavirus, there is a risk that patients and/or staff could contract hospital acquired covid-19 infection as a result of inadequate or insufficient infection prevention and control processes and procedures, which may not be known due to evidence base available at the time of the pandemic	S(4) x L (2) = 8 Moderate Risk	S(4) x L (2) = 8 Moderate Risk	[14/10/2021] This risk remains there continues to be community transmission of Covid-19 and significant changes to the controls within the community i.e. optional mask wearing. UHD Guidance on facemasks for all in hospitals settings remain as does social distancing. Risks assessments reviewed for high risk ward areas and reviewed by Matrons and Ventilation group. Co2 Monitoring increased. Updates in staff risk assessments. The organisation continues to have its controls (as listed) in place and oversight i.e. IPC Cell, IPC group and attendance at Dorset Wide IPC ICS cell and review of BAF. Covid1-19 booster programme has also started within UHD in Oct 2021. Fit testing task and finish group reviewing process/policy. Outbreak PIR learning and action plan in place. Outbreak process in place and learning shared. Regular communication on IPC & regular review of epicell data Continued monitoring and oversight by	Quality Committee, Infection prevention and control group	S(4) x L (2) = 8 Moderate Risk	
		Chief Nursing Officer (PS)	Paul Bolton	1172	There is a risk that if the Trust does not meet contractual targets for monitored organisms, this may result in patients acquiring hospital infections, loss of confidence with patients and public and reputational damage.	S(3)xL(3) = 9, Moderate Risk	S(3)xL(3) = 9, Moderate Risk	No change in Q2	• Infection Control Group	S(3) x L(2) = 6 Low Risk	
		Chief Medical Officer (AOD)	Chief Medical Officer (AOD)	1607	It the Trust fails to maintain hospital standardised mortality metrics at as or below “expected” levels it is probable that there are identified(and unidentified) and unmitigated risks to patient safety and patient outcomes. This brings the additional risk of reputational damage, damage to public confidence and regulatory scrutiny	S(4)xL(3) = 12, Moderate Risk	S(4)xL(3) = 12, Moderate Risk	[08/11/2021] Overall trust metrics have returned to the as expected domain Covid mortality review reported to ICS review group. Variation in metrics between sites persists and is not yet fully explained. Covid mortality significantly greater impact on the Poole site than the Bournemouth site despite very similar proportions of deaths Ongoing work being hindered by delays in Dr Foster uploads which are now 4 months behind [11/10/2021 Paper to to presented to QC and Board in Oct/Nov 21. Oversight via Mortality Surveillance Group. Audit of M&M processes in place. IT project to implement mortality review process across UHD to restart in Nov 21	Quality Committte, Mortality Surveillance Group	S(3) x L(1) = 3, Very Low Risk	
	3.2 To redesign and transform our outpatient pathways, with a Digital First offer, improving access to care, reducing travel times, and supporting patients through and changes.	Chief Operating Officer (COO)	Sarah Macklin	1464	Re-designing outpatient services for future demand Risk that the Trust fails to respond to the challenge of changing models of outpatient care in line with National trend information relating to population growth and aging population needs. Developing innovation and new models of care is essential to future-proof access to relevant clinical intervention and advice in a timely way.	S(3)x L(3) = 9 , Moderate Risk	S(3)x L(3) = 9 , Moderate Risk	[09/11/2021] There has been confirmation of significant outpatient TIF for progressing of digital platforms/process to support delivery and streamlining patient clinical pathways. These consist of a patient portal, virtual consultation PODs, electronic patient flow models, RPA process to ensure clinic slot utilisation is at its optimum and RPA for referral management, electronic clinic room scheduling. However, these will take time to come to fruition and therefore the risk level should remain until the transformation project workstreams have completed the works involved.It is recognised that some works may have to wait until the Single PAS project is completed at the end of March 2022.	Finance & Performance Committee	S(2) x L(2) = 4 Low Risk	

		Chief Operating Officer (COO)	Michele Roberts	1242	Risk relating to the continuity and operational performance of outpatients as a result of reduced staffing - The Outpatient department is experiencing increasing levels of work in respect of volume of amendments, clinic cancellations, delays in the pre-reg of patients. This compromises optimum patient care and impacts on RTT. Staff are impacted by increased workloads and risk to wellbeing.	S(2) x L(3) = 6 , Low Risk	S(3)x L(3) = 9 , Moderate Risk ⇧	[08/10/2021] Reviewed at OPD quality & risk group. Over the last 4 weeks the vacancy rates across UHD outpatients have not improved with daily short staffing in all teams. There has been further Covid isolation of staff and sickness. The nursing teams escalate staffing concerns on a daily basis, often requiring support form other departments and cancelling training with staff coming in on days off to cover. Phlebotomy staff have been too exhausted to cover additional shifts and errors, including wrong blood in tubes have been reported related to workload and stress. Recruitment has been successful but due to the lengthy process of appointment and waiting for a Trust induction slot new staff in nursing and phlebotomy will not start until Nov-January 2022. Risk rating to be reviewed with Matron and GDON	Finance and Performance	S(2) x L(2) = 4 Low Risk	
		Chief Operating Officer (COO)	Darren Jose	1292	Outpatient Follow-Up appointment Backlog - Insufficient capacity to book within due dates	S(3)xL(4) = 12 , Moderate Risk	S(3)xL(4) = 12 , Moderate Risk	[09/11/2021] The FU waiting list remains under the Elective recovery group to oversee with the clinical teams the clinical validation/oversight of these lists. There has been a newly developed report which has been developed (COSMOS FU Dashboard portal) and is currently being utilised by the Outpatients teams for booking overdue follow up and it is accessible to the specialty teams for their oversight on their FU waiting lists. The dashboard also demonstrate where the patients are passed their due dates and whether or not they have an appointment booked or not.	Finance and Performance	S(3)x L(3) = 9 , Moderate Risk	
	3.3 To implement the elective care priority programmes for Dorset, so as to improve quality and sustainability of these services: • Ophthalmology	Chief Operating Officer (COO)	Barry Alborough - Duell, Directorate Manager	1442	Ophthalmology: achieving eye theatre efficiency of 85%	S(2) x L(3) = 6 , Low Risk	S(2) x L(3) = 6 , Low Risk	[18/10/2021 Update from Ophthalmology RaGG meeting: awaiting report on efficiency (currently running at 72%). Business Case is being considered for Day Case Ward to increase Theatre Efficiency but this has not been approved. Bed capacity remains a challenge due to medical outliers.	• Finance & Performance Committee • Ophthalmology Directorate Governance Group	S(1) x L(2) = 2, Very Low Risk	
		Chief Operating Officer (COO)	Barry Alborough - Duell, Directorate Manager	1476	Backlog of overdue follow up patients.There is a risk to the positive outcome for patients who are unable to be seen with planned FU timescales	S(3)x L(3) = 9, Moderate Risk	S(3)x L(3) = 9, Moderate Risk	[18/10/2021] Discussion at Ophthalmology RaGG Meeting 18/10/2021: Insoucring not to continue for cataract procedures but will continue with lasers. Contract being reviewed with Spa-Medica.	• Finance & Performance Committee • Ophthalmology Directorate Governance Group	S(3) x L(2) = 6 , Low Risk	
	To implement the elective care priority programmes for Dorset, so as to improve quality and sustainability of these services: • Orthopaedics, as part of the Dorset wide MSK plans	Chief Operating Officer (COO)	West, John - General Manager, Trauma Orthopaedics, Surgery PH site	1439	Orthopaedic operational pressures ,outlying patients and reduced ward footprint. Potential lack of capacity to admit routine Orthopaedic Patients for their surgery creates inability to maintain or recover RTT position. This may lead to more complaints around compromising wellbeing of patients attributable to deteriorating access and waiting times. Operations may be cancelled when unable to maintain ringfenced bed base to meet GIRFT requirements. Demand has not reduced to the level previously anticipated following the introduction of MSK triage in 2017 and referrals have steadily increased after an initial fall. Additions to waiting list now exceed removals by an average of 37 patients per month in the past year	S(2)x L(5) = 10, Moderate Risk	S(2)x L(5) = 10, Moderate Risk	[04/10/2021 weekly performance monitoring in place.	Finance & Performance Committee	S(2) x L(3) = 6 , Low Risk	

	To implement the elective care priority programmes for Dorset, so as to improve quality and sustainability of these services: • Theatres	Chief Operating Officer (COO)	House, Nichola - Directorate Manager - Surgery - RBH site	1490	Lack of Hybrid Theatre. As part of the CSR, it was highlighted that there is a need for a Hybrid theatre. This issue was also recommended in the Vascular GIRFT report.	S(2) x L(2) = 4 Low Risk	S(2) x L(2) = 4 Low Risk	[18/10/2021] Unable to progress owing to operational demands. Business case is still required. Workstream implemented within the Steering Group with Clinical assigned to lead.	Surgical RAGG	S(1) x L(2) = 2, Very Low Risk	
	3.4 Improve Urgent and Emergency Care (UEC) flow and quality of care as measured by the new national UEC Emergency Department waiting time standard and same day emergency care outputs.	Chief Operating Officer (COO)	Alex Lister	1460	Urgent and Emergency Care (UEC) performance There is a potentional risk to patients waiting in excess of National Standards	S4) x L(5)=20 High Risk Increased Risk from 15 to 20 in Q1	S4) x L(5)=20 High Risk	[11/10/2021] Risk remains unchanged [10/09/2021] Score remains at 20 given current operational pressures and continued challenges with key metrics. CEO/exec system meetings have been progressed in relation to challenges at front and back doors as well as with flow. Meeting held with SWAST to review ambulance handover escalation process and cohorting principles. Further actions being reviewed by Home First Board to support discharges over winter - awaiting final approved and funded proposals. Internally, escalation beds remain open. ED action plan has been reviewed and a number of actions already commenced including review of blue pathways through EDs, ambulatory area established at RBH site, review of clerking documents - see separate ED action plan.	• Finance and Performance Committee	S(2) x L(2) = 4 Low Risk	
	3.5 To reduce towards zero the number of patients in hospital beds who don't have a reason to reside, by working with partners and improving our own processes to support safe and timely discharge from hospital	Chief Operating Officer (COO)	Donna Parker, Deputy COO	1053	Lack of capacity for elective & non elective activity and risk to patient harm due to LLOS and NRTR patients	S4) x L(5)=20 High Risk	S4) x L(5)=20 High Risk	[09/11/2021] Risk score remains the same and under close review. Following the system Rapid Decant project, some improvement has been seen in the number of patients with No Reason to Reside (NRTR). However, this remains variable and a sustained downward trend is awaited. Some additional care homes beds have been secured, the Decant project continues and the system winter plans, which are now approved, are awaited (e.g. further Care Home beds, support to brokerage capacity etc). Home First Board 2nd workshop has taken place - working towards future model, demand and capacity planning	• Finance and Performance Committee	S(3) x L(2) = 6 Low Risk	
		Chief Operating Officer (MM),	Donna Parker, Deputy COO	1387	Demand & Capacity: Demand will exceed capacity for acute inpatient beds	S(3) x L(5)=15 High Risk Increased to 16 from 15 in Q1	S(4) x L(5)= 20 High Risk Increased to 20 from 16 in Q2	[09/11/2021] Occupancy has remained extremely high across both sites with ongoing high level of challenge around key UEC metrics. This has been exacerbated by the increased number of Covid inpatients, including in ITU, plus the increased workforce challenges to staff these areas, the pathways and increasing demand. Epicell data indicates this peak in Covid demand may not yet be reached. Some progress has been seen following the system Rapid Decant project, including additional care home beds secured. Therefore, risk score remains the same and closely monitored	Finance and Performance Committee	S(3) x L(2) = 6 Low Risk	

		Chief Operating Officer (COO)	Donna Parker, Deputy COO	1131	Current challenges around patient flow and capacity due to increased demand, delays in external discharge and bed closures have become increasing difficult to manage and presents risk to patient safety	S(3) x L(5)=15 High Risk Increased to 16 from 15 in Q1	S(4) x L(5)=15 High Risk Increased to 20 from 16 in Q2 ↑	[09/11/2021] High occupancy, higher levels of Covid inpatients and a higher number of occasions at OPEL 4 have continued, thereby challenging flow through the hospital. The UEC QPIP continues and has refreshed workstream priorities for the remainder of the year. Key areas of focus include: SDEC - enhanced capacity and pathways; NRTR/discharge - internal C2R programme and external Home First; Ops Flow - clinically ready to proceed standard and bed booking system; ED - internal action plan and informed by ECIST audit. The system Rapid Decant project has seen some improvement in the number of patients with NRTR. Risk score remains the same but closely monitored	• Finance and Performance Committee	S(4) x L(2) = 8 Moderate Risk	
To be a well governed and well managed organisation that works effectively in partnership with others, is strongly connected to the local population and is valued by local people	4.1 Strengthen and improve communications/engagement with staff, governors, patients, local people and key stakeholders through a communication and engagement plan, delivered over the year and reviewed by February 2022. A key focus is leading for Equality, Diversity and Inclusion strategy and our work as an ICS partner on	Chief Strategy and Transformation Officer (RR)	Chief Strategy and Transformation Officer (RR)	1466	Effective relationships with local partner To transform and improve our services in line with the Dorset ICS Long Term Plan, by separating emergency and planned care, and integrating our services with those in the community.	S(2) x L(2) = 4 Low Risk	S(2) x L(2) = 4 Low Risk	No change in Q2	Transformation Committee	S(2) x L(1) = 2, Very Low Risk	
	4.2 Support delivery of a continuously improving organisation and culture of improvement by developing a QI strategy and an innovation strategy. Implement the strategies across UHD and the Dorset ICS to improve outcomes and deliver efficiencies	Chief Strategy and Transformation Officer (RR)	Alan Betts	1600	If we do not deliver the Trust's QI and Innovation Strategy there is a risk that the Trust will not improve outcomes or deliver efficiencies in line with the Trust's values of being an improving organisation	S(2) x L(2) = 4 Low Risk	S(2) x L(2) = 4 Low Risk	[08/11/2021] QI training being rolled out with QI practioner courses scheduled throughout 2021/22 and 2022/23 QI lite course developed and 3rd cohort scheduled QI awards day scheduled for November 24th ongoing work on culture of improvement	Transformation Committee	S(2) x L(2) = 4 Low Risk	
	4.4 Develop the Bournemouth University partnership, including the partnership strategy to be approved by Trust Board by July 2021 and implementing throughout 2021/22 and future years	Chief Strategy and Transformation Officer (RR)	Alan Betts	1601	If we do not continue to develop the partnership with Bournemouth University it may lead to a failure to fulfil our potential as University Hospital which may mean we don't continue to attract staff and research opportunities as a leading University Hospital	S(2) x L(2) = 4 Low Risk	S(2) x L(2) = 4 Low Risk	[08/11/2021] Annual review of BU partnership completed, report going to Trust Board end of November Debbie Fleming to meet John Vinney re:progress on 10th November Programme plan for year 2 of partnership underway	Transformation Committee	S(2) x L(2) = 4 Low Risk	
To transform and improve our services in line with the Dorset ICS Long Term Plan, by separating emergency and planned care, and integrating our services with those in the community.	5.1 Develop a robust plan for reconfiguration to create the emergency and planned hospitals. This includes site decants and clinical services moves starting in 2021, and teams being prepared and understanding their trajectory so they are ready with new models of care, and to occupy new estate when it is delivered.	Chief Strategy and Transformation Officer (RR)	SK	1602	Risk that In year delays to the critical path programme can lead to costs increasing by £0.5m a month. Complexity of the programme and external approvals required for capital expenditure generate the likelihood	S(5) x L(4) = 20 High Risk	S(4)xL(2) = 8 , Moderate Risk ↓	[10/11/2021] Treasury approval was formally received at the end of September as planned. With funding certainty now confirmed, the risk of not funding items on the critical path have been significantly reduced, and therefore the likelihood can be reduced to 2. Overall risk can drop to 8	• Transformation Committee	S(4)xL(3) = 12 , Moderate Risk	

		Chief Strategy and Transformation Officer (RR)	Davies, Edwin - Associate Director Capital and Estates	1260	There is a risk that we are unable to maintain the Trust estate in line with Clinical and regulatory requirements. Risk to staff and patient safety and risk of regulatory action if statutory breaches identified. Ensuring Estates are compliant with regulatory standards (SFG20/HTM00) across fire, water, electricity, gases and air handling	S(4)xL(3) = 12 , Moderate Risk	S(4)xL(3) = 12 , Moderate Risk	12/10/2021 - SRA's and Surveys are underway due for completion this year. Fire warden training is in hand, escape plans are in place in clinical areas, we are progressing well against plan however shortage of material and labour will delay the installation of new fire doors	Quality Committee	S(4)xL(2) = 8 , Moderate Risk	
	5.2 Establishing robust arrangements for taking forwards Health Infrastructure Plan with Dorset partners and NHSI/E, such that Dorset programme business cases start to be submitted in 2021/2 including the new entrance, ward refurbishments and that options appraisals on other cases are completed	Chief Strategy and Transformation Officer (RR)	Chief Strategy and Transformation Officer (RR)	1604	Risk of delay in securing UHD and wider Dorset New Hospital Programme (NHP) funds in sufficient time to enable the wider reconfiguration by 2024/26. Risk is delayed benefits by later than planned reconfiguration. Securing NHP enabling funds required in year to allow progression of key capital works	S(4) x L(4) = 16 High Risk	S(4) x L(4) = 16 High Risk	[10/11/2021] Following the JIC approval of the SOC, UHD has been asked to manage all NHP projects within its proposed allocation of £205million. This has led to an options review for the NHP schemes to prioritise projects in light of COVID and escalating building inflation. The OBC will therefore be submitted at the end of March 2022. Also a concern about revenue affordability of the capital case that needs to be assessed and resolved prior to OBC submission. Risk score should remain until OBC	• Transformation Committee	S(4) x L(2) = 8, Medium Risk	
	5.3 Under the national requirements for establishing a new Dorset ICS, work with system partners to develop a provider collaborative across Dorset and help to shape the Dorset Integrated Care System as it transitions onto a statutory basis from April 2022.	Chief Executive (DF)	Chief Strategy and Transformation Officer (RR)	1603	The risk is establishing the Statutory ICS by April 2022 in a way that has effective governance and relationships that deliver against the 4 ICS objectives:- - improving population health and healthcare; - tackling unequal outcomes and access; - enhancing productivity and value for money; and - helping the NHS to support broader social/economic development) Failure to achieve the above leads to UHD being unable to fulfil its requirements and regulatory compliance.	S(2) x L(2) = 4 Low Risk	S(2) x L(2) = 4 Low Risk	No change in Q2	• Board of Directors	S(2) x L(1) = 2, Very Low Risk	
	5.4 Play an active part in the key Dorset transformation plans programmes, including Digital Dorset, by implementing four core clinical applications (Dorset Care Record, order communications, electronic prescribing and medicines administration, health of the ward) and support the clinical leaders of these programs transform clinical processes to achieve the maximum benefit from these investments; migrate all devices to Windows10, stabilise the underlying infrastructure and mitigate against all IT security threats	Chief Informatics and IT Officer (PG)	Martin Davis, IT Security Manager	1273	Cyber Security Risks, Threats and Vulnerabilities- There are risks related to cyber security that, potentially, can affect the resilience of the Trust's IT systems and data. This could adversely affect all trust business.	S(2)xL(4) = 8 , Moderate Risk	S(4) x L(5)= 20 High Risk Increased to 20 from 8 in Q2	07/11/2021] The Cyber Security Task and Finish Group continues to make very good progress towards the requirements of the DSPT. High confidence of achieving the requirements by 31/12/21 at which point this risk score will be formally reviewed. The risk rating has been increased as a result of a recent review of the extent of the unsupported (obsolete) operating systems at UHD and a presentation of the same at the Board of Directors (30.6.21). There is a funded plan to resolve this position by 31.12.21 in line with our re-submission to the Data Security and Protection Toolkit.	Information Governance Group	S(2)xL(3) = 6 , Low Risk	
		Chief Informatics and IT Officer (PG)	Sarah Hill	1434	Delays to the implementation of the Dorset Care Record	S(3)xL(2) = 6 , Low Risk	S(3)xL(2) = 6 , Low Risk	[13/10/2021] Pathology testing due to commence shortly. Medication feed unable to progress without an EPMA upgrade to move to FHIR Message standards. MyDCR project commencing to start to expand upon the solution with a patient portal	Information Governance Group	S(2)xL(3) = 6 , Low Risk	

		Chief Informatics and IT Officer (PG)	Russell King	1437	There is a risk of total outage of the computing services at RBCH if the single point of failure of electrical supply fails	S(3)xL(1) = 3 , Very Low Risk	S(4) x L(3)= 12 Moderate Risk Increased to 12 from 3 in Q2 	[19/10/2021] Great progress has been achieved by the Infrastructure team in the creation of a new data centre at RBH and the total evacuation of the "Frame Room". Regarding the intersite links, the last (hopefully) configuration change takes place on 21/10/21 after which a failover test will take place and this risk may be downgraded following this test	Information Governance Group	S(1)xL(1) = 1 , Very Low Risk	
		Chief Informatics and IT Officer (PG)	Chief Informatics and IT Officer (PG)	1298	There is a risk that we fail to maintain and develop the Trust IT services in line with clinical and operational requirements	S(5)xL(2) = 10 , Moderate Risk	S(5)xL(2) = 10 , Moderate Risk	[02/09/2021] Wifi work is now delayed to November 2021. Workload continues to be a challenge within the team.	Information Governance Group	S(4)xL(2) = 8 , Moderate Risk	
		Chief Medical Officer (AOD)	Sarah Hill, Assistant Director of IT Developmen	1378	Lack of Electronic results acknowledgement system - A lack of an electronic results acknowledgement system for requested clinical tests is a risk to patient safety and could result in missed diagnosis and suboptimal treatment.	S(2)xL(4) = 12 , Moderate Risk	S(2)xL(4) = 12 , Moderate Risk	[04/11/2021] No new sentinel risks identified Update on progress with teams based notifications required but work is ongoing	Information Governance Group	S(2) x L(1) = 2, Very Low Risk	
		Chief Informatics and IT Officer (PG)	Axtell, Camilla - IG and Data Protection Officer	1591	Information Asset Management.There is a risk of data loss and/or service interruption as a result of the inadequate management of the large suite of Information Assets that contain Personal Identifiable Data.	S(3)xL(4) = 12 , Moderate Risk	S(3)xL(4) = 12 , Moderate Risk	[19/10/2021] Work continues to performance manage and support the IAOs in undertaking the necessary work. No change to the risk score at this stage	Quality Committee, Information Governance Group	S(3)xL(2) = 6 , Low Risk	
		Chief Informatics and IT Officer (PG)	Sarah Hill Assistant Director of IT Development	1592	Electronic Prescribing and Medicines Administration Project Delay. There is a risk that the EPMA project will be significantly delayed as a result of Covid 19 and the availability of a signed off version of the software from the vendor (Wellsky). This will increase the overall costs of the project beyond its project budget and delay the clinical benefits.	S(4) x L(4)=16 High Risk	CLOSED	[19/10/2021] Agreement has been gained at CMG that this overspend will be accommodated from the COVID budget and hence this risk is now closed	Quality Committee, Information Governance Group	S(3)xL(2) = 6 , Low Risk	

University Hospitals Dorset
NHS Foundation Trust

COUNCIL OF GOVERNORS PAPER PART 1 – COVER SHEET

Meeting Date: 27 January 2022

Agenda item: 5.4

Subject:	Election of Lead Governor and Deputy Lead Governor

Prepared by:	Sarah Locke, Deputy Company Secretary
Presented by:	Sarah Locke, Deputy Company Secretary

Purpose of paper:	To approve the process for the election of a Lead Governor and a Deputy Lead Governor. It is proposed that separate elections will be held for each of the roles. To approve that the terms for the Lead Governor and the Deputy Lead Governor will be changed from a one year term to a two year term.
Background:	University Hospitals Dorset NHS Foundation Trust's Constitution states that the Council of Governors shall appoint one of the Governors to be the Lead Governor and the Deputy Lead Governor via a process agreed with the Council of Governors and the Associate Director of Corporate Governance.
Key points for the Council of Governors:	The process for the election for Lead Governor and Deputy Lead Governor is as follows: • The Deputy Company Secretary will request expressions of interest from members of the Council of Governors. • Any Governor can stand to be Lead Governor or Deputy Lead Governor. • All Governors who have expressed an interest in becoming Lead Governor or Deputy Lead Governor shall submit to the Deputy Company Secretary a short statement (300 words maximum) on how they are suited to the role. • The Deputy Company Secretary shall circulate by email all statements to members of the Council of Governors. • Governors will return their vote via email. • All emailed returns will be acknowledged by the Deputy Company Secretary and the result of the ballot will be reported formally at the next Council of Governors meeting. • The above will be based on a 'first past the post'

	approach and the Governors with the highest number of votes will be appointed as Lead Governor and Deputy Lead Governor in their respective elections. • In the event of a hung vote, the Chairman would have the casting vote for both elections • Candidates will be able to withdraw from the process at any time.
Options and decisions required:	For the Council of Governors to approve the appointment of the Lead Governor and Deputy Lead Governor for two year terms.
Recommendations:	Approve the process to hold two individual elections for the Lead Governor post and the Deputy Lead Governor post. Approve the Lead Governor and Deputy Lead Governor to hold term for two years.
Next steps:	Start the process for appointing the Lead Governor and the Deputy Lead Governor. Notify the committee of the results of the election at the Council of Governors at April 2022 meeting.

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	AF5
BAF/Corporate Risk Register: (if applicable)	
CQC Reference:	Well Led

Committees/Meetings at which the paper has been submitted:	**Date**

PROCESS FOR THE APPOINTMENT OF A LEAD GOVERNOR and DEPUTY LEAD GOVERNOR

1. INTRODUCTION – THE CONTEXT

The Governors provide an important link between the Trust, the members and the stakeholders. They have an interest in the wider health community and the views of all people who live in the Trust's catchment areas. The Governors represent the interests of the members of the Trust as a whole and the interests of the public. The Lead Governor holds an important role in being the key contact for the Governors. They also hold an essential role of working with the Chair of the Trust in the development of partnership working between the Board and the Council of Governors.

2. TERM OF OFFICE

The appointment as Lead Governor and Deputy Lead Governor shall be for a period of two years or until they resign the position of Lead Governor or Deputy Lead Governor by giving notice to the Chairman and Associate Director of Corporate Governance in writing.

3. PROCESS

The Trust's Constitution states that the Council of Governors shall appoint one of the governors to be Lead Governor and Deputy Lead Governor via a process agreed with the Council of Governors and the Associate Director of Corporate Governance. The process proposed is as follows:

- The Deputy Company Secretary will request expressions of interest from members of the Council of Governors.
- Any Governor can stand to be Lead Governor or Deputy Lead Governor.
- The Governors who have expressed an interest in becoming Lead Governor or Deputy Lead Governor shall submit to the Deputy Company Secretary a short statement (300 words maximum) on how they are suited to the role.
- The Deputy Company Secretary shall circulate by email all statements to members of the Council of Governors.
- Governors will return their vote via email.
- All emailed returns will be acknowledged by the Deputy Company Secretary and the result of the ballot will be reported formally at the next Council of Governors meeting.
- The above will be based on a 'first past the post' approach and the Governors with the highest number of votes will be appointed as Lead Governor and Deputy Lead Governor in their respective elections.
- In the event of a hung vote, the Chairman would have the casting vote for both elections.
- Candidates will be able to withdraw from the process at any time.

4. PERSON SPECIFICATION FOR LEAD GOVERNOR AND DEPUTY LEAD GOVERNOR OF THE COUNCIL OF GOVERNORS

The Role

The main duties of the Lead Governor and Deputy Lead Governor are to:

- Facilitate a good working relationship among Governors with the support of the Associate Director of Corporate Governance.
- Provide additional assurance to Governors gained through meetings with the Chairman.

- Provide a regular link to the Chairman and reflect the views of Governors on issues affecting the Trust and the Governors' role.
- Contribute, along with the other governors, to the annual appraisal of the Chairman by the Senior Independent Director in accordance with the process determined by the Council of Governors.
- Act as a point of contact for NHS Improvement should the regulator wish to contact the Council of Governors on an issue for which the normal channels of communication are not appropriate. This should only happen in exceptional circumstances.
- Be the conduit for raising with NHS Improvement any Governor concerns that the Foundation Trust is at risk of significantly breaching the Conditions of its Provider Licence, having first made every attempt to resolve any such concerns locally.
- Be a point of contact when Governors wish to seek advice and/or raise issues.
- Chair such parts of meetings of the Council of Governors which cannot be chaired by the Chairman, Vice Chair or another Non-Executive Director if there is a conflict of interest in relation to the business being discussed.
- The Deputy Lead Governor will deputise for the Lead Governor when required.

The Person Specification

Any Governor can stand to be Lead Governor or Deputy Lead Governor.

To be able to fulfill this role effectively the Lead Governor and the Deputy Lead Governor should:

1. Have the confidence of Governor colleagues.
2. Be willing to challenge respectfully and constructively.
3. Have the ability to influence and negotiate.
4. Be able to present a well-reasoned argument.
5. Be committed to the success of University Hospitals Dorset NHS Foundation Trust.
6. Have the ability to Chair meetings.
7. Understand the role of NHS Improvement and the basis on which NHS Improvement may take regulatory action.
8. Demonstrate an understanding of the Trust's Constitution, the role of the Council of Governors, the Nomination Remuneration and Election Committee and the Council of Governor Informal groups.
9. Be able to commit the time necessary to undertake the role.

January 2022