University Hospitals Dorset
NHS Foundation Trust

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

BOARD OF DIRECTORS – PART 1 MEETING

Wednesday 1 May 2024

9:30 – 12:15

via Microsoft Teams

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

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

BOARD OF DIRECTORS – PART 1 HELD IN PUBLIC

The next meeting of the University Hospitals Dorset NHS Foundation Trust Board of Directors Part 1 will be held at 9:30 on Wednesday 1 May 2024 via Microsoft Teams.

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

Rob Whiteman
Chairman

AGENDA – PART 1 PUBLIC MEETING

9:30 on Wednesday 1 May 2024

Time	Item		Method	Purpose	Lead
9:30	**1**	Welcome, Introductions, Apologies & Quorum	**Verbal**		**Chair**
9:32	**2**	Declarations of Interest	**Verbal**		**Chair**
9:35	**3**	Patient Story	**Verbal**	**Discussion**	**CNO**
9:50	**4**	**MINUTES**			
9:50	**4.1**	For Accuracy and to Agree: Minutes of the Board of Directors Meeting held on 6 March 2024	**Paper**	**Approval**	**Chair**
9:51	**4.2**	Matters Arising - Action List – *none outstanding*	**Verbal**	**Information**	**Chair**
9:55	**5**	**TRUST CHAIR AND CHIEF EXECUTIVE UPDATES**			
9:55	**5.1**	Trust Chair's Update	**Verbal**	**Information**	**Chair**
10:00	**5.2**	Chief Executive Officer's Report	**Paper**	**Information**	**CEO**
10:15	**6**	**STRATEGY, RISK AND PERFORMANCE**			
10:15	**6.1**	Board Assurance Framework and Risk Register: review of significant risks; new risks rated 12 and above	**Paper**	**Assurance**	**Execs**
10:25	**6.2**	Integrated Quality, Performance, Workforce, Finance and Informatics Report *Questions to the Executive Team by exception*	**Paper**	**Assurance**	**Execs**
10:40	**6.3**	Quality Committee – Chair's Report – March and April 2024 • Maternity Safety Champions Report *(to be presented by Director of Midwifery)* • Mortality Report	**Verbal** **Paper** **Paper**	**Assurance** **Assurance** **Assurance**	**Committee Chair**

		• Quality Impact Assessment Report	**Paper**	**Assurance**	
10:50	**6.4**	People and Culture Committee – Chair's Report – April 2024 • Guardian of Safe Working Hours Annual Report	**Verbal** **Paper**	**Assurance** **Assurance**	**Committee Chair**
11:00	**6.5**	Finance and Performance Committee – Chair's Report – March and April 2024 • Feedback from Council of Governors and our community on the draft Annual Plan	**Paper** **Paper**	**Assurance** **Approval**	**Committee Chair**
11:10	**6.6**	Population Health and System – Chair's Report – March 2024	**Paper**	**Assurance**	**Committee Chair**
11:20	**6.7**	Audit Committee – Chair's Report – April 2024 • Annual Certificates	**Paper** **Paper**	**Assurance** **Approval**	**Committee Chair**
11:25	**6.8**	Transforming Care Together – Chair's Report – April 2024	**Verbal**	**Assurance**	**Chair**
11:30	**7**	**PEOPLE AND CULTURE**			
11:30	**7.1**	Staff Survey	**Paper**	**Assurance**	**CPO**
11:40	**7.2**	Gender Pay Report	**Paper**	**Assurance**	**CPO**
11:50	**7.3**	Freedom to Speak Up Guardian Report & Strategy	**Paper**	**Assurance** **Approval**	**FTSUG**
12:00	**8**	**ITEMS FOR APPROVAL**			
12:00	**8.1**	Fit and Proper Persons Policy	**Paper**	**Approval**	**CoSec/ CPO**
	8.2	Independence of Non-Executive Directors	**Paper**	**Approval**	**Chair**
	8.3	Register of Directors' Interests	**Paper**	**Approval**	**Chair/ CoSec**
	8.4	Membership of Board Committees	**Paper**	**Approval**	**Chair**
	8.5	Board's balance, completeness and appropriateness statement	**Paper**	**Approval**	**Chair**
12:05	**9**	Any Other Business	**Verbal**	**Discussion**	**Chair**
	10	Reflections on the Board Meeting	**Verbal**	**Discussion**	**Chair**

	11	Questions from the Council of Governors and Public arising from the agenda. Governors and Members of the public are requested to submit questions relating to the agenda by no later than noon on Sunday 28 April 2024 to company.secretary-team@uhd.nhs.uk			
	12	**Date and Time of Next Board of Directors Part 1 Meeting:** Board of Directors Part 1 Meeting on Wednesday 3 July 2024 at 9:30.			
	13	**Resolution Regarding Press, Public and Others:** To agree, as permitted by the National Health Service Act 2006 (as amended), the Trust's Constitution and the Standing Orders of the Board of Directors, that representatives of the press, members of the public and others not invited to attend to the next part of the meeting be excluded due to the confidential nature of the business to be transacted.			
12:15	**14**	**Close**	**Verbal**		**Chair**

* Late paper

[R] Associated item in Reading Room

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

Items for Next Board Part 1 Agenda

Standing Reports

- Patient Story
- Trust Chair's Update
- Chief Executive Officer's Report
- Board Assurance Framework
- Integrated Performance Report
- Risk Register Report
- Maternity Safety Champions Report

Quarterly Reports

- Guardian of Safe Hours Report

Bi-annual/Annual Reports

- Annual Complaints Report
- Board Committee Terms of Reference
- Board Committees – Effectiveness Reviews
- Board Meeting Schedule

AGENDA – PART 2 PRIVATE MEETING

12:30 on Wednesday 1 May 2024

Time	Item		Method	Purpose	Lead
12:30	**15**	Welcome, Introductions, Apologies & Quorum	**Verbal**		**Chair**
	16	Declarations of Interest	**Verbal**		**Chair**
12:32	**17**	**MINUTES AND ACTIONS**			
12:32	**17.1**	For Accuracy and to Agree: Minutes of the Board of Directors Meeting held on 6 March 2024 and 3 April 2024	**Paper**	**Approval**	**Chair**
12:33	**17.2**	Matters Arising – Action List	**Paper**	**Review**	**Chair**
12:35	**18**	**UPDATES**			
12:35	**18.1**	Chief Executive Officer's Update	**Verbal**	**Information**	**CEO**
12:50	**18.2**	Escalations from Committee Chairs (not already covered in Part 1)	**Verbal**	**Information**	**Committee Chairs**
12:55	**18.3**	Feedback from Service Visits	**Verbal**	**Information**	**All**
13:10	**19**	**STRATEGY AND FINANCE**			
	19.1	Going Concern	**Paper**	**Approval**	**CFO**
	19.2	Draft Annual Accounts	**Paper**	**Review**	**CFO**
	19.3	Operational and Financial Plan Update	**Paper**	**Review**	**CFO/ CSTO**
13:45	**20**	**QUALITY AND PEOPLE**			
13:45	**20.1**	Serious Incident Report	**Paper**	**Review**	**CMO**
13:50	**21**	**ITEMS FOR APPROVAL**			
13:50	**21.1**	Patient First	**Paper**	**Approval**	**CEO/ CFO**
	21.2	New Hospitals Programme – Contract 11 Works	**Paper**	**Approval**	**CFO**
	21.3	Microsoft Enterprise Agreement	**Paper**	**Approval**	**CFO**
	21.4	Airwaves Lease	**Paper**	**Approval**	**CSTO**

	21.5	AECC Licence/Lease	**Paper**	**Ratification**	**COO**
	21.6	Annual Governance Statement	**Paper**	**Approval**	**CEO**
	22	Any Other Business	**Verbal**		**Chair**
	23	Reflections on the Board Meeting	**Verbal**		**Chair**
	24	**Date and Time of Next Standing Board of Directors Part 2 Meeting:** Board of Directors Part 2 Meeting on Wednesday 5 June 2024 at 9:30.			
14:00	**25**	**Close**	**Verbal**		**Chair**

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Items for Next Standing Board Part 2 Agenda

Standing Reports

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

Bi-annual/Annual Reports

- Quality Account – draft
- Annual Report and Accounts – draft

Ad Hoc

- Digital Strategy
- Clinical Strategy

List of abbreviations:

Officer titles

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

Other abbreviations

CDEL – Capital Delegated Expenditure Limit
CIP – Cost Improvement Programme
ED – Emergency Department
HSMR – Hospital Standardised Mortality Ratio
ICB – Integrated Care Board
ICS – Integrated Care System
IPR – Integrated Performance Report
ITU – Intensive Therapy Unit
MSG – Mortality Surveillance Group
NHSE/I – NHS England/Improvement
#NOF – Fractured neck of femur
NRTR – No reason to reside
OPEL – Operational Pressures Escalation Levels
RTT – Referral to Treatment
SDEC – Same Day Emergency Care
SHMI – Summary Hospital-Level Mortality Indicator
SMR – Standardised Mortality Ratio
SWAST – South West Ambulance Service NHS Foundation Trust

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

BOARD OF DIRECTORS PART 1

Minutes of the Part 1 meeting of the Board of Directors held on Wednesday 6 March 2024 at 9:30 via Microsoft Teams.

Present:	Rob Whiteman	Trust Chair *(Chair)*
	Pankaj Davé	Non-Executive Director
	Judy Gillow	Non-Executive Director
	Siobhan Harrington	Chief Executive
	John Lelliott	Non-Executive Director
	Helena McKeown	Non-Executive Director
	Pete Papworth	Chief Finance Officer
	Richard Renaut	Chief Strategy and Transformation Officer
	Sharath Ranjan	Non-Executive Director
	Cliff Shearman	Non-Executive Director
	Paula Shobbrook	Chief Nursing Officer
	Tina Ricketts	Chief People Officer
	Claire Whitaker	Non-Executive Director
In attendance:	Colin Blebta	Public Governor
	David Broadley	Medical Director – Integrated Care
	Robert Bufton	Public Governor
	Sue Comrie	Appointed Governor
	Samantha Dean	Deputy Sister
	Jamie Donald	Associate Director of Communications
	Yasmin Dossabhoy	Associate Director of Corporate Governance
	Rob Flux	Staff Governor
	Ewan Gauvin	Acting Deputy Company Secretary
	Colin Hamilton-Welsh	Staff Governor
	Stuart Lane	Sustainability and Carbon Manager
	Keith Mitchell	Public Governor
	Claire Rogers	Group Director of Nursing, WCCSS *(until BoD057/24)*
	Jeremy Scrivens	Public Governor
	Diane Smelt	Public Governor
	Kani Trehorn	Staff Governor
	Michaela Turton	Project Manager
	Whitehurst, Michele	Public Governor
	(*Six members of the public in attendance)*	

BoD 047/24	**Welcome, Introductions, Apologies & Quorum** Rob Whiteman welcomed everyone to the meeting. He congratulated Michele Whitehurst who would be taking up her term of office as Lead Governor. Welcoming Tina Ricketts, who had joined the Trust as Chief People Officer, he extended thanks to Irene Mardon who had served as Acting Chief People Officer. No apologies had been received from members of the Board: The meeting was declared quorate.
BoD 048/24	**Declarations of Interest** No existing interests in the matters to be considered were declared. In addition, no further interests were declared.
BoD 049/24	**Patient Story** Paula Shobbrook introduced the Patient Story, aligned to the strategic objective of improving flow for the Trust's patients. A video was presented about the success of the Departure Lounges as a service. Tash Kelly, matron, who had recently taken over charge of the Discharge Lounge acknowledged Nikki Manns and Georgie Bryant who were key drivers behind this initiative as well as the work of the whole team. She had been at the Trust for 24 years and she considered this to be the most successful discharge lounge. Siobhan Harrington commented upon the energy and enthusiasm shown by the staff, particularly Rory. She referenced having met with Ernie, a volunteer shown in the video, on several occasions and commended how fortunate the Trust was with its volunteers. Sue Comrie expressed her thanks for the recognition of the volunteers, with age being no barrier. Ernie was 92 years of age with Jackie, in Poole was 79. Tash Kelly explained that the current only limiter was space. Thanking her for presenting to the Board on the day of her annual leave, Rob Whiteman asked that thanks also be passed on to all of the staff and volunteers. The Board NOTED the Patient Story.
BoD 050/24	**For Accuracy and to Agree: Minutes of the Part 1 Meeting of the Board of Directors held on 3 January 2023** The minutes of the Part 1 meeting of the Board of Directors held on 3 January 2024 were APPROVED as an accurate record.
BoD 051/24	**Matters Arising – Action List** It was noted that there were no outstanding actions.
BoD 052/24	**Trust Chair's Update** Rob Whiteman presented the Trust Chair's Update highlighting that: • It was Budget Day. Overall the economy was stagnant with there having been a move into recession in the last quarter. Overall, the economy was only due to grow by 0.6%. It appeared that the Government would have to take some decisions in relation to tax cuts as a priority with a view to stimulating the economy. It was difficult for public services, with there being large backlogs of work post-Covid. If books were to be balanced by putting efficiency or productivity targets into spending that had already been agreed, it would be a difficult time. Inviting Pete Papworth to comment on any expectations, Pete

	Papworth reported that nothing had been announced as yet. The final planning guidance and final allocations remained expected. • Two hours and forty-five minutes were being allowed for the duration of the meeting as there had been a sense that items towards the end of the Board meetings were sometimes rushed. However, if the full meeting duration was not needed, then it would finish earlier. • There were welcome improvements in performance that would be discussed during the meeting but also some issues where assurance was needed in relation to individual cases of quality and the consistency of care. • A positive Board to Board meeting had been held with Dorset Healthcare and Dorset County. There was a keenness to strengthen the provider collaborative. He expressed thanks to Siobhan Harrington and Matthew Bryant as well as the company secretary teams for the planning. • The Transforming Care Together Group had commenced, to have some focused governance upon the New Hospitals Programme and being build ready and service ready. This would also help to co-ordinate those aspects that would be presented to Board Committees to avoid duplicating governance. In future, reporting back from the Group to the Board would occur. • The recent Board and Council of Governors Development session had included a focus upon engagement, which would be a continuing theme for the Trust. It was good to think about focusing the work between the Board and Council of Governors. • Good discussions had taken place at a Board Development session on risk, that would inform future iterations of the Risk Management Strategy. • He expressed thanks to Board members for the joint visits that were taking place between Executive and Non-Executive Directors. It was beneficial for triangulation. The Board NOTED the Trust Chair's Update.
BoD 053/24	**Chief Executive Officer's Report** Siobhan Harrington introduced the Chief Executive Officer's Report, highlighting: • The impressive response to the management of industrial action, including the Trust having come out of five days of junior doctor action. Teams were pulling together including medical, nursing teams, allied health professionals and others. She particularly noted the work of the booking teams to schedule and reschedule appointments and talking to people about the impact of the industrial action on waiting times. • 8 March 2024 would be International Women's Day. She had been invited to speak at events in Dorset. The theme of the day was "Let's Inspire Inclusion". • Thanking Paula Shobbrook on what would be her final Board meeting at the Trust, she recognised her support to the Executive Team. She had been Acting Chief Executive prior to Siobhan Harrington starting in the Chief Executive Officer role at the Trust. Her impact as a nurse had been widespread through Dorset and beyond. She hoped she would enjoy her final month before she retired. Echoing this, Rob Whiteman thanked Paula Shobbrook for her contribution on behalf of the Board. • She wanted to acknowledge the sad case of the death of a patient in the Trust's care that had been recently reported in the media. A 56

	year old man who had Down's Syndrome and dementia had died from pneumonia at Poole Hospital in 2021. Sincere condolences were with the family and the Trust had apologised for the failings that resulted in his death. A number of changes had been implemented following the incident, shared with the family. There was reflection when the care provided was not of the standard that she as Chief Executive Officer or the Board wanted it to be. The Trust was currently very much focused on continuous improvement and being better. There had been considerable learning and actions put in place, which had been reported through to the Quality Committee. • On 27 January 2024, there had been a mass musculoskeletal clinic at Christchurch hospital, not only for the Trust but all physiotherapists across Dorset working together in a large clinic where over 100 patients were seen. This was held alongside colleagues from LiveWell Dorset, with promotion and discussion in relation to diabetes. • She commented upon the integrated performance reports, with some notable positive areas. Key messages included that the financial position of the Trust remained a challenge. The planning guidance had not been formally published; however, work was underway with colleagues in Dorset. Next year, across the whole of Dorset, there was a significant financial challenge. • Echoing Rob Whiteman's welcome to Tina Ricketts, Siobhan Harrington referenced the benefit of having Tina's experience of having worked in a trust where the Patient First methodology had been implemented. • The recruitment process for the Chief Nursing Officer had been undertaken. • Staff survey results remained embargoed until 7 March 2024. These would be discussed at future meetings. • She continued to receive approximately 50 nominations per month for the staff excellence awards, with colleagues referenced in her report. Reflecting upon the impact of flow on the health ecosystem and working with partners in councils which may also be facing pressures, Pankaj Davé enquired whether there were particular risks of which the Board needed to be conscious in the context of additional pressure on no criteria to reside. Responding to this, Rob Whiteman commented upon the need to be mindful of this and to discuss it with partners; the local government sector was under a significant amount of pressure. There had been 19 councils that week which had not become bankrupt as they were allowed to capitalize their revenue deficit. BCP and Dorset were not amongst that number, with both having set balanced budgets. BCP Council continued to be in a tight financial position. The Secretary of State had not been minded to allow it any council tax flexibility to increase to more than the referendum limit. Both councils were of lower risk than many other councils; however, the whole local government sector was at risk. Consequently, the relationship between health and local government had to remain under discussion. Adding to this, Siobhan Harrington reported that within the last month the Chief Executives of the ICB, trusts and councils had met with constructive conversations having taken place about working together over the next 12 months. No criteria to reside numbers at the Trust had improved. She was struck by the relationships with partners and how they continued to be strengthened. The Board NOTED the Chief Executive Officer's Report.

BoD 054/24	**Integrated Performance Report (IPR)** Rob Whiteman invited Mark Mould, Peter Wilson and Paula Shobbrook to provide an initial introduction to the Trust's performance and key issues. Mark Mould noted that although the report was focused upon the January 2024 position, it was important to provide a flavour of the current status and a view of the remainder of the year. He highlighted that: • The expected challenges post-Christmas were as predicted, with high numbers of escalation beds open in the organisation, peaking at 95 during January 2024. Coupled with that was the highest number of no criteria to reside, peaking at 270 and two periods of industrial action, both of which impacted upon the elective recovery programme. • With the cancer standards, the report reflected one of the best performances seen in the organisation for the 28 day standard. This was a step up from December 2023, which had improved even further in February 2024. Currently, this was showing the best performance in two years and eight months. The long wait cancer patients were at the lowest levels for two years. • Elective work had seen a slight increase in the number of long wait patients in January 2024. Moving into February 2024, this had been seen to come back down, with collective efforts to achieve as close to zero for year end as possible. As at the date of the meeting, a 7% reduction in waiting lists had been seen. • Collective working had taken place in agreeing a difficult bed plan. This was a plan for the right services to be in the capacity previously occupied. The plan was described in the meeting materials. Phase 1 – to reduce the number of open capacity by just over 20 spaces in the first two weeks – had been achieved and had gone further. A quality impact assessment had been completed. This was being tracked through each of the phases. This had required support of partners. Non-criteria to reside needed to keep track with each of the phases. There had been a reduction in Phase 1 of 26 patients who ceased to have no criteria to reside. It was very difficult and required regular collective conversations with partners to get support. In the first phase, Same Day Emergency Care (SDEC) across the organisation had been re-opened. With Peter Wilson's leadership, there was no escalation process to convert them to beds. SDECs needed to be protected even at the most difficult times. • Treatment Investigation Unit had moved from the theatre area back into its appropriate space, supporting patients and staff. There had been some concerns expressed by patients about the use of that area. It had allowed refurbishment of some theatres on Poole site, which required refurbishing by the end of the year. • There had been a focus for 76% of patients to be seen within four hours. This was a clinical standard, was important for patients and gave a better experience for staff working in a department that was not crowded. The organisational focus upon it had been difficult and challenging. He, Peter Wilson and Paula Shobbrook met with the emergency department on a weekly basis. The previous week, he and Siobhan Harrington had been invited to a national conversation about the ask to ensure that during the month of March 2024 the Trust met that standard. The Trust had set out at the start of the year to perform the standard. A number of actions were ongoing for that standard. As at the current date, the Trust was 10% behind where it needed to be

for March 2024. However, collectively, individually and teams, were doing what they needed to.

Inviting Peter Wilson to comment upon the professional standards, Peter Wilson added that:

- The professional standards had been revamped, with all directorates signed up to it. The escalation policy was currently being worked through. It would be relaunched, was not only about flow, but also about working together. David Broadley had been undertaking a piece of work related to how it worked with primary care into the organisation.
- Paula Shobbrook also referenced the multi-disciplinary approach to timely admission and discharge.

In relation to the Quality domain, Paula Shobbrook highlighted:

- Notwithstanding the busy environment, the higher numbers of friends and family tests (FFT), which had been reported to the Quality Committee. Good feedback was being received from patients on the Trust SMS. For the past seven months, FFT had been positive. This was all in the context of continuous improvement.
- During the month, there had been a number of beds open, with costs of agency staff increasing. Conversations had already taken place between her and Tina Ricketts about how to move further faster. Care hours per patient day had remained stable. The rate card had reduced. HR people metrics were improving and vacancies reducing. There had been considerable focus on healthcare support worker vacancies.

Referencing the Mortality Report, Peter Wilson highlighted that:

- Hospital Standardised Mortality Ratio (HSMR) was currently between 102 and 104.
- He commented favourably on the levels of assurance. There was clarity that one of the significant areas where there was an issue was palliative care coding. With the new company being used and better data, HMSR would be between 93 and 95 if palliative care coding were correct. The SHMI was now 0.85. The teams were making positive inroads.
- With the move to Patient Safety Incident Reporting Framework (PSIRF), there had been a concern that there would be a decrease in reports that would come through which would provide false assurance. However, the number had remained the same. Severe incidents were slowly decreasing compared to a year ago. There was assurance that the reporting was not deteriorating.

In relation to the emergency department (ED), Cliff Shearman commented that despite the pressures there was palpable appetite for change. As the Trust was addressing ED, attendances were increasing. This was puzzling with the year being milder and he enquired whether this was being looked at. Responding to this, Mark Mould explained that the Trust ran the urgent treatment centre (UTC); as the increase had been coming through ED, more capacity had been blocked out to screen people. There was potentially a larger discussion working with the help of David Broadley about engaging with the ICB and primary care to utilise primary care capacity in a different way. He outlined the change that had been made, working with the ICB, about when UTC capacity could be booked in.

Cliff Shearman also enquired about any bottlenecks arising, noting the constraints with anaesthetics. Answering this, Mark Mould provided highlights of the visit from the elective care centre at Frimley Park. The Executive Team

	had subsequently discussed bringing changes at scale and having a different risk appetite to make use of important capacity available within theatres. Referencing the transformation, Judy Gillow commented upon the importance of education. She had noted in the integrated performance report the increased requests in relation to availability of rooms and enquired about the facilities for education being considered to achieve new ways of working. Richard Renaut explained that there was significant time and space for simulation training when moving into areas. This had worked successfully in theatres. The paediatric floor would be free for nearly nine months, with this being considered for training, including generic therapy in ward based areas. For traditional classroom training, the Trust was looking to further work with Bournemouth University. The longer term approach would take more time. Adding to this, in relation to maternity specifically, Paula Shobbrook highlighted that improvement in levels of training, which would be covered in more detail as part of the Maternity Safety Champions Report. In relation to no criteria to reside, Rob Whiteman noted that there was a focus upon people being in the right place for their care. However, the no criteria to reside numbers had historically fluctuated and he wanted to understand what was being watched to see that this did not re-occur. Noting that this was a complex question, Mark Mould referenced the importance of walking in the local authorities' shoes and understanding their challenges. Internally, there was curiosity about capacity which was not bed based for example, intermediate care teams, interim care teams and domicillary care teams and how to unlock blockages. Having the curiosity supported better and more informed conversations with partners. There was a commitment across the ICB to continue to see a reduction, with the Trust being dependent upon that to see its bed spaces reduce. Peter Wilson also outlined the internal approach to decreasing length of stay. In relation to the Trust finance position, Pete Papworth added to the report that: • In relation to capital, the formal request to re-profile the £19.1 million of capital funding into future years had now been accepted. • In relation to the revenue position, some further improvements were expected in February and March 2024. Additional funding was expected for the industrial action. However, the Trust remained reliant on significant income support from the ICB in recognition of those pressures to get back to a balanced position. Efforts were currently focused upon a forecast across Dorset that gave confidence of delivering the £12m deficit. • The pressures within the NHS were challenging, with a recurrent underlying deficit going into next year. There were events occurring across Dorset the following week to consider collective opportunities to improve the position further. • The different approach in the organisation – such as the bed reconfiguration plan, productivity improvement plan and quality improvements – would drive safe reduction in cost and improve the quality for patients. In light of this, while optimistic that a better financial position could be delivered than in previous years, the challenge would be whether sufficient time would be given to deliver such position. The Board NOTED the Integrated Performance Report.
BoD055/24	**Quality Committee – Chair's Report – January and February 2024** Rob Whiteman introduced the Committee Chairs assurance reports, requesting that the Chairs comment on whether overall there was assurance

	for the items referenced. There were some items where the Board was being asked for approval, rather than assurance. Cliff Shearman, Chair of the Quality Committee, outlined that there were six items to be brought to the Board's attention. • The Board Assurance Framework in relation to the three areas for which the Committee was the monitoring committee had been discussed. Mortality had been discussed in detail. • The risk register had been received, with no new risks presented. • A deep dive in relation to patient flow had been received, with considerable focus on different ways of doing things. Committee received significant assurance about actions going forward. • A CQC update in relation to the actions the Trust needed to achieve was received, including a focus upon timely completion of those that had to be completed. • A detailed report about a clinical incident had been received. • Detailed assurance from Peter Wilson relating to progress on the electronic health record (EHR) had been received. However, it was important for the Board to be aware that there was a plan which was being progressed with pace. During that time, there would be risk; the risk would be mitigated as much as possible but until the EHR was implemented, the Trust would carry those risks. Regular reports would be received and discussed. • The Maternity Safety Champions Report had been received. This included the maternity survey, which had been positive, particularly in light of the circumstances under which everyone was working. In relation to the case that Siobhan Harrington had referenced in her Chief Executive Officer's Report and which had come into the media recently, the Committee had received a detailed report. This related to the case of the patient who had sadly passed away in 2021. The clinical details would not be discussed in the meeting, but the Committee meeting had received considerable information. This included: • Actions taken at the time and what had been done since. • There had been a formal serious incident review and the case reviewed through the external Learning Disability Mortality Review. • A duty of candour process had been taken out with the family, with details of how that had been conducted provided to the Committee. • How the process of review had been undertaken, which had included the Director of Nursing and matron for that service and the ward team. • 10 substantive whole-time equivalent medical staffing posts had since been made. • Care of people with learning disabilities had since changed. • Processes had changed in relation to team working. • Other Trust-wide work in this area included the Nutrition Steering Group. • A more recent review of the case notes had been undertaken by the Deputy Chief Medical Officer, Becky Jupp. Although there were aspects that the Trust could have done better, there were no additional recommendations or key lines or inquiry for further investigation. The Committee therefore considered that the process at the time had been handled in a satisfactory manner. There was no new information of which the Committee was aware that stimulated the media interest in the case.

Maternity Safety Champions Report

Claire Rogers presented the Maternity Safety Champions Report.

Paula Shobbrook referenced that she and Judy Gillow met with Lorraine Tonge and the broader maternity team before the report was presented to Quality Committee. She had been pleased to note the improvements that had been embedded and sustained.

In her capacity as Non-Executive Maternity Safety Champion, Judy Gillow commented that she visited the unit regularly and had observed a commitment to improvement. Sustaining that improvement would be important, particularly in relation to staffing. At the Quality Committee, Peter Wilson had reported that there was further obstetric consultant recruitment support that his team could provide.

Referencing the audit of translation services in the report, Rob Whiteman enquired whether improvement was being seen from the actions that had been put in place. Although it was early days, Claire Rogers confirmed that Lorraine Tonge would provide an update on this at the next Part 1 meeting of the Board.

In relation to embedding of improvement, Siobhan Harrington added that it had been agreed that Maternity would be part of the second wave for Patient First training, which would give an opportunity to align the improvement work and its embedding.

Cliff Shearman also commended the outcomes from the maternity survey.

Mortality Report

In relation to the Mortality Report, Cliff Shearman referenced there having been a change with the HSMR having increased to 114. Peter Wilson had presented a detailed report about the rationale for this which appeared to relate to coding. There were two aspects that provided assurance in relation to this rationale:

- The difference between the HMSR and the SHMI. He also drew attention to the differences between the Trust and North Hampshire Hospitals in terms of palliative care.
- As the data was corrected, with a month lag, data was now being seen to be where it was expected, albeit a month later.

The Committee were therefore assured that it was a coding issue. This was being addressed. Peter Wilson also clarified that there were two separate coding issues:

- The first related to the timing of the coding about which Pete Papworth had been working with the coding team. This related to staffing and how quickly the coding could be provided.
- The second related to palliative care coding, which was a consultant issue, rather than a coders issue. Work was ongoing through the Mortality Surveillance Group and the Clinical Governance Group to encourage clinicians' practices in relation to coding. This had a linkage to finances.

In relation to the finances, John Lelliott enquired about the scale of the coding issue and its impact. Responding to this, Pete Papworth outlined that there were three aspects:

- Clinical coding resource and turnover in the clinical coding team. Although a significant number of trainee coders had been appointed,

	they needed training and their coding had to be checked by a qualified coder. However, there was a plan in place. • The depth of the recording of information from medical staff and healthcare professionals. • The systems, with some codes that had not been flowing through to SUS submissions. The Trust had been supported by the ICB, regional and national team with re-setting some of the data. This was one of the drivers for the recovery in elective income. He summarised that the timeliness, accuracy and depth of the coding did drive the financial position, not only on elective activity. <u>Quality Impact Assessment report</u> Paula Shobbrook confirmed that the Quality Impact Assessment report was reviewed, with nothing to escalate to the Board. The Board NOTED the Quality Committee Chair's Report and the Maternity Safety Champions Report.
BoD056/24	**People and Culture Committee – Chair's Report – February 2024** Rob Whiteman invited Pankaj Davé to present the People and Culture Committee Chair's Report, noting that there had already been a discussion in relation to car parking at a Part 2 meeting of the Board of Directors. Pankaj Davé highlighted that it had been reported to the Committee that: • Theatre staffing risks had reduced from 12 to 9. • Vacancies had reduced. • There was considerable pressure on staff, with concerns in relation to employee wellbeing and the need to ensure staff had enough support. • The Freedom to Speak Up Guardian had shared the challenges through people being stretched, with industrial action not having helped. • Pressure existed within the Care Groups in relation to open beds. Not only was it important to consider the financial aspects but also staffing plans. • Agency spend remained a risk. • It would be important to consider sexual harassment for women in surgery, as part of the Trust's work on the sexual safety charter. • Data harmonisation had been completed. Policies had not yet been fully harmonised, with an extended timeline to June 2024 having been agreed. • A forward establishment review and resource plan would be needed as part of the transformation. • A talent management pipeline plan would be presented to a future meeting of the Committee. The Board NOTED the Safe Staffing Report and the Maternity Safe Staffing Report. Later in the meeting it also NOTED the Guardian of Safe Working Hours Report. Richard Renaut presented the Car Parking Policy and Operating Procedure, which had been through the staff partnership side. He outlined the significant inflationary rises seen and the Trust having to bring its pricing in line with similar trusts. The Board NOTED the People and Culture Committee Chair's Report and APPROVED the Car Parking Policy and Standard Operating Procedure.

BoD057/24	**Finance and Performance Committee – Chair's Report – January and February 2024** John Lelliott presented the Finance and Performance Committee Chair's report, noting that: • There had been considerable discussion at the Committee in relation to the budget and the Trust's financial performance, which had largely been covered by Pete Papworth and Mark Mould earlier in this meeting. • Going forward, the Committee would look at the regulatory aspects of operational performance, particularly to avoid duplication with the Quality Committee. • It would be important to have clarity on the medium term capital commitments. • The Committee had endorsed recommendations in relation to going concern and key judgments and estimations. Going concern would also be presented to the Audit Committee. • In relation to IT, the Committee would focus upon this further. This was not only in relation to EHR but the wider Digital Strategy and projects underway within the Trust. Pete Papworth was working on a form of reporting to be presented to the Committee. • The Committee had received a paper in relation to car parking, with the need for more parking space, particularly at Bournemouth hospital and also a report in relation to automatic number plate recognition. Wessex Fields would be discussed in Part 2 of the meeting. • In relation to Estates, the Committee would be focusing upon statutory and legal compliance, meeting the standards and planning for major works going forward. • An update had been received on transformation, particularly build ready and service ready and how this would be reported upon going forward. <u>Estates Masterplan</u> Richard Renaut reported that the Estates Masterplan was being presented for information, with it being updated periodically to reflect decisions or opportunities, albeit not all funded. <u>Green UHD Plan</u> Richard Renaut invited Stuart Lane, who had undertaken considerable work on the Green UHD Plan over a number of years to present. Stuart Lane shared slides, giving the Board a detailed presentation. John Lelliott extended his thanks to the team and commended the plan as an exemplar. There would be considerable focus upon sustainability going forward. Also commending the plan, Helena McKeown referenced the window of opportunity for change in behaviour that the reconfiguration would provide for staff transport. She also enquired about the potential to further reduce the use of gloves, with this having already reduced in ITU. Noting the comment about communications resources that had been made, Claire Whitaker emphasised the importance of this being considered. She echoed Helena McKeown's comments about integration into reconfiguration plans. Judy Gillow commented upon how the presentation brought the Green Plan to life. She considered it key to quantify savings and link that to productivity gains. Echoing earlier comments about communication, there was an

	opportunity with staff to communicate about how much had been saved by changing practice and for people to become engaged. Pankaj Davé emphasised the importance of setting expectations correctly and prioritise expenditure. In relation to transport issues, Richard Renaut referenced Mobilityways providing staff members with a personalised travel plan and he also referred to other transport incentives. In addition, he further outlined the investment in transport support as staff transferring sites and the communication approach. From a capital perspective, some of the works would be through invest to save, with other aspects requiring investment. Some trusts that were not undertaking the work were being fined for lack of progress on their carbon reduction. *(Claire Rogers left meeting)*. Also commending the plan, Siobhan Harrington suggested that: • consideration needed to be given on embedding some of the metrics into Patient First. • Tina Ricketts explore the current mandatory training and what further could be injected into this. • Board members consider signing up to the ecoearn app if they had not already. In relation to Helena McKeown's question about glove reduction, Stuart Lane referenced the "gloves off" campaign taking place in May 2024. The Board NOTED the Finance and Performance Committee Chair's Report and the Estates Masterplan and APPROVED the Green UHD Plan.
BoD058/24	**Population Health and System Committee – Chair's Report – January 2024** Helena McKeown reported that there were no escalations to be made to the Board. The Board NOTED the Population Health and System Committee Chair's Report.
BoD059/24	**Audit Committee – Chair's Report – January 2024** Judy Gillow reported that: • A key focus of the meeting of the Committee had been on the risk management action plan. This had been discussed at a recent Board Development Session. The Committee would continue to oversee the delivery of the actions. • The Trust's Freedom of Information Act compliance was at 65%. From a regulatory perspective, this needed to be improved. This would be recorded on the risk register and the mitigations reviewed. Best practice from other organisations performing better than the Trust would also be considered. • Consultant job planning was progressing. The Trust was on track to have all consultant job planning on a single platform by April 2024. This would be re-audited, potentially in quarter 4 of the following financial year. • Within the 2024/25 audit plan would also be included private practice versus NHS work. • The maternity incentive scheme would be audited annually. The Trust would share audits with Dorset County. • The Committee had a discussion about the Managing Conflicts of Interest Policy, which was endorsed. It was proposed to enhance the references to family member interests.

	• In its system role, the Committee was also starting to look at cross-organisational audits. It had been suggested that there potentially be a cross system audit in relation to EHR in the next financial year. The Board NOTED the Audit Committee Chair's Report.
BoD060/24	**Charitable Funds Committee – Chair's Report – February 2024** Claire Whitaker reported upon a good meeting of the Charitable Funds Committee. The Committee had agreed to the funding of some sleeping pods. The charity was performing well and an additional pipeline of requests would be considered. The Board NOTED the Charitable Funds Committee Chair's Report.
BoD061/24	**Risk Register – review of significant risks; new risks 12 and above** Paula Shobbrook introduced the Risk Register, noting that there were no relevant new risks to be presented to the Board. The Board APPROVED the Risk Register Report.
BoD062/24	**Patient First** Paula Shobbrook presented the Patient First Highlight Report. Meetings had taken place with all of the Care Groups, working through the strategic objectives discussed at the Board. In a "catchball" process, the priorities of the Care Groups had been reviewed. She outlined the new approach that had been taken at Trust Management Group the previous day reviewing scorecards, through a very structured methodology. Further feedback would be provided about the impact of this work, aligning closely with staff survey. Going forward, Peter would take SRO role for Patient First working alongside Deb Matthews. Rob Whiteman noted how well Paula had performed with the SRO role for Patient First. The Board NOTED the Patient First Highlight Report.
BoD063/24	**Transforming Care Together – Terms of Reference** Rob Whiteman introduced the Transforming Care Together Group Terms of Reference, noting that Pete Papworth was to be added to the members. Subject to this amendment, the Board APPROVED the Transforming Care Together Terms of Reference.
BoD064/24	**Risk Management Strategy** Presenting the Risk Management Strategy, Paula Shobbrook outlined that considerable further work was is in progress to review the Trust's Risk Management Strategy. The version being presented to the Board for approval was the current one. Work was in progress to review and further develop the Trust's risk appetite and risk tolerance. Risks would continue to be aligned to relevant Board monitoring committees. Close oversight would continue to be maintained through the Board Assurance Framework. The risk ratings for escalation to the Board were being reviewed. The ICB had a risk management strategy which was also being reviewed, including in relation to system wide risk. The work being undertaken by the Trust related to the Risk Management Strategy was set out in an action plan which was being overseen by the Audit Committee.

	Judy Gillow emphasised the importance of pace in having a revised Risk Management Strategy, with Paula Shobbrook confirming that the updated version would be presented to the Board in July 2024. Helena McKeown enquired whether the Population Health and System Committee objective on page 309 of the materials sufficiently captured the risk appetite statement and the Committee's responsibility related to the Dorset ICS Long Term Plan. Paula Shobbrook confirmed that this would form part of the revisions going forward. The Board APPROVED the Risk Management Strategy.
BoD065/24	**Engagement Policy – Board of Directors and Council of Governors** The Board APPROVED the Engagement Policy – Board of Directors and Council of Governors.
BoD066/24	**Annual Objectives** Richard Renaut introduced the Annual Objectives, referencing that objectives were being set for next year. As the national guidance was received, there would be some updates made through the Chief Executive – for example, to the exact referral to treatment and performance. The Board APPROVED the Annual Objectives with delegated authority given to the Chief Executive to make minor amendments to take into account the national guidance.
BoD067/24	**Register of Use of Seal** The Board NOTED the Register of Use of the Seal.
BoD068/24	**Any Other Business** The Board APPROVED the Guardian of Safe Working Hours Report. No further items were raised.
BoD069/24	**Reflections on the meeting** There were no reflections on the meeting.
BoD070/24	**Questions from the Council of Governors and Public arising from the agenda** Diane Smelt, Public Governor, had raised the following questions in advance of the meeting: *In a recent report into the death of a lady in North Durham, the Coroner raised concerns regarding a new computer system which had been introduced into the Emergency Department at UH North Durham by Cerner,which is now owned by the Oracle Corporation.* *The Coroner heard evidence that the previous software in use in the Emergency Department included a "RAG rating" system which ensured that the acuity of patients was easily identifiable by looking at a single page on a display screen. The new software which had been introduced in the Department did not include this software but instead had symbols next to a patient's name, that when clicked on, provided an indication of the level of acuity of the patient but not a clear indication at first glance.* *The Coroner was informed that the previous RAG rating system was an effective tool in quickly identifying patients requiring urgent oversight by Clinicians, especially when Emergency Departments, were under pressure, and he concluded that a quick and clear way of identifying the most critically ill patients was an important tool that could prevent future deaths.* *In view of this Matter of Concern report by HM Coroner can the Trust give an assurance that the new Agyle computer system recently introduced in A/E*

	addresses these concerns and is an effective tool for quickly identify patients who require urgent oversight by senior clinicians. Responding to this, Pete Papworth confirmed that the Agyle system did include clear RAG rating with the acuity highlighted alongside the RAG rating for triage scores as part of the licensed Manchester triage system. These scorings were available on all screens routinely used by senior clinicians and was an improvement on the previous IT system that was used within the department for the identification of acuity. The Agyle system also used digital treatment whiteboards which were unique and prompted the nursing team when repeat observations were required in line with the Trust guidance. In addition, Diane Smelt had asked the following question in advance of the meeting: *Security of Staff and Patients at RBH* *There are allegations on social media that a man has been harassing local people in various locations in the vicinity of RBH asking for money for various reasons. A post has also been added to a site by a member of UHD staff saying she was approached by this man late at night on site when she finished her shift, which she said was very frightening.* *Can the Trust give an assurance that the Security arrangements for our all of our staff and the patients in our care are robust and are reviewed and updated on a regular basis and can staff be reminded of the process for reporting such behaviour.* In relation to safety of staff and patients, Mark Mould emphasised this being a priority. Internally and externally the Trust had different levels of influence. Externally, it was possible to speak with local authority partners. It was worth recognising that at any point in time, one could walk into a town centre, for example, and be faced with people asking for money but this did not dilute how people felt. The Trust did currently have security staff in its organisation that were able to respond to incidents. There was a movement and a change in direction that the Trust would start to employ its own security staff, with a recruitment process having been undertaken and individuals starting to joint the organisation. They would be undertaking training including to have consistency of approach. At certain times of reduced incidents, they could also support the wider teams within the Trust. The Trust had CCTV in strategic locations. The cameras were not manned 24/7; however, they were visible in key locations, particularly in the control rooms, sighted not directly onto patients but in areas to keep patients and staff safe. The Trust had an accreditation scheme, with additional powers for a number of staff to deal with actions that police would normally undertake. Where there were areas that were more likely to have incidents, the Trust worked with its teams in undertaking risk assessments. While the Trust did its best, there was an increase in events occurring across the organisation internally and externally. The Trust responded with the resources it had in the way it supported its staff and patients to be safe. On occasions, incidents would occur and the Trust had to prioritise how it responded. Siobhan Harrington added that the Trust was strengthening its security. At the Trust induction earlier in the week, she had met a new staff member, Stacy, who had joined from the Royal Free security team. Referring back to discussions about transport earlier in the meeting, Sue Comrie made an observation that the buggy service at Bournemouth hospital was operated by volunteers. Only one buggy was currently being run and it would be beneficial to promote this service further if it could be extended and the offering further improved. Colin Blebta enquired about the implications if the Trust were not to achieve a break even position. Responding to this, Pete Papworth explained that the

	ICB had a statutory duty to break even. As a provider organisation, the Trust had a duty to collaborate so that the ICB could break even. More fundamentally, if the Trust did not break even, it would likely move into a lower Single Oversight Framework rating, which would bring intense scrutiny. He also commented upon the affordability of the capital program linked to the reconfiguration and the effect of using cash by running a revenue deficit. In response to a question from Robert Bufton about clinical coding, Pete Papworth emphasised how highly valued the clinical coding team were by him and the wider Trust. Clinical coders were highly sought after who had to go through an intense training period and there was a national shortage. Rob Whiteman requested that although the next meeting of the Board on 1 May 2024 was scheduled to be virtual, that the Company Secretary Team seek to make it face to face.
BoD071/24	**Resolution Regarding Press, Public and Others** The Board APPROVED, as permitted by the National Health Service Act 2006 (as amended), the Trust's Constitution and the Standing Orders of the Board, that representatives of the press, members of the public and others not invited to attend to the next part of the meeting be excluded due to the nature of the business to be transacted. There being no further business, the meeting was closed.
	The date and time of the next Standing Board of Directors Part 1 Meeting was announced as Wednesday 1 May 2024 at 9:30 via Microsoft Teams and in person location TBC.

CHIEF EXECUTIVE'S REPORT
MAY 2024

Thank you to everyone at UHD for helping us deliver significant improvements to patient care through 2023/24. Although we still have much to do it is great to see the progress in the last year to improve our urgent and emergency pathways, our waiting times for patients and our patient and staff surveys. We also met our financial plan. With the backdrop of recovery and industrial action and ongoing changes this is a big achievement. The year ahead, as we are currently concluding the planning round, will continue to be challenging. As we transition to the emergency and planned care changes over the next 18 months, maintaining the focus on patient safety and looking after each other will continue to be the golden thread alongside our delivery of continuous improvement. Thank you, Team UHD.

1. National updates

Dame Ruth May, Chief Nursing Officer for England, has announced her retirement later this year. Ruth visited the Trust in March this year helping us to bury our Covid time capsule and also talking with nursing colleagues at UHD. She has provided a voice to nurses through a very challenging period in the NHS and we thank her for her leadership.

National Planning Guidance.

The planning guidance was received for 2024-25 on 27 March 2024. The priorities for the year are

- Maintain collective focus on the overall quality and safety of services, particularly maternity and neonatal services, and reduce health inequalities
- Improve ambulance response times and A&E waiting times by supporting admissions avoidance and hospital discharge and maintaining the increased acute bed and ambulance service capacity that systems and providers committed to put in place for the final quarter of 2023-24
- Reduce elective long waits and improve performance against core cancer and diagnostic standards
- Make it easier for people to access community and primary care services
- Improve access to mental health services so that more people of all ages receive the treatment they need
- Improve staff experience, retention and attendance.

NHS Providers Visit

Sir Julian Hartley, Chief Executive of NHS Providers along with Amber Jabbal, Head of Policy and Strategic Projects, visited us as a senior leadership team on 17 April at the Royal Bournemouth site. We discussed our short-term plans, our Patient First approach, the planned and emergency care changes. A future blog regarding UHD will

be published in due course. Sir Julian and Amber also toured the new BEACH building.

NHS sets out measures to improve the working lives of doctors

A letter from NHSE was received on 25 April regarding improving the lives of junior doctors. We will bring a specific report on this back to the Board and through our Workforce Committee.

2. Dorset

Operational Planning 2024/25.

Work is progressing to finalise with Dorset Integrated Care Board (ICB) and wider system partners 2024-25 operational plan. The plan includes finance, operational and quality standards and workforce. There will be a meeting with the National Team in May for Dorset Chief Executives to discuss the plan.

3. Quality & Safety

3.1 Urgent Emergency Care (UEC)

The integrated performance report demonstrates the improvements delivered in 2023-24. We continue to see improvements to our urgent and emergency care pathways and flow through the organisation. In March, the Trust was in a position to ensure that seven out of ten patients were seen and admitted or discharged within four hours. This is a significant improvement of over 6% compared to February. However, numbers of patients who do not meet the criteria to reside in an in-patient bed, remain consistently high, which results in high occupancy levels. We are continuing to implement our plan to reduce escalation beds, this requires partners to support reducing no criteria to reside patients (NCtR) to deliver safety. UHD completed our capacity de-escalation plan in March and as per the plan our Same Day Emergency Care (SDEC) capacity and Treatment Investigation Unit (TIU) has been released from escalation and is functioning as admission avoidance capacity.

Planned Care

With regards to planned care the Trust ends the year having achieved a number of its ambitions for elective and cancer care. Fewer patients are waiting on a referral to treatment (RTT) waiting list and a higher proportion of patients have been seen or treated within 18 weeks. We are reducing our very long waiters and have the ambition the eliminate 78 week waits in quarter 1 and 65 week waits by the end of quarter 2. Our cancer waiting times are also improving. We achieved the national standard to support patients who are referred with suspected cancer to be either told they do not have cancer or to have a cancer diagnosis confirmed within 28 days. We also reduced the number of patients waiting start of treatment over 62 days. We also understand we are no longer in Tier 2 for elective care performance.

Maternity Incident

We are investigating an incident in our maternity unit in September 2023 in which a baby was handed to the wrong mother. We deeply regret any distress that was caused and have reached out to the mother to offer her support. We would urge her to get back in touch with us to assist in our investigation. The safety of our parents and babies is the highest priority and we are committed to providing full support to the affected families.

4. Finance

Our financial plan was achieved in 2023-24. In 2024-25 we have a challenging plan to deliver a breakeven position including a 5% £42m cost improvement plan and achieve 109% of elective activity delivered pre-covid in 2019-20. Our current focus is on improving our cost improvement plans and project management functions.

5. Transforming Care Together

Wessex Fields

We attended the Bournemouth, Christchurch and Poole full Council meeting on 23 April 2024 where the council supported the recommendation of the sale of Wessex Fields to UHD. This is great news for the Trust and will enable us to take our plans forward.

Solar at Poole

Solar panels have been installed to provide renewable energy in line with our decarbonisation strategy. The installation will be complete at the end of April and will be functioning in May 2024. A further installation will be on the Poole multistorey car park in the summer of 2024, additional areas will follow on the Bournemouth site.

Enabling work at RBH

Three significant enabling works are currently underway on the Bournemouth site. The fire road diversion around the lake is underway. This is to allow the boarded off construction area outside the Bournemouth Medical Education centre to allow for the demolition and preparation for the new ward block. In addition near the Bournemouth residences further work is ongoing to provide the access road into the site from the Wessex Way. The completion of the road is scheduled for late in 2024.

Progress to Maternity move

Preparation for the move of maternity to the BEACH building continues and is now planned for April 2025.

TIU

The two TIU units based at the Bournemouth and Poole sites are being combined from the beginning of June and will be based at Poole as part of the clinically led transformation of our services. This is part of the change to Poole becoming the major planned care site for east Dorset and Bournemouth the major emergency care site.

Consolidating our TIU services at Poole Hospital will streamline the care - with the entire TIU team available to support and care for patients through their treatment.

Haematology Inpatient Relocation

In the ongoing transformation of University Hospitals Dorset, we are relocating the Poole inpatient haematology ward (Durlston) to Ward 7R at the Bournemouth site from next week.

This move is designed to improve care for our haematology inpatients consolidating into a single hospital site, thereby streamlining resources and fostering the development of a unified, highly skilled team for patient care. We anticipate significant

benefits for our haematology patients, including the establishment of a sustainable specialist service, aimed at ensuring the delivery of optimal outcomes.

In our letters to patients, and wider communications, we have offered a reassurance that this relocation is not expected to impact on any cancer care treatment, aside from the change in the location for inpatient admissions, which will now be at the Bournemouth site from Monday.

However, we are aware that this matter may raise some questions we have added a FAQ factsheet and update on our public website here.

Pathology Hub Opening

We are holding an official opening ceremony of the Dorset Pathology Hub at the Royal Bournemouth Hospital on Wednesday 22 May 2024, between 1-3pm. The new innovative facility is part of the One Dorset Pathology network - a collaborative partnership between Dorset County Hospital and University Hospitals Dorset.

The new laboratory is designed for rapid routine and advanced specialist testing and will support hospitals across the region to improve diagnostic tests for patients. At the event we will be joined by well-known broadcaster and Chancellor of Bournemouth University, Kate Adie OBE.

6. Electronic Health Record (EHR)

Work continues with NHS Somerset and NHS Dorset to develop an outline business case which will come to the Board in June 2024.

7. Patient First

We continue to embed our improvement approach of Patient First across the Trust. We are now running our strategic deployment reviews for which our Business Intelligence team have developed an incredible scorecard.

Our wave one teams are now having regular improvement huddles and wave two training for clinical teams has started.

Peter Wilson is now the senior responsible officer for the Patient First Programme.

8. Workforce

Fiona Hoskins – Interim Chief Nursing Officer

Fiona Hoskins, Interim Chief Nursing Officer, has been successful in being awarded a Chief Nursing Officer role in Milton Keynes. We wish her all the best for her future role and know that she will go on to bring her considerable skills and experience to her new post. I would like to thank her for her for all she has done at Royal Bournemouth and across UHD.

Sarah Herbert, Chief Nursing Officer

I am pleased to share that Sarah Herbert our new Chief Nursing Officer will be joining the Trust on 16 May 2024. We look forward to welcoming her to UHD.

Staff Survey Results

Firstly, I want to thank every single member of staff who responded to the 2023 NHS Staff Survey. UHD's response rate of 59% was the highest we have had in the past four years and is significantly higher than the national average response rate of 45%. This shows how engaged our workforce is and how much we all care about UHD.

The feedback has shown that in the majority of areas we have improved since last year, although we still have more to do to achieve our aim of making UHD the best place to work. The areas in which we have improved and where we are higher than other organisations' average scores are across the People Promise elements that make up the staff survey which are:

- we are compassionate and inclusive,
- recognised and rewarded,
- have a voice that counts,
- safe and healthy,
- always learning,
- work flexibly,
- we are a team,
- staff engagement and morale.

Two specific highlights were:

- In 2022 72.9% of our staff said that care of patients is a top priority at UHD. In 2023 that has risen to 76.2%.

- In 2022 56.2% of our staff said they would recommend UHD as a place to work. In 2023 that has risen to 63.4%.

We also have areas where we need to do better. Individual team feedback has been shared with managers and actions to improve are being identified.

Annual Staff Excellence Awards

Our second Annual Staff Excellence Awards are to be held on 20 June 2024 at the Pavilion in Bournemouth. Both staff and the general public are being asked to nominate staff who reflect and demonstrate our UHD values.

Ensuring that we recognise staff is so important and helps us to keep our wonderful staff motivated and feeling valued.

We have increased the number of awards and look forward to receiving even more nominations than 2023. Nominations close at midnight on 3 May 2024.

Monthly Staff Excellence Awards

In February, March and April 2024 the following staff were nominated and won Excellence Awards.

- Sam Murray, Pharmacy and UHD Women's Network

- Paula Shobbrook, Chief Nursing Officer

- Michael Roque, Catering Supervisor

- Pharmacy Aseptic Team

- Lucy Fairbrass, Neonatal Intensive Care Unit
- Susie Taylor, OPAU
- Main Theatres, Poole

My thanks and congratulations to them all.

9. May Campaigns and Events

May is a busy month in the NHS Calendar and amongst many things we will be marking: International Day of the Midwife, Nurses Week, Staff Networks Day, Mental Health Awareness Day, Dementia Action Week, Deaf Awareness Week and many more.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 01 May 2024

Agenda item: 6.1

Subject:	Risk Register Report and Board Assurance Framework Report
Prepared by:	Natasha Sage, Head of Patient Safety and Risk Jo Sims, Associate Director for Quality Governance and Risk
Presented by:	Executive Leads

Strategic themes that this item supports/impacts:	Systems working and partnership ☒ Our people ☒ Patient experience ☒ Quality: outcomes and safety ☒ Sustainable services ☒ Patient First programme ☒ One Team: patient ready for reconfiguration ☒
BAF/Corporate Risk Register:	All
Purpose of paper:	Assurance
Executive Summary:	**Board Assurance Framework – Year end summary**

BAF Risk	Initial Risk Rating 1/4/23	Current Risk Rating 31/3/24	Target Risk Rating 31/3/24
Risk of not meeting the patient national constitutional standards for planned care (RTT)	20	9	6
Risk of not meeting the patient constitutional standards for emergency care	20	20	6
Risk of not significantly improving staff experience and retention over the next 3 years	12	12	8
Risk that not every team is empowered to make improvements using patient feedback, in order that all patients receive quality care which results in a positive experience for them, their families and/or carers	8	6	6
Risk of not improving hospital mortality and being in the top 20% of trusts in the country for HSMR over the next 3 years	10	8	6
Risk of not managing patient safety in a manner that decreases	8	6	6

unwarranted variation leading to worsening outcomes			
Risk of not returning to recurrent financial surplus from 2026/27	16	16	8
Risk of not successfully and sustainably adopting the patient first approach across UHD	9	12	6
Risk of not integrating teams and services and then reconfiguring to create the planned and emergency hospitals	20	16	12
Risk that the Trusts EPR not fit for purpose for UHD	20	20	6

Risk Register Report

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

Background:

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

To provide details of the risks rated 12+ on the UHD NHS Foundation Trust risk register

Key Recommendations:

For information.

Implications associated with this item:

Council of Governors	☐
Equality, Equity, Diversity & Inclusion	☐
Financial	☒
Health Inequalities	☐
Operational Performance	☒
People (inc Staff, Patients)	☐
Public Consultation	☐
Quality	☒
Regulatory	☐
Strategy/Transformation	☐
System	☐

CQC Reference:

Safe	☒
Effective	☐
Caring	☐
Responsive	☐
Well Led	☒
Use of Resources	☐

Report History: Committees/Meetings at which the item has been considered:	Date	Outcome
Trust Management Group	23/04/2024	Meeting has not taken place at the time of submission of this report.
Quality Committee	26/04/2024	Meeting has not taken place at the time of submission of this report.

Board Assurance Framework - Plan on a Page 2023/24

NHS
University Hospitals Dorset
NHS Foundation Trust

Team UHD
Our 7 objectives
2023-24

SEE OUR PATIENTS SOONER

BE A GREAT PLACE TO WORK

IMPROVE PATIENT EXPERIENCE BY ACTING ON FEEDBACK

SAVE LIVES BY IMPROVING PATIENT SAFETY

USE EVERY NHS POUND WISELY

START ON OUR PATIENT FIRST JOURNEY

WORK AS ONE TEAM, FIT FOR FUTURE CHANGES

TITLE	BAF Risk 1 - Risk of not meeting the patient national constitutional standards for Planned Care (No patients waiting more than 65 weeks on Referral to Treatment (RTT) pathway by March 2024)													
Ref	1074	Timely access to Planned Care - If we do not deliver on effective improvement plans to meet access standards then we will create patient safety risk, widen inequalities and be subject to regulatory action.												
Strategic Priority	**Population and System Working**	**Risk Score 2023/24**												
Review Date	14/3/24	**Apr**	**May**	**Ju**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Target**
Executive Lead	Chief Operating Officer	20	20	20	20	16	16	16	16	16	16	16	9	6
Lead Committee	Finance & Performance Committee													
Risk Rating		Likelihood			3	Consequence			3	Gaps in Controls			Moderate	

Context	**Controls**	**Gaps in Controls or Assurances**
NHSE 2023/24 operational planning priorities for planned (elective) care require Trusts to: • Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties) • Deliver the system- specific activity targets UHD has set the following strategic target and stretch target for 2023/24: • To have no patients waiting in excess of 65 weeks on an RTT pathway to be seen and treated by 31 March 2024 • Stretch: To have 0 non admitted patients above 52 weeks by March 2024	• Annual Operational plan 23/24 and recovery trajectories. Revised in October 2023. • Planned Care Improvement programme to control variation and efficiency. • Trust Access policy and SOPs for waiting list management set out standard way of working. • Clinical prioritisation/risk stratification of waiting lists and harm review process for patients waiting beyond planned dates reduces the likelihood and impact of any delays for patients. • Planned Care and performance governance arrangements aligned to the Trust's Accountability Framework. • Elective Recovery Funding and activity plan agreed, which aims to control the level of reliance on temporary staffing and independent sector providers to provide necessary capacity • Single PAS to enable equitable and timely patient access. • Performance reports to track performance metrics and activity targets, with deep dive analysis of data where required.	**Gaps in controls** Significant reconfiguration programme and operational pressures impact on operational and improvement capacity to respond to the issues and take necessary action. *Mitigation: Alignment of Planned Care Improvement Programme, Patient First and Reconfiguration programme (Lead = COO)* Weaknesses in improvement plans to deliver an increase in activity levels at the level needed to support demand. *Mitigation: Full review of planned care improvement programme undertaken Electivity activity planning tool developed to support planning in 24/25 (Lead = COO)*

PROGRESS – 14 March 2024

What's going well: Action plan & incl. future opportunities	**What are the current challenges incl. future risks**	**How are these challenges being managed**
[11/04/2024] 6% reduction in the RTT waiting list in 2023/24 and maintained an improvement in 18 Week RTT performance at 62% compared to 53.8% in March 2023. A reduction in both RTT waits greater than 78 weeks and 65 weeks in March 2024 delivered, however the Trust was not able to recover against its trajectory to eliminate long waiters due to the in-year impacts of lost activity due to Industrial Action, workforce challenges and high non-elective bed occupancy. A review of the improvement actions for 2024/25 is now underway. Key actions: • Prioritising patients at risk of breaching >65 weeks before Sept 2024 • Elective Recovery Fund activity plan has been deployed focused on maintaining safe wait times. • Achieving a minimum of 104% elective activity. • Delivering on productivity improvement plans for outpatients, theatres, endoscopy, length of stay and radiology.	• Impact of Industrial Action on provision of services (Risk 1863) • Bed occupancy remains high and continues at times to impact on elective capacity (Risk 1053) • Cancer demand is above planned levels and may increase further due to national awareness campaigns and high-profile cases including among the Royal family (Risk 1386) • Radiographer staffing (Risk 1283) cellular pathology (Risk 1395) • High follow up waiting list backlog (Risk 1292) – ongoing reduction plan in place • Capacity to see or treat the volume of patients on PTL>18 weeks (1053) • Endoscopy capacity and demand (1393)	Planned Care Improvement programme in place as a Corporate Project and underpinned by 5 action plans for: outpatients, cancer, data and validation optimisation, diagnostics and theatres. Monitoring group – Operational Delivery Group. Monthly update on delivery at Trust Management Group. Risk appetite for maintaining a level of electives during IA agreed between COO/CNO/CMO. Ongoing recruitment to vacancies and insourcing.

TITLE	BAF RISK 2: Risk of not meeting the patient national constitutional standards for Emergency Care													
Ref	1460 1429	Ability to meet UEC National Standards and related impact on patient safety, statutory compliance and reputation. Ambulance handover delays - risk to patient harm, performance and organisational reputation												
Strategic Priority	Population and System Working	Risk Score 2023/24												
Review Date	9/4/2024	Apr	May	Ju	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target
Executive Lead	Chief Operating Officer	20	20	20	20	20	20	20	20	20	20	20	20	6
Lead Committee	FPC													
Risk Rating		Likelihood	5	Conseq uence	4	Gaps in Controls		Moderate						

Context – Free text

The Delivery plan for Recovering Urgent and Emergency Care Services published January 2023 by NHSE set out the requirement for "*Patients being seen more quickly in emergency departments: with the ambition to improve to 76% of patients being admitted, transferred or discharged within four hours by March 2024, with further improvement in 2024/25*".

UHD Trajectory developed to achieve 76% against the 4-hour standard, with increased scrutiny in March 24 nationally.

24/25 operational plan requires delivery of 78% performance by March 2025.

Controls

- Requirement to monitor and report against National Standard
- Daily Performance reporting against metrics
- Daily operational meetings to support UEC flow and challenges 7 days a week
- Timed Admissions Process evoked (Push model)
- Compliance with Trust and ED Escalation plans/SOPs
- IPS optimisation
- Diagnostic delays standards (blood tests/x-ray and CT)
- 'Surge Management' criteria and plan
- Implementation of 4 and 12 hour escalation process and UHD ambulance divert policy.
- 4 hour performance metrics linked to ED escalation
- Escalation email/text process along with ED shift report template improvement
- MIU and UTC Type 3 ED attendances being reported
- Daily Breach Review Meetings

Gaps in Controls or Assurances

Performance Monitoring and Reporting:

- Gaps in assurance for sustainable delivery of 4-hour standard.
- Type 3 data from MIU and UTC remains a manual process needs to be automated for new standards

ED and Hospital Processes

- Plans to deliver effective change and monitoring are not developed to maturity.
- SDEC pathways not in place 12 hours a day 7 days a week across all services.

Workforce

- Gaps in recruitment remain a key challenge – pulling consultants onto nights and reducing senior decision maker cover.
- Capacity across the organisation to respond to the issues and take necessary action, including change management capacity.

External Factors

- UEC growth and NCtR numbers contribute to reduced patient flow and performance

PROGRESS – 9th April 2024

What's going well: Action plan & incl. future opportunities

- Performance against the 4-hour standard for March 2024 was 70.2% against a plan of 76%
- SDECs areas released from escalation
- Focused curiosity and oversight improving 4 hour awareness and delivery
- Executive-led weekly enhanced support meeting continues and has adopted the NHSE Tier 1 methodology.
- Revision of legacy action plans to develop single working plan compete.
- A revised fortnightly UEC Programme Board has been launched to promote Trust-wide engagement and ensure plans are being robustly monitored.

What are the current challenges incl. future risks

- 24/25 operational plan requires delivery of 78% performance
- ED middle grade staffing continues to be a significant challenge.
- SDEC Services not 12 hours a day, 7 days a week in key specialties
- Unable to sustain performance overnight and at weekends resulting in long waits and inability to recover performance.
- Demand on UTC primary care capacity
- No reduction in No Criteria to Reside numbers at a system level (inc DCH and Community beds).

How are these challenges being managed

- UHD has completed our capacity de-escalation plan in March. This has seen SDECs released from being bedded but not delivered all objectives.
- Focused work with BI ensures a full suite of data to support recovery – reporting now going to UEC Programme Board
- ED medical staff template funded in budget setting 23/24 – recruiting, ongoing gaps in middle grade tier.
- Surgical SDEC now 7 days. Medical plans delivering weekend service from November 2023 one in three, clear ask for more.
- UHD UEC Programme board established - aligning to patient first methodology and patient pathways.
- ECIST review and Criteria to Admit Audit agreed for April 24

TITLE	BAF Risk 3 – Risk of not significantly improving staff experience and retention over the next 3 years (and not being in the NHS staff survey results top 20% of comparator trusts).														
Associated significant risks	1492 1811 1493	Resourcing Pressures – Staffing (12) Staff Vacancies and skill mix deficit – Theatres (12) -to be reduced to 9 Absence, Burnout and PTSD (12)													
Review Date	05/2/24		Apr	May	Ju	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target
Executive Lead	CPO		12	12	12	12	12	12	12	12	12	12	12	12	8
Lead Committee	PCC														
Risk Rating		Likelihood	3	Consequence	4	Gaps in Controls	Moderate								

Context – *Free text*	Controls	Gaps in Controls or Assurances
The NHS relies on its workforce to deliver patient centred care and services. There is evidence that staff working within the NHS are tired, feeling burnt out and also demoralised by national pay concerns which has led to industrial action across the NHS and has further impacted on staff morale, satisfaction and retention. UHD also has a major programme which requires some staff to move sites. Risk 1492 – Vacancy rates have fallen across the organisation and the joining rate has been higher than turnover rate for 15 months. There is a significant focus on reducing vacancies, improving rostering and staff planning/utilisation, and eliminating high-cost agency. Staff are our biggest asset and key to the success of our services and organisation and in achieving our aim of being a great place to work. Risk 1811 theatres – recruitment / induction of new starters is on-going. Risk to be reduced to 9 and reviewed at the end of March	Health and wellbeing staff offer, occupational health service standards, policies and procedures Access to proactive and preventative services (performance standards) Staff survey (local and national) action plans Return to work and Annual Leave procedures Flexible working policy Staff sickness absence policy Recruitment and retention policy CQC well led key lines of enquiry Staff survey standards Agency reduction plan	Refresh of the People & Culture Strategy Reliance on the temporary workforce Better exit information that is reviewed locally and triangulated with other data Stay questionnaire survey data to aid retention Medical staffing rostering ongoing. Workforce Baseline Data as part of the Patient First Corporate Project to improve confidence in workforce deployment, utilisation and planning.

PROGRESS – 5th February 2024		
What's going well: Action plan & incl. future opportunities	**What are the current challenges incl. future risks**	**How are these challenges being managed**
Risk 1493- Risk description sickness absence levels continue to reduce over the 12-month rolling period but levels are not reducing consistently month on month with some variations. Strong staff networks support staff engagement and the current high completion rate for the staff survey is encouraging.	Attracting recruiting and retaining staff who feel supported and optimistic about the changes in buildings, services and sites and not worried about the personal impact for them. Managing the scale of the changes including staff consultations continues. Pressure on HR operational staff to support organisational change consultations.	The roll-out of sickness absence training for leaders continues to take place. Audits to ensure assessment tools and support are being used for staff off with stress, anxiety and depression in line with our policies Demonstrating the return on investment for health and well-being support and reviewing

Staff support through the Occupational Health and Psychological Support and Counselling Service (PSC) along with stress assessment tools are in place and in use Staff on AFC contracts and medical and dental ESR data cleanse has been completed in terms of confirming staff in post is now an accurate portrayal of data in ESR Ward template reviews completes with agreement given at Trust Management Group. Risk 1811 – Positive progress has been made with recruiting to the templates with the care groups and leads. Theatre vacancies have reduced from 18% to 10% with a further reduction anticipated. The amount of over time worked across UHD theatres has reduced with the implementation of the enhanced rates which have proven to be of benefit to the staff, but first and foremost more patients are being seen for their surgery through theatres. The risk level is due to be reduced to 9 by Theatres and reviewed formally once again at the end of March 2024	New adverts now include the changes in sites to minimise associated turnover and costs. Stress / anxiety / depression remains one of top 5 reasons despite comparison data showing a decrease compared to previous years. Recording on this reason for absence does not distinguish about workplace stress or home external stressors The theatre template is continuing to be reviewed to meet the RTT and activity required to treat patients. Improvement required in rostering practice at ward and department level and making sure that people are rostering in advance, managing leave, managing unused hours to standard system of operation. The same applies to Health Rota and Job planning for medical staff	regularly the services provided and communicating these effectively. A staff ready stream is being set up under the Transforming Care Together programme Roster performance stats shared with more training being developed to improve understanding and better forward planning. Change to shift request reasons implemented and a heightened focus. Patient First corporate project to focus on E roster and Health rota.

TITLE	BAF Risk 4 – Risk that not every team is empowered to make improvements using patient feedback, in order that all patients at UHD receive quality care, which results in a positive experience for them, their families and/or carers.														
Ref	1920	Risk that the Trust does not have adequate systems and processes in place to promote, gather, triangulate and utilise patient feedback consistently across UHD. It is therefore recognised that this may result in missed opportunities for learning and improvement in patient experience.													
Strategic Priority	Patient Experience	Risk Score													
Review Date	30/6/23	new	Apr	May	Ju	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target
Executive Lead	CNO	L=4 S=2 RR=8	8	8	8	8	8	8	8	8	8	8	6	6	6
Lead Committee	QC														
Risk Rating	6	Likelihood	3	Consequence	2	Gaps in Controls	Moderate								

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

PROGRESS – 31/3/24		
What's going well: Action plan & incl. future opportunities	What are the current challenges incl. future risks	How are these challenges being managed

1. Patient experience strategy is being driven through PEG and reported in Quarterly reports 2. Have your say survey has been designed with core questions and additional questions driven by departments, these can be adjusted to support continuous improvement. Now published on website and linked to SMS messaging. 3. Sustained and increased number of returns being realised since UHD SMS text messaging service commenced. Rating of Very Good/ Good remains over the upper control. 4. FFT returns being received from more services Number of zero returns dropped from 113 to 30. 5. BI developing the patient experience board to ward level dashboard with Patient First driver and watch metrics. HYS data now coded for reporting 6. Change the format of the Quarterly Patient Experience report to report on the Patient Experience strategy and Patient First metrics	1. Ensuring staff understand the strategic direction and all work is aligned. 2. HYS data transfer to BI for inclusion on dashboard. Data needing more detail for mapping. 3. Working toward 'every contact has a SMS'- different platforms for CT/MRI and Pathology still need to be joined. ED still not online through Agyle. 4. Problems with accuracy of data as patients often do not know which outpatient clinic they visit 5. Platform being developed, need it to be interactive and useable 6. New format of report which has always been well received at Quality committee .	1. Working with Strategic Nursing and professions forum, Ward leads embedding the strategy. 2. Seeing some returns, but accuracy of location needs improving- BI and PEXt working together. 3. PEx team working with BI to ensure the data can be transferred from the warehouse. Change request outstanding for Agyle- near completion. Soliton consent being checked- but data ready. 4. PEx team working with BI to ensure FFT for OPD is coded to speciality. Further discussion with BI/PExt care groups planned for Q1. 5. PExt with BI developing the platform further. 6. Feedback on new way of reporting positive.

TITLE	BAF Risk 5 – Risk of not improving hospital mortality and being in the top 20% of trusts in the country for HSMR over the next 3 years													
Ref	1922	If the Trust does not fully implement and embed an effective Trust wide learning from deaths process, then there is a risk that patient safety and patient care will be sub-optimal increasing the risk of avoidable deaths and an above expected HSMR.												
Strategic Priority	Quality	Risk Score												
Review Date		New	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target
Executive Lead	CMO	L=2 S=5 RR=10	10	10	10	10	10	10	8	8	8	8	8	8	6
Lead Committee	QC														
Risk Rating	10	Likelihood	2	Consequence	4	Gaps in Controls	Moderate								

Context – *Free text*	Controls	Gaps in Controls or Assurances
HSMR has been steady rising over the last 3 years There is variation across our sites	UHD Learning from Deaths Policy UHD Medical Examiners Policy LERN policy and toolkit	Audit of M&M meetings (2022/23) identified inconsistent approach to mortality governance across UHD Compliance with mortality case note reviews not consistent

PROGRESS – 31 March 24		
What's going well: Action plan & incl. future opportunities	**What are the current challenges incl. future risks**	**How are these challenges being managed**
MSG ToR and Learning from Deaths policy (and supporting Toolkit) to be reviewed – Medical Director for Quality leading. New Mortality dashboard now live New mortality metrics available via HED, training provided. Review of MSG in progress – new structure to start in June. Risk rating (March) remains the same due to identified gaps in controls and assurances.	eLearning from deaths process rolled out across UHD (but not currently embedded) Inconsistent approach to mortality governance across UHD, new approach aligned with Care Group governance processes discussed and agreed. Due to start in June 24.	Resource requirement to support redevelopment of eMortality system raised at SDR 5/3/24 and to be raised at April meeting. Reconfiguration will reduce number of reviews required and increase quality and detail of ones completed.

TITLE	BAF Risk 6 – Risk of not managing patient safety in a manner that decreases unwarranted variation leading to worsening outcomes.														
Ref	1923	There is a risk that implementation of the new Learning from Patient safety Events (LFPSE) system will have a significant negative impact on reporting numbers and safety culture. There is a risk that there will be less reporting and therefore lost opportunities for learning and improvement. There is a risk that a lack of confidence and engagement in the new process will impact on the Trust safety culture and national staff survey results.													
Strategic Priority	Quality	Risk Score													
Review Date	30/6/23	new	Apr	May	Ju	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target
Executive Lead	CMO	L=4 S=2 RR=8	8	8	8	8	8	8	8	8	8	6	6	6	6
Lead Committee	QC														
Risk Rating	8	Likelihood	4	Consequence	2	Gaps in Controls	low								

Context – *Free text*	Controls	Gaps in Controls or Assurances
The definitions for reportable patient safety incidents will change with the introduction of LFPSE. Reportable incidents will not include external incidents, IG incidents, medical device incidents that do not result in patient harm, infection control breaches that do not result in patient harm, medication incidents that do not result in patient harm e.g., incorrect storage, incorrect CD counts etc. Decreasing the overall number of typically near miss or no harm events will impact on the Trust reporting profile. The change in the national definitions of levels of harm will also impact on baseline figures.	UHD Risk management strategy (and Governance structure) PSIRF Plan LERN Policy LFPSE Implementation plan and comms	LFPSE questions and taxonomy set nationally. Form design restricted by nationally mandated questions and Datix design. NRLS data will not be available after Sept 23 and no alternative national benchmark date will be able after this date. Data uploaded to LFPSE will be unvalidated when sent. Currently there is no information available on how Trust will be able to amend any incorrect records sent. I.e. staff can code incidents incorrectly without internal checks or validation.
PROGRESS – 31 March 24		
What's going well: Action plan & incl. future opportunities	**What are the current challenges incl. future risks**	**How are these challenges being managed**
LFPSE went live 1/12/23 PSIRF approved by ICB at December Quality meeting PSIRF policy (and Toolkit) in draft and aim for discussion at Feb 24 CGG. Implementation of new model proposed for 01/04/23. PSIRF training for investigators booked for Feb and March 24	Patient safety incident investigator training in Feb/March 24. 30 staff attended first sessions. Investigators will need time to complete reviews – funding and capacity to be agreed. AAR training required to be rolled out Work improvement plans and training in safety huddles needed.	Comms plan for LFPSE and PSIRF in place. Pilot of UHD PSaF Restructure of Quality and Risk Team to support PSIRF AAR training plan to be developed

Patient safety culture focus in Core Brief Jan 24 UHD version of MaPSaF developed and in progress of roll out to Patient First early adopters (CC, XCH Day hospital, Stroke). Good support from Patient First Team (IN) Patient safety culture questions rolled out in People Pulse survey Jan 24 No reduction in reporting seen in Dec- March 24. New LERN forms introduced for non LFPSE incidents and new Restraint Form implemented. Training and education on going. 2023 Staff survey results show improvement in safety culture scores Risk rating reduced in Jan 24.		Plan to pilot PSIR plan in Surgical Care Group and Maternity in Q1 24/25

BAF RISK 7	Risk of not returning to recurrent financial surplus from 2026/27
Strategic Priority	Sustainable Services
Risk Reference	1595
Review Date	December 2023
Executive Lead	Chief Finance Officer
Lead Committee	Finance and Performance

RISK SCORE													
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	TARGET
	16	16	16	16	16	16	16	16	16	16	16	16	8

Context – *Free text*	Controls	Gaps in Controls or Assurances
The Trust set a balanced revenue budget for 2023/24, which if delivered in full recurrently would leave a recurrent underlying deficit of £33m. At the end of March the Trust has reported a surplus of £0.065 million against a planned break-even position. However recurrent over spends, including an under delivery of the Efficiency Improvement Programme target, have been off-set by non recurrent under spends and additional non recurrent income. As a result, the Trusts underlying deficit has not improved and thus there remains a significant risk in relation to the recurrent underlying financial position of the Trust.	• Budgets developed with directorate teams, formally accepted at Care Group level and fully devolved to named budget holders. • Dedicated financial support in place including additional variance analysis and reporting. • Scheme of delegation, Standing Financial Instructions, Financial Management Accountability Framework and other finance policies and procedures in place. • Monthly reporting to TMG, FPC and Board highlighting risks and mitigating actions. • Care Group and Corporate directorate quarterly performance reviews. • Alignment of approved nursing templates, e-roster templates, and budgeted establishment. • Enhanced vacancy and non pay controls implemented to support financial recovery.	• Weaknesses in temporary staffing controls. Mitigation: External review of TSO, re-establishment of e-roster steering board, new e-form in development for approval of nursing/ HCA agency (Lead = CPO). • Incomplete medical job plans and inconsistent premium medical rates. Mitigation: Refreshed job planning policy, use of electronic systems, review of premium rate card (Lead = CMO). • Weaknesses in the approval process for the opening of unfunded escalation capacity. Mitigation: New SOP approved to inform consistent escalation process, de-escalation plan developed and progressing (Lead = COO).

PROGRESS – 22 November 23

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

	• Premium pay expenditure. • Industrial action.	

TITLE	BAF Risk 8 – Risk of not successfully and sustainably adopting the patient first approach across UHD														
Ref	**1924**	Risk that benefits of transformation, improvement and innovation are not realised													
Strategic Priority	**Patient First Programme**	**Risk Score**													
Review Date	30/01/2024	**new**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Target**
Executive Lead	**CEO**	2992	9	9	9	9	9	9	16	16	12	12	12	**12**	6
Lead Committee	**TMG**														
Risk Rating		Likelihood	3	Consequence	4	Gaps in Controls	Moderate								

Trust has made good progress in delivery of year one of the programme: **Phase 1:** Organisational Readiness Assessment Complete [Jan 23] **Phase 2:** Strategy Development Complete **Phase 3:** Strategy Deployment Underway **Phase 4:** Organisational Improvement System Underway **Phase 5:** Leadership Behaviours and Development Underway **Phase 6:** Governance In preparation	PID (to ensure clarity on the scope) Programme pillars Steering board ToR Reporting to TMG, and assurance to BoD Patient First methodology A3 thinking methodology Annual patient first cycle linked to annual plan	Moderate gaps in controls A full benefits realisation plan is required to align directly with strategic themes and corporate projects following completion of Phase 2

PROGRESS – 11 March 2024

What's going well: Action plan & incl. future opportunities	What are the current challenges incl. future risks	How are these challenges being managed
Delivery of first cohorts of Patient First for Leaders, Patient First Improvement System and A3 training to be completed by end of March 2024. Evaluation of training programmes underway. Catchball#1 for all care groups completed (Dec'23) with scorecard development in progress ahead of Catchball#2 (Feb '24) Corporate SDR templates now under development for piloting 5.3.2024 Culture champions trained and undertaking appreciative enquiry activity with senior leaders and departmental teams. 2023 NHS staff survey record completion rate at 59%. Good attendance at regular Patient First: "Let's have a Conversation" sessions facilitated each month by our executive team to encourage engagement and involvement of all staff. Board development sessions for NEDS to ensure non-executive directors are a) adequately briefed on progress and b) identify opportunities to engage in several continuous improvement activities with UHD staff.	Key Risks: • Slippage of key milestones and deliverables resulting in programme delays and delayed delivery of outcomes (RPF004) • Patient First programme scope reduced, or time scale extended due to time constraints execs and operational teams (RPF006) • Failure to gain support from regulators resulting in uncertainty and potentially additional work pressures on staff (RPF 008) • Failure to decommission other activities not linked to True North and Breakthrough objectives (RPF007) • Failure to access robust business intelligence support resulting in failure to carry out analysis of the opportunities (RPF009) • Lack of ongoing programme management resource and appropriate budget to drive implementation and roll out (RPF003) • Lack of ability to release staff for Patient First training leading to reduce skills transfer / lower value for money (RPF011) Key Issues:	Risk log reviewed monthly. Latest mitigations: • Key future milestones to be agreed including 3 year plan for PFIS roll out. • Additional support from PF team offered to Execs toc complete corporate project templates ahead of corporate SDR • UHD engaged with NHS IMPACT programme & network – Clinical Director visit to UHD 5.4.24 • Completion by Execs of X matrix and meetings filter prioritised Q4 2024/25 • Work to develop scorecards now progressing well – draft corporate scorecards expected before start Q1 2024/25 • Risk increased - feasibility of reducing length of training programmes being explored due to trusts financial challenge • Execs supporting managers to prioritise staff attendance at PF training. • Patient First Communications plan to be reviewed March 2024. Work underway to support staff to access advice & share success.

Details and approval for year 2 consultancy support to be agreed March 2024	• Communication of Patient First purpose and benefits to staff is currently ineffective (RPF015)	

TITLE	BAF Risk 9 – Risk of not integrating teams and services and then reconfiguring to create the planned and emergency hospitals														
Ref	1784	Critical Path Management													
Strategic Priority	One Team	Risk Score													
Review Date	29/01/24		Apr	May	Ju	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target
Executive Lead	CSTO	1784	20	20	20	20	16	16	16	16	16	16	16	16	12
Lead Committee	FPC														
Risk Rating		Likelihood	4	Consequence	4	Gaps in Controls	Moderate								

Context	Controls	Gaps in Controls or Assurances
Taking lessons from previous relocations, such as the one in Bristol, we have recognized the importance of integrating and operating services as a unified entity at least 6 to 9 months prior to any move. As our build programs become more defined, our efforts need to shift towards the integration of teams. Therefore, as we approach the integration phase, our governance structure will be aligned with the four phases of reconfiguration, with a greater emphasis on preparing services for reconfiguration rather than solely focusing on the build program. The Acute Reconfiguration Capital Group will be renamed the Build Ready Group and ensure delivery of the buildings and manage risks. The Reconfiguration Oversight Group will be transformed into the Service Ready and Move Group and manage the critical path to being ready for treating patients in our reconfigured services. There will also be potential challenges associated with the hygiene factors such as staff rest areas and transport and we will need to have effective governance and communications in place to manage this.	**Prevention** Evidence of effective governance: • Speciality level plans in place • Meeting structure, attendance, escalation and resolution from speciality steering groups into CG and then Service Ready Group (SRG) • Service Reviews to assess readiness for moves with actions followed up by Care Groups • Robust critical path timeline that clearly articulates deliverables and interdependencies between specific deliverables • Good and effective management of individual programmes (Beach, NHP, Decants, Clinical Integration) • Focus on Critical Path actions **Detection:** Internal Audit, NHP Scrutiny/Governance, external Gateway process, result of Service Review findings and progress on critical path actions. Go/No Go checklist and criteria	Moderate gaps: Development of Service reviews and associated scorecard. Focus on critical path actions during 2024. Changes to the build programme and interdependency with the reconfiguration programme Assurance that actions identified at speciality, CG and during Speciality reviews are completed Effective Working Groups in place to manage the hygiene factors (e.g Travel Working Group and Improving Staff Experience Group)
PROGRESS – 27 March 2024		
What's going well: Action plan & incl. future opportunities	**What are the current challenges incl. future risks**	**How are these challenges being managed**
• Scored reduced to 16 (Likelihood reduced from 5 to 4) as transition to new governance complete and working well • Inaugural meeting of Transforming Care Together Group held on 26 Feb 2024 and TOR's agreed as assurance group reporting into Board. • Care Group reporting strengthened and new focus on critical path actions from January 2024.	Risk score reduced to 16 in August 2023 as revised governance and service review process now in place. However, issue remains the same with biggest risk being capacity and capability to implement integration plans, actions identified by service reviews and actions identified by SRG and CG TSG's. Progress variable access different specialties with operational pressures taking precedence	Monthly meetings (BRG, SRG, Care Grp TSG's) that reviews and escalated any barriers and delays. Linking of operational and integration plans via COO.

• Service review process well underway with 36 initial services now reviewed and clear action plans in place. 8 services rated red to date and will be reviewed again in 3 months to review progress. Haematology Service Review moved from red to amber with good progress on move planning for April 2024 move. Theatres and H&N moved from red to red/amber in March 2024. • Service Review schedule amended to prioritise services moving in April 2025 • Agreed for go/no go checklist and QIA to be used for all Move Early service to ensure consistency • Maternity Big Room Event on 19 Feb 2024 to start moving planning process/approach – all corporate services involved and launch of Go/No Checklist • Transitional funds reviewed and monies to support operational delivery brought forward – current recruitment of operational change delivery resources to support capacity in Care Groups to deliver integration plans and service review actions • FBC A approved at Joint Investment Committee on 22.03.24. FBC B drafted for submission in April 2014 • Recent changes to parking permits and update to Staff Partnership Forum on travel actions. Recruitment for Transport and Travel Manager now commenced.	Move planning for Maternity needs to start April 2024. 2 workshops in February and March to prepare for this. Workforce planning remain key risk for Service ready - some workforce plans still outstanding. Review process being developed with ED and Maternity but need to understand those services that cannot manage within workforce envelop in new build and the appetite to restrict beds. Also need to understand number of staff moving with their services. We have total number expected to move. The actual number will not be confirmed until consultations completed and we can then assess the gap. Workshop scheduled for this on 25 March 2024. From a build ready perspective, Building Safety Act is now key risk. Both Bournemouth and Poole main buildings (plus Parkstone House) fall within the parameters of the Building Safety Act and must comply. This will increase the programme time and cost for all projects which fall under Category A works. Possible delays to Junior Dr Mess could impact on critical path. Space also remains a challenge but space requests to be submitted by 1 April 2024 and space principles document going to BRG/SRG in April 2024. Scenario testing being completed in March to understand impact and mitigations for build delays and operational readiness on overarching programme.	External support and Internal Audit review of Reconfiguration Programme

TITLE	BAF Risk 10 - Risk that the trusts Electronic Patient Record (EPR) not fit for purpose for UHD and this contributes to the 3 risks referenced below														
Ref	1950 1872 (20) 1378 (15)	**The Trust Electronic Patient Record (EPR) will be unsupported from April 2027 and is not fit for purpose** Patient Flow: Risk to patient safety, statutory/performance compliance & reputation - downstream capacity/front door crowding Lack of Electronic results acknowledgement system													
Strategic Priority	Population and System Working	Risk Score 2023/24													
Review Date	01/03/24	Apr		May	Jun	Jul	Aug	Sept		Oct	Nov	Dec	Jan	Feb	Mar	Target
Executive Lead	Chief Finance Officer	20		20	20	20	20	20		20	20	20	20	20	20	6
Lead Committee	FPC															
Risk Rating	20	Likelihood	5	Consequence					4	Gaps in Controls		High				

Context	Controls	Gaps in Controls or Assurances
UHD has an EPR (Graphnet) using 1990s computer code, to which few coders can now use. UHD is the sole remaining customer and the supplier will only support the system until April 2027. The Medical Staff Committee (MSC) at UHD have written as a body highlighting there are considerable clinical risks with Graphnet, and these are reflected in the Trust risk register. These risks are: i. Inhibited Patient Flow and increased length of stay, due to poor functionality (risk rating 20) ii. Lack of closed loop reporting of results, leading to delayed or missed diagnosis (risk rating 15) Clinicians are also highlighting the impact of reduced productivity as less patients are seen per clinic, theatre list and ward round due to the time taken navigating multiple disjointed, separate systems. Doctors in training rotating between Trusts see the difference and are less likely to want a career at UHD due to "unsafe, and labour-intensive IT systems."	The Electronic Health Record Programme (EHR) is moving forward where UHD will partner with Somerset and Dorset to procure a new system that will replace all the current key IT systems, an update was provided to the Board in January 2024. The majority of the trust IT systems that make up the EPR ecosystem have the following controls in place: • Underpinning legal contracts with software suppliers • Immutable backups (i.e. cannot be affected by malware) • Staff training programmes • Active Information Asset Owners who undertake appropriate audits in line with the Data Security and Protection Toolkit • UHD wide Business Continuity Plan • Dedicated Subject Matter Experts in the clinical applications who maintain them in their optimal state • Teams of people working to ensure that the underlying IT Infrastructure is maintained in an optimal state	• Substantial gaps in the functionality of our EPR ecosystem relating to the management of the workflow of diagnostic results and reports and assured clinical transactions generally (e.g. therapy input and interprofessional referrals). • No effective single user interface for clinicians to manage their core care processes. • Local departmental Business Continuity Plans are not yet in place – these are in development with a plan to develop by April 2024.

PROGRESS – 4th April 2024

What's going well: Action plan & incl. future opportunities	What are the current challenges incl. future risks	How are these challenges being managed
• Dorset and Somerset Partnership Board and Programme Board are now running regularly. • Outline business case progressing but due to outstanding affordability issues the date has moved to the end of April 2024. • Pre-Market Engagement costs have been re-sought from the market with the confirmed scope for Dorset. • Current scope – Somerset Acute / Community / Mental Health and Dorset Acute / Mental Health	The current timeline for the EHR Programme is being challenged to see if the contract award can be done by end of March 2025. This should then ensure delivery into live use before end of March 2027, removing the EPR risk.	• Single Dorset and Somerset Partnership Board with Chief Execs, SROs and the Programme Director has had their first meeting, regular dates now in the diary. • Single Dorset and Somerset EHR board is now in place and running monthly to keep decisions moving forward. • Somerset Programme director is leading the Business case and procurement process jointly. And Ethical remains supporting the Dorset Programme for readiness.

• Communication plan needs to be stepped up to increase the Trust wide communications, but this will be progressed once the business case is in the approval process. • Specification for the EHR has now been completed with an aligned spec for the scope.	Affordability for other organisations in Dorset remains a challenge. We are looking at scope changes / phasing as a mitigation. Risk of a further delay to business case submission being proposed to resolve the affordability issues.	• Weekly EHR Leadership meting to ensure workstreams are progressing as required. • Dorset contract for support by Ethical was extended for 3 months from 1st April/

University Hospitals Dorset
NHS Foundation Trust

Risk Register Report

Report for Board of Directors

For the period to end March 2024 (as on 02/04/2024)

Risk Register

SUMMARY

The report details new, current and closed risks rated at 12 and above, in month.

A risk rating is undertaken using an NHS standard five by five matrix according to their severity consequence and likelihood, as per the Trust's Risk Management Strategy and Risk Assessment Toolkit. There are:

Current risks rated at 12 and above on the risk register	35
Potential new risks for Approval	3
12+ Risks that have changed score	3
Reduced, closed or suspended risk(s) no longer 12+ to note	3

DEFINITIONS

Movement in month - Key:

	New Risk		A decrease in risk score
	The score remains the same		A rise in risk score

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

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

Risk Rating Status

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

Risk Matrix and Risk Scores

See Appendix B and C

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

1. **There are 210 approved risks on UHDs Risk register, of which 35 are rated as 12 and above**

2. **There are 3 new risks rated as 12 and above to be reviewed.**

Risk Ref	**1966 (Discussed at QC 26/3/24 but awaiting formal approval at next BoD meeting)**
Risk Rating	12
Risk Title	Review and treatment time delays in Dermatology, particularly for Skin Cancer
Risk Description	Risk to patients having delayed diagnosis, review and treatments for skin cancers due to high waiting times. This has been caused by increased demand and capacity not matching demand and has been compounded by the impacts of industrial action. This affects patients newly referred into the service and those awaiting skin cancer follow ups. The capacity also affects patients with other skin conditions on an RTT (referral to treatment) pathway who have been waiting in excess of a year for first appointments.
Risk Background	FDS performance has dropped to below 50% in December 2023. Patients are currently waiting 6-7 months for skin cancer follow up appointments - some longer particularly if clinics are cancelled (e.g from strikes or sickness). NICE melanoma guidelines recommend higher risk melanoma patients are seen 3 monthly. There is not currently the required capacity to safely deliver the melanoma follow-up service at Poole. This is predominantly because there is a lack of staff and inadequate clinic space/facilities to run this. As a result, patients will be delayed, and this has a direct impact on patient safety & their potential outcome. Gradual increase in delays for skin cancer follow up appointments, now c 6-7 months. Recently brought to attention due to case of delayed metastatic melanoma diagnosis (L110428). The number of patients is significant – most need to be seen on a 3 monthly basis. In recent years, the numbers of patients on systemic treatment has increased. Their pathway is very complex. These patients' life expectancy has increased and therefore this impacts on the future delivery of our follow up pathway. Some patients will be having adjuvant or palliative treatment.
Exec Lead	COO
Controls	monitoring of LERNS and SIs Complaints and feedback from patients Additional capacity from UHD staff - wellbeing and financial impact Additional insourced capacity - quality and financial impact
Gaps in controls	Template capacity vs anticipated demand not matching. National guidance and performance metrics not being met. Trust Cancer target is failing. High sickness potentially linked to additional hours worked and performance metrics.

Action plan(s)	Katie Garside	Dermatology	Recovery Action Plan	Recovery Action plan covering all aspects of improvement required to effectively manage capacity and demand is attached - see Documents section. The live document is stored in the Medical Specialties Management Teams Channel under Dermatology and can be accessed via a member of the Derm/Med Spec management team.	Waiting time recovery to within safe timeframes as recommended by NICE, NHSE and BAD.

Risk Ref	**2000 (to be discussed at TMG 23/4/24 and QC 26/4/24)**
Risk Rating	12
Risk Title	Lack of substantive consultants in restorative dentistry and delay to patients consultant-led reconstructive treatments
Risk Description	If there continues to be a lack of substantive consultants within the restorative dentistry service, then UHD will not be able to deliver the Head and Neck specialised commissioning contract. The consequences include lack of knowledge and oversight for patient care, lack of senior decision-making to accept/reject referrals into the service, lack of appropriate skills to deliver reconstructive care to patients, a lack of support for junior staff, impact to service compliance and trust reputation and an increase in PALs complaints. If we continue to deliver care to restorative patients without supervision of an appropriately trained consultant who can recognise inappropriate treatment plans and/or monitor and change treatment plans that are not progressing appropriately, then there could be harm to patients
Risk Background	The UHD Restorative Dentistry service has had no substantive consultant working since April 2021 and no substantive consultant employed since April 2022. This has meant a significant reduction in activity and has increased waiting times for reconstructive treatments/ implants following treatment for Head & Neck cancer. There are currently over 200 patients awaiting follow up with a restorative consultant. There are increasing numbers of patients who require implant planning as part of the treatment planning stage for their H&N cancer. There is not adequate supervision of the clinical assistant employed within the service and there is no lead clinician for Restorative Dentistry. Last recruitment attempt for a substantive consultant was June 2023 and no appointable candidates applied for the post. The UHD service has been working with regional partners including Taunton & Somerset NHS Trust and South West Dental commissioners to increase stability for the service and to ensure consultant-level advise and guidance could be available to the dental team at UHD. Some of our longest waiting patients were able to be escalated to Taunton to be treated by an appropriate restorative consultant. If we continue without a substantive consultant, then there will be increased delays to treatment, increased lack of appropriate treatment planning to get the best outcome for the patient and continued significant risk to supervision of the dental team within the service.
Exec Lead	CMO
Controls	Management of long waiting patients policy and ongoing compliance - Support from Restorative Dentistry Managed Clinical Networks (MCN) Chair for advice/guidance for clinical assistant at UHD - Contingency planning to prioritise patients by clinical urgency, undertaken and reviewed with OMFS Clinical Lead and MCN Chair for Restorative Dentistry - 100% compliance with essential core skills for staff - 100% compliance with professional standards for each dental professional

Gaps in controls	Lack of substantive consultants - Regulatory framework GDC compliance states that a service should have a substantive consultant - MDT guidelines as set out by British Association of Head & Neck Oncologists (BAHNO) and British Association of Oral and Maxillofacial Surgeons (BAOMS) that a service must have a restorative consultant to deliver a Head & Neck cancer pathway - Service level agreement with a regional partner for consultant-led advice/guidance/escalation of patients - Locum consultant to maintain service delivery - Appropriate staffing with qualifications/experience who can support supervision of clinical assistant - Future planning for maintaining and delivering service sustainably
Action plan(s)	

Responsibility ('To')	Specialty	Title of Action	Description of action to be taken	Evidence of Effective Implementation
Rachel Crooks	Oral Maxillo Facial Surgery	Recruitment of a locum restorative consultant	To advertise and recruit a locum restorative consultant	Locum consultant recruited and working in department - email to confirm this will be supplied.
Rachel Crooks	Oral Maxillo Facial Surgery	Advert for substantive consultant	To advertise for a substantive restorative consultant	Advert up - email to confirm this.
Rachel Crooks	Oral Maxillo Facial Surgery	SLA in place to provide consultant-led advice/guidance/ escalation of patients	To have an SLA in place with UHD and a regional partner to provide consultant advice/guidance/supervision/ patient escalation for clinical team based at UHD	SLA agreement.
Rachel Crooks	Oral Maxillo Facial Surgery	Identify Exec Lead for risk	Identify Exec lead for risk	Exec lead identified and details added
Rachel Crooks	Oral Maxillo Facial Surgery	Risk to be approved at OMFS Clinical Governance meeting	Risk approval at OMFS CGM	Risk approved at CGM and reflected in minutes.
Rachel Crooks	Oral Maxillo Facial Surgery	Approval of risk at directorate level	Approval of risk	Approval of risk in H&N directorate governance minutes.

Risk Ref	**1970 (to be discussed at TMG 23/4/24 and QC 26/4/24)**
Risk Rating	12
Risk Title	Glaucoma Virtual Review Backlog
Risk Description	If we don't address glaucoma reviews being done in a timely manner then there is a risk to patients of preventable, irreversible sight loss. There is also a risk to the Trust of litigation.
Risk Background	The risk has arisen because we have moved many of the glaucoma patients to a virtual clinic to make the most of resources and there has been a reduction in the amount of staff able to carry out the virtual reviews. The staffing reduction includes Consultants, Trust Grade Doctors, Specialists Doctors and Optometrists. There is also limited capacity in the glaucoma service at UHD to manage identified high risk patients. Currently, some patient's notes are on Evolve system and other patient's notes are on the Medisight system which makes the virtual review difficult. On 07.09.23 there were 722 patients waiting for a clinic decision following their appointment. These appointments occurred from 01.06.23 to 15.09.23.

	A Band 7 Optometrist was largely responsible for the glaucoma reviews. However, since she went on maternity leave in August 2023, there has been no maternity cover for this part of her role.
Exec Lead	CMO
Controls	If a patient's eye pressure is found to be high (more than 30mmHg) then they are prioritised for a review. If the Technicians have any concerns then they will flag the patient using a separate email account. This is then prioritised. The patient is advised to present to Eye Emergency if the Technicians are really concerned and identify that the patient needs to be reviewed on the same day their pressures have been taken. The Technicians ask a series of questions which will inform them whether to flag the patient as a concern. Timetable review for Glaucoma Nurse Specialists to enable them to support with virtual reviews.
Gaps in controls	When a patient's pressure is high, but less than 30mmHg, or they have progressive field loss, as the patient is often not aware of the field loss, they can have permanent sight loss.
Action plan(s)	Mahesh Ramchandani / Ophthamology / To present the plan to set up additional clinics to the directorate / To present the plan to the directorate. People involved? Locations? Barriers? Equipment? / To set up the additional clinics to review patients' backlog. To make sure that there is protected time for staff to attend the clinics. To set up the process for evaluation of the progress. To set up the process to measure the effectiveness of these clinics.

3. There are 3 risks that have changed risk rating, but remains 12 or above, in month.

Ref	New risk rating	Description	Update	Previous risk rating	Last review date	Risk trend
1221	15	If unable to recruit and retain Medical Staff in Older People's Services then there is a risk to patient safety, quality and reputation. There will also be financial implications of mitigating via Locum doctors.	Risk score increased from 12 to 15. This was discussed at both OPS Governance, Care Group Governance and the Medical Transformation Steering Group in March.	12	28/03/2024	
1840	15	If OPS has a high number of patients outlying in non-specialty areas, then it could impact on patient safety, communication, patient flow and staff morale/stress.	Discussed in OPS Governance. Risk linked. Outlier numbers at RBH have increased since the beginning of March. Length of stay has increased on both the RBH and Poole site for OPS patients and escalated beds remain open.	12	28/03/2024	
1202	12	If the Obstetrics and Gynaecology Medical staffing rota understaffed then risk that patients will not be treated within the required timeframe, both in the elective and emergency setting.	Maternal medicine consultant job has been published and shortly to advertise the maternal and fetal medicine consultant post. There are 2 consultants on fixed term contracts, aiming to have a recruitment day in July 24. Approval to obtain agency to fill long term sickness gaps. Risk rating reduced to a moderate 12.	15	27/03/2024	

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

Ref	Risk rating	Description	Update	Date risk accepted as a 12+ risk	Last review date	Risk Trend
1863	9	If industrial action across healthcare professions, it may cause disruption to delivery of commissioned emergency and elective activity.	No planned Industrial action. Reduced incidence rating pending future announcements.	18/09/2023	28/02/2024	Risk reduced from 12 to 9 
1876	8	If patients with maternity emergency complications are not seen appropriately by the correct staff, there is a risk to patient safety.	2 tier rota has commenced, and current vacancies in the junior workforce has decreased. Risk decreased from a moderate 12 to 8. 1 clinical fellow and 2 SHO posts are out to advert.	26/07/2023	27/03/2024	Risk reduced from 12 to 8 
1416	closed	Risk of not achieving efficiency and productivity opportunities identified through the Getting it Right First Time (GIRFT) programme	CFO confirmed risk closed at 31/3/24 and will be included in main financial risk.	22/11/2021	28/03/2024	Risk closed 

5. Risk updates.

Risk Number	Title	Rating (current)	Last review date	Last Update	Risk Handler	Executive lead
Population and System						
1460	Ability to meet UEC 4-hour safety standard and related impact on patient safety, statutory compliance and reputation.	20	02/04/2023	Overall improvement in month in 4hr performance at 69% -Breach meetings now embedded. - Ongoing Enhanced support and weekly caregroup ED performance meetings. - Enhanced UTC streaming now in place. - IPS successfully relaunched with governance wrap around weekly.	Bradley, Richard	Chief Operating Officer
1784	Risk of not integrating teams and services and then reconfiguring to create the planned and emergency hospitals	16	25/03/2024	25/3/2024 - The initial clinical moves and opening of the BEACH in April 2025 continues with the major reconfiguration still planned for December 2025. The risk for the major reconfiguration for Dec 2025 has been impacted by the Building Safety Act and other dependencies which could have an impact on the ability to do the reconfiguration in December 2025. The team are reviewing all options and scenario planning to mitigate this risk, however there is a possibility that this could slip into March 2026. Risk remains the same.	Killen, Stephen	Chief Strategy and Transformation Officer
1053	Lack of capacity for elective & non elective activity and associated risk to patient harm due to LLOS and NCTR patients	16	01/04/2024	March remained challenging after early success of reducing bed escalation and re-establishing SDEC and TIU progress stalled. Discharge profile remained static with no increase to p1-3. Consequently, flow remained a key daily challenge with elective activity impacted, and long delays in the ED bed flow. In week 3 the ICB COO wrote to all organisations requesting immediate action against 5 key actions. Initial response made from UHD, actions for IPS (DC focused) being developed.	Gabrielli, Antonia/ Alex Lister	Chief Operating Officer
1483	Pharmacy vacancies are affecting patient care	16	27/03/2024	Out for recruitment across the team, looking especially for 14 wte junior pharmacists to fill gaps. So far 6 have been appointed.	Bleakley, Stephen	Chief Medical Officer
1840	OPS Outlying patients	15	28/03/2024	Outlier numbers at RBH have increased since the beginning of March. Length of stay has increased on both the RBH and Poole site for OPS patients and escalated beds remain open.	Pigott, Lisa	Chief Medical Officer
1697	Increased waiting list for SACT treatment/ Capacity on Day units	15	14/03/2024	Increased Cap in day case units has stopped the wait list getting longer. Struggling to use entire allowance, due to nursing staffing and delays to treatment arriving on units, now monitoring and working with Pharmacy. Reviewing treatments that can be moved to community setting. Reviewing private sector options to support service.	Bundy, Daniel	Chief Medical Officer

1502	Mental Health Care in a Physical Health environment	15	02/04/2024	MH review report has been received by acting CNO, and due to be cascaded. Agreement from DHC for 1 day per week per site of senior resource to support MH development in UHD. Specifically - - Training - Debriefs post incidents - Right care right person - other priority areas for UHD Start date TBC.	Aggas, Leanne	Chief Nursing Officer
1665	School age Neurodevelopmental service	15	02/04/2024	Risk remains - awaiting ICB business case. Recruitment to substantive posts still outstanding.	Hannington , David	Chief Medical Officer
1429	Ambulance handover delays - risk to patient harm, performance and organisational reputation	15	02/04/2024	Ongoing maintenance and improvement in performance following introduction of XCAD. - Escalation processes now firmly embedded. - Alternate Weekly meeting in place with SWAST. Focus on flow in and 4hr performance in March have improved position against KPIs.	Bradley, Rick	Chief Operating Officer
1292	Outpatient Follow-Up appointment Backlog - Insufficient capacity to book within due dates	12	18/04/2024	Reopened actions for the surgical and WCCSS care groups, No change to current risk score at present time, to be reviewed once actions completed by care groups.	Curtin, Sara	Chief Operating Officer
1303	Therapy Staffing	12	02/04/2024	Escalated beds continue to operate through April with ward on Poole site scheduled to close end of April which would reduce excess demand to a small degree. In-patient teams continuing to struggle to meet demand with large numbers (100's) of high and urgent contacts not seen same day every month. This will be extending patient length of stay and reducing flow although community services also remain blocked reducing flow out for other reasons beyond therapy assessment.	Godden, Rebekah	Chief Nursing Officer
1386	National Cancer Waiting Times Standards	12	21/03/2024	The performance against the national waiting times standards is expected to achieve the March 24 targets. Additional clinical sessions are scheduled to support the impact of the bank holiday. Full review of this risk is scheduled in April 2024 with the intention to reduce this risk with the approval of the Operations Care Group Board.	Lake, Katie	Chief Operating Officer
1409	Radiotherapy Ventilation/Capacity & Demand	12	21/03/2024	Project completion is expected by e/o October 24.	Thomas, Gillian	Chief Strategy and Transformation Officer

1872	Patient Flow: Risk to patient safety, statutory/performanc e compliance & reputation - downstream capacity/front door crowding	12	01/04/2024	Waiting for a decision on whether the changes are possible within Consultant Connect to achieve the solution for this risk. Waiting on Outpatients to complete the review to respond to this.	Wersby, Stuart/Alex Lister	Chief Operating Officer
Our People						
1221	Medical Staffing Shortages - Medicine and Older Persons Medicine	15	28/03/2024	Risk score increased from 12 to 15. This was discussed at both OPS Governance, Care Group Governance and the Medical Transformation Steering Group in March.	Pigott, Lisa	Chief Medical Officer
1283	Radiotherapy staffing and service demands	12	28/03/2024	Recruitment of graduates has taken place; candidates will be in post across the summer months from July. Further roles interviewed and recruited some internally. Gradual improvement anticipated but not in place currently. Expected increase demand for radiotherapy by a minimum of 15% over 10 years and insufficient staff to meet demand. WCA has employed a workforce transformation manager to support radiotherapy to determine staffing needs. Continued struggle to recruit staff for all grades.	Tanner, Mandy	Chief Nursing Officer
1492	Resourcing Pressures - Staffing	12	02/04/2024	BI advice is that following the annual establishment review, the HCSW vacancy rate has increased by 50 WTE. Fortnightly placement meetings are to enable placing of pipeline HCSW and International Nurse candidates. Over 50% of International Nurses being recruited this FY have been offered and are being progressed through employment checks for a start date of May 2024 onwards.	Gill-Parker, Tracy	Chief People Officer
1498	Patient Safety due to inadequate Medical Registrar Out of Hours Cover (RBH)	12	04/03/2024	Risk reviewed and unable to reduce risk level currently. Will review again in one month with a view to reducing	Whitney, Sue	Chief Medical Officer
1692	Safe Staffing - Medical Workforce	12	01/02/2024	Risk reviewed. Description and title amended. Risk score to remain the same at present as the extent of the gap is yet to be identified. Workstreams are ongoing and the expectation is that all medical workforce job plans and rostering are on HealthRota by the end of March 2024. Health Rota is superseding Allocate.	Jupp, Becky	Chief Medical Officer
1771	Radiology Service Demands/ Radiologist staffing	12	07/03/2024	Discussed at Radiology Q+R Meeting. Outsourced figures for January: Hexarad Cold 1069, Hexarad Hot 63, Hexarad OOH 911. Equates to 22.86% of out-patient studies and 19.25% of in-patient/ED work.	Knowles, James	Chief Medical Officer
1933	Medical Workforce ED	12	05/03/2024	February 2024: - Medical Staffing Co-ordinator. - ED Operations & Perf Manager Drafting recruitment plan.	Bradley, Richard	Chief Medical Officer

				-SBARN completed around option for acute management of issues covering risk till Apr 24, mitigating gaps in rota. - 3 x Middle grades appointed with 1 in pipeline to start in Apr 24. - Trial process for MG staff within supernumerary period against nights to support gaps.		
1202	Medical Staffing Women's Health	12	27/03/2024	The maternal medicine consultant job has been published and are about to advertise the maternal and fetal medicine consultant post. There are 2 consultants on fixed term contracts, aiming to have a recruitment day in July 24. Approval to obtain agency to fill long term sickness gaps. Risk rating reduced to a moderate 12.	Taylor, Mr Alexander	Chief Medical Officer
Quality (Safety and Outcomes)						
1214	Risk of misdiagnosis/ incorrect treatment from use of ungoverned Point of Care devices.	16	29/03/2024	Risk score unchanged. Rollout of new glucose and ketone meters ongoing. Contract for replacement of blood gas machines trust wide is being negotiated. CB engaging with commercial services. Progress being made on connectivity of Rotem analysers.	Massey, Paul	Chief Medical Officer
1276	Unsafe and delayed patient care due to delays in surgery for # Neck of Femur patients	15	29/03/2024	Sustained improved performance (>50%) No change to risk	West, John	Chief Operating Officer
1378	Lack of Electronic results acknowledgement system	15	02/04/2024	ICE upgrade work under way. Process maps being completed to support the review of an interim solution with the CCIO. Ultimately the full solution for this issue will be the new EHR solution.	Hill, Sarah	Chief Finance Officer
1397	Provision of 24/7 Haematology/ Transfusion Laboratory Service	15	29/02/2024	Another substantive BMS joining the OOH rota from this weekend, we are recruiting into our final vacancies currently. But overall the risk rating won't be able to be downgraded until we transition more onto the rota. Hopefully that by the end of the summer we will be in a better place.	Macklin, Sarah	Chief Nursing Officer
1690	Interventional Radiology Nurse Staffing	12	07/03/2024	Discussed at Radiology Q+R Meeting. Service being supported by agency and bank staff. NHS cap on agency spending due for implementation, and still not enough substantive staff to run service. Loss of agency staff would reduce service. Interviews held and 2 WTE posts offered, awaiting confirmation of start dates.	Jenkins, Anne-Marie	Chief Nursing Officer
1758	Chemotherapy production in pharmacy now at capacity and limiting patients accessing treatment	12	27/03/2024	3 month pilot to trial majority of the workload at Poole underway Feb to April. Capacity increased to 72 patients per day during March at the requests by the executives, required compromising the ward clinical service further. April, May and June actions in place to sustain a limit of 65 per patients per day. Options appraisal being completed to consider long term options	Bleakley, Stephen	Chief Medical Officer

Sustainable Services						
1950	Graphnet Electronic Patient Record (EPR) is not fit for purpose	20	02/04/2024	Interim CIO and Finance leads at UHD have got the EHR case as affordable for UHD. We are now waiting on the other organisations to achieve the affordability to support the case being approved. Now aiming for end of April 2024 to get the business case approved.	Hill, Sarah	Chief Finance Officer
1881	Financial control total 2023/24	16	28/03/2024	The risk was reviewed by the FPC as part of the financial report, with the recommendation for it to remain unchanged and kept under close review.	Papworth, Pete	Chief Finance Officer
1595	Medium Term Financial Sustainability	16	28/03/2024	The risk was reviewed by the FPC as part of the financial report, with the recommendation to retain the current position.	Papworth, Pete	Chief Finance Officer
1355	Lack of integration between the Electronic Referral System (eRS) & Electronic Patient Record (ePR)	15	02/04/2024	Informatics have been waiting since December 2023 for a decision on whether the changes are possible within Consultant Connect to achieve the solution for this risk. Waiting on Outpatients to complete the review to respond to this.	Hill,	Chief Medical Officer
1395	Lack of Capacity in Cellular Pathology Causing a Delay in Processing and Reporting.	15	05/02/2024	Multiple posts have been approved by Finance and Care Group but at VRP stage (Bd 8a LTS cover – 6 months, Bd 3 LTS cover – 6 months, 1 x Bd 6, 3 x Bd 5s and 3 x Bd 3s)	Massey, Paul	Chief Medical Officer
1594	Capital Programme Affordability (CDEL)	12	28/03/2024	The risk was reviewed by the FPC as part of the financial report	Papworth, Pete	Chief Finance Officer
1924	Risk of not successfully and sustainably adopting the patient first approach across UHD	12	20/03/2024	Controls updated to show contract for consultancy in year 2 not yet agreed	Matthews, Deborah	Director of Improvement and OD

6. Risk Heat Map- UHD

Current Risk Grading		Likelihood				
		No Harm (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Severity	Almost Certain (5)	3	11	10	2	
	Likely (4)	2	30	13	6	
	Possible (3)	3	33	45	5	1
	Unlikely (2)		11	22	8	3
	Rare (1)		1	2	1	

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

Current Risk Score– UHD total	April 23	May 23	Jun 23	Jul 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Very Low (1-3)	5	5	4	5	3	3	3	5	8	6	6	**6**
Low (4-6)	67	63	63	72	76	80	74	74	72	78	76	**72**
Moderate (8-10)	73	78	78	82	86	86	84	91	89	91	97	**97**
Moderate (12)	18	20	21	22	21	19	19	21	21	20	19	**16**
High (15 -25)	21	24	21	20	22	23	23	23	23	21	19	**19**
Total number of risks under review	184	190	187	201	208	211	203	214	213	216	217	**210**

7. Compliance and Risk Appetite

Summary of compliance UHD overall:

Current Risk Grading	*No: of risks under review*	*Number of Risks compliant with Risk Appetite timescales*	*% of Risks Compliant with Risk Appetite timescales*	*Month on month position*
12 and above	35	33	94%	⬆ 2%
8 to11	97	81	84%	⬇ 1%
4 to 7	72	66	92%	⬆ 4%
1 to 3	6	3	50%	⬇ 50%
Total	**210**	**183**	**87%**	⬇ **1%**

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

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

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

Appendix B: Matrix for Risk Register Assessment

Table 1 Consequence scores

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

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

Table 2 Likelihood score (L)

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

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

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Date: 01 May 2024

Agenda item: 6.2

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

Strategic themes that this item supports/ impacts:	Systems working and partnership ☒ Our people ☒ Patient experience ☒ Quality: outcomes and safety ☒ Sustainable services ☒ Patient First programme ☒ One Team: patient ready for reconfiguration ☒
BAF/Corporate Risk Register: (if applicable)	BAF Risks 1-7 Trust Integrated Performance report for April 2024 - Appendix A
Purpose of paper:	Assurance
Executive Summary:	The Trust ended the financial year with a small surplus of £0.065million. This has been delivered following additional contract income of £10.7 million which has offset the key cost pressures including energy (£5.1m) and unfunded escalation beds (£6.3m). Premium pay costs have been offset by non pay underspends. Industrial action costs have been reimbursed. The overall outturn for Dorset ICS is a deficit of £14.6 million against a forecast outturn of £12.3 million. Emergency Department (ED) attendances and conveyances increased again in March 2024. As well as remaining significantly higher than March 2023, performance has seen an improvement to 70.2% which is the highest performing month and an increase of 6.4% from February 2024. Whilst March 2024 saw continued improved levels of No Criteria to Reside (NCtR), there remains >200 beds occupied by NCtR patients. UHD completed our capacity de-escalation plan in March and as per the plan our Same Day Emergency Care (SDEC) capacity and Treatment Investigation Unit (TIU) has been released from escalation and is functioning as admission avoidance capacity. The Trust has a draft capacity plan for 2024/25 that will be shared with the Trust Board in May following discussion through the relevant Trust forums.

23/24 ends the year having achieved a number of its ambitions for elective and cancer care. Fewer patients are waiting on an RTT waiting list and a higher proportion of patients have been seen or treated within 18 weeks.

Table 1: Trust progress on operational standards 23/24

Performance Metric	31 March 2023	31 March 2024
4 Hour care Emergency Dept standard	56.8% (commenced reporting April 23)	70.2%
Diagnostic 6 week standard - % greater than 6 weeks	7%	10.7%
Referral to Treatment - % patients within 18 weeks	53.8%	62.0%
Referral to Treatment - number of patients waiting >52 weeks	4,100	2,767
Referral to Treatment - number of patients waiting >65 weeks	1,070	329
Referral to Treatment - number of patients waiting >78 weeks	96	29
Referral to Treatment - number of patients waiting >104 weeks	0	0
Referral to Treatment - number of pathways	72,770	68,398
28 day Faster Diagnosis Standard (Target 75%)	75.4%	76.1% (provisional)
31 day Cancer Standard - % patients diagnosed being treated within 31 days (Target 96%)	97.1%	95.9% (provisional)
62 day Cancer Standard - % patients being seen 62 days from urgent GP referrals (Target 85%)	65.5%	65.1% (provisional and likely to increase)

Background:

The integrated performance report (IPR) includes a set of indicators covering the main aspects of the Trust's performance relating to safety, quality, experience, workforce and operational performance. It is a detailed report that gives a range of forums the ability if needed to deep dive into a particular area of interest for additional information and scrutiny.

As part of our commitment against the CQC Well-Led Framework we continue to develop the format and content of the IPR by:

- Extending best practice use of Statistical Process Control (SPC) Charts.
- Greater focus on key indicators as part of our Patient First roll-out programme linked to the Trust Strategic priorities and the Trust Refreshed SDR process.
- Providing SPC training to operational leads who compile the narrative against the data included within the report.

We recognise as a Trust Board that behind every single metric discussed in this paper there is a patient.

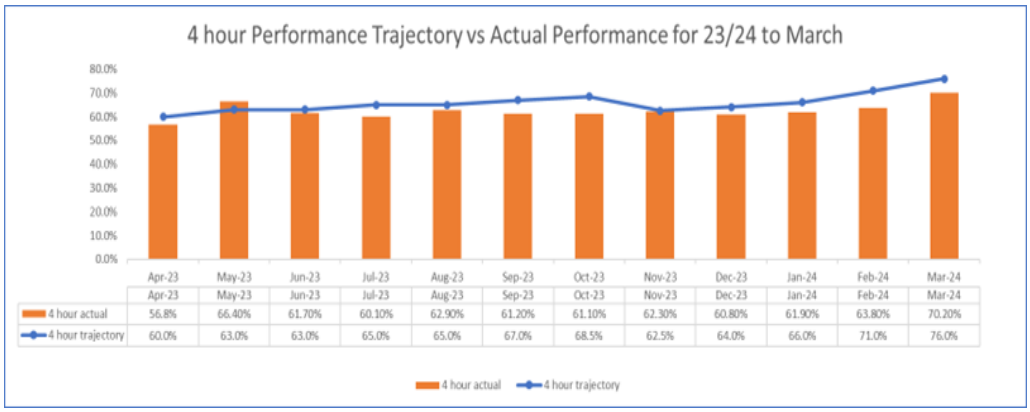
Urgent & Emergency Care (1 Advise)

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

Advise (1): Performance against the 4-hour standard for March 2024 is 70.2% against the year-end target to achieve 76% by March 2024.

- Whilst the organisation did not meet its trajectory, 70.2% was a significant improvement of 6.4% from February 24 and the fourth consecutive month of continuous improvement.
- Patient admitted flow out of the A&E department continued to improve, with admitted performance of 33%, which was an improvement from February at 26.7%.
- Mean time in the department as well as time to admit saw a reduction.
- The total number of handovers that were over 60 minutes in February was 7.5%, a sustained improvement from the winter period November 23-January 24.

The IPR provides detailed performance against the national Urgent & Emergency Care standards.



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

Review of the Trust's trajectory for 24/25 is underway as the performance requirement increases to 78% from 76%. This remains a risk and is articulated in the Risk Register and BAF.

Improvement Actions

- Executive-led weekly enhanced support meetings continue.
- The Single work plan was updated in March 2024 to meet national push to achieve 76% by year end which included March specific actions to close the gap. Next steps are to review given performance improvement to ensure sustainability.
- The revised fortnightly UEC Programme Board is using the patient first methodology and reports to TMG. Engagement and plans are being monitored. A suite of metrics is in place.

Key areas of focus remain:

1. **Signposting -** Review of UTC service provision cross site is on-going with the ICB. Internal actions are seeing a sustained increase in slot utilisation and direct streaming from ED to UTC up to 400 slots per week whilst maintaining directly bookable capacity.
2. **Clinical Workforce capacity:** Improving capacity in our Ambulatory Care Area (ACA) Clinician and working through medial workforce capacity plans. Non admitted performance improved to 73.8% up from 68.5% in March.
3. **Senior clinical assessment** – Continued focus on supporting and increasing senior decision-making capacity (Triage & RAT) within the non-admitted function of the emergency department.
4. **Reduce time in ED, with senior leaders escalating** so the blocks are removed – professional standards / culture.
5. **Signposting to alternatives**: Improve access to SDEC, increasing availability now on a 1:3 basis for Medicine at weekends and 6 days a week for Surgery every weekend.

	6. **Work with system partners** to improve admission avoidance and timely discharge.
Occupancy, Flow & Discharge (1 Alert)	**Strategic goal: To meet the patient national constitutional standards for Planned and Emergency care supporting reducing inequalities in outcome and access and improving productivity and value.** **Alert (1) Ongoing challenges with occupancy and flow are resulting in escalation beds/spaces open, with an average of 82 escalation beds open in March (40 funded), and >200 beds occupied by patients with No Criteria to Reside.** The largest factor driving occupancy remains patients with No Criteria to Reside (NCtR) who occupy acute hospital beds at UHD. March has seen some improvement; however, this remains at c21% of adult bed base. The number of patients has reduced to an average of 209 in March. A joint system capacity has been developed and identified the bed gap across the year at UHD even after the inclusion of 40 additional core beds. **Improvement Actions:** In March all partners in the ICB received a letter from the ICB Chief Operating Officer asking for immediate focus on 5 key actions aimed at improving pathways for patients ready to leave hospital. This is being progressed at a Place level within the Dorset system, with UHD working closely with BCP Local Authority. This work is expected to gain increased momentum through April 2024. A bed capacity paper will be shared at a future Trust board. There are key workstreams at UHD to support improved processes. • The Poole Trauma wards are involved in testing a process that removes a significant number of steps in progressing a patient to a community rehabilitation bed, this is now being rolled out to older persons wards. • In addition, a selection of wards are supporting earlier discharge planning and testing a single worklist (Health of the Ward) • the EDD (Estimated Date of Discharge) is now included in the data set shared with partners daily. • Focus on patients waiting over 21 days with a criteria to reside to make sure that we have optimised the patient pathway for these group of patients. Further internal actions are in place to continue to optimise discharges operationally daily, measured through the UEC programme board.
Referral to Treatment (RTT) (1 Advise, 2 Assure)	**Strategic goal: To meet the patient national constitutional standards for Planned and Emergency care supporting reducing inequalities in outcome and access and improving productivity and value.** **Assure (1) The Trust has delivered a 6% reduction in the Referral to Treatment (RTT) waiting list in 2023/24 and has maintained an improvement in 18 Week RTT performance at 62% compared to 53.8% in March 2023.**

Advise (1) The Trust delivered a reduction in both RTT waits greater than 78 weeks and 65 weeks in March 2024, however was not able to recover against its trajectory to eliminate long waiters due to the in-year impacts of lost activity due to Industrial Action, workforce challenges and high non-elective bed occupancy.

- There is an overall improving trend in the waiting list that is 7,809 below the operational planning trajectory (76,972).
- 29 patients with a wait greater than 78 weeks remained at the end of March 2024. This represents a significant improvement from 45 in February 2024. Ongoing actions are taking place to support elimination of 78 week waits in Q1 2024/25.
- Waits over 65 weeks also reduced to 328, which was above the trajectory (279), but a significant reduction compared to 840 in February and the Trust has delivered a reduction of over 99% in the cohort of patients who were at risk of waiting >65 weeks in 2023/24.
- In 2024/25, the focus of elective care will be on increasing capacity and productivity to eliminate waits over 52 weeks. 52 week waits fell by 200 in March.

Planning requirement	Feb 24	March 24	
Referral to treatment 18-week performance	61.3%	62.0% ▲	National Target 92%
Eliminate > 104 week waits	0	0	Plan Trajectory 0 by March 2023 (Excl. IA)
Eliminate >78 week waits	45	29 ▼	Plan Trajectory 0 by March 2023 (Excl. IA)
Eliminate >65 week waits	840	328 ▼	Plan trajectory 279 March 2024 (Excl. IA)
Hold or reduce >52+ weeks	2,967	2,767 ▼	Plan Trajectory 4,034 by March 2024 (Excl. IA)
Stabilise Waiting List size	66,909	68,398 ▼	Plan Trajectory 76,972 March 2024 (Excl. IA)

Theatre productivity: Performance trends are showing that the theatre case opportunity target can be achieved within current processes, although March's performance was above the target. Theatre utilization rates remain below the national target (85%) however there is much less variation and greater control in the process with reported capped utilization at 77% and uncapped at 81%.
Reduced variation in the outpatient DNA rate has also been delivered in 2023/24 year to date alongside an overall reduction. The current rate is 5.3% in March against a target of 5% and a baseline position of 7.1% in March 2023. The Trust plans to switch on text reminders across all clinics in Quarter 1 2023/24, unless a clinically led opt-out rationale is provided by specialty teams (currently 79.7% of all clinics have text reminders switched on – an improvement of 25.7% in March 2024).

	Improvement actions are detailed within the Integrated Performance report and include: • Prioritising patients at risk of breaching >65 weeks before September 2024 to eliminate these waits. • An agreed Elective Recovery Fund spend plan has been deployed focused on maintaining safe wait times for patients on cancer pathways or waiting urgent elective care. • Achieving a minimum of 104% elective activity. • Delivering on productivity improvement plans for outpatients, theatres, endoscopy, length of stay and radiology. **Assure (2): The percentage of fractured NOF patients operated on within 36 hours of admission improved in March.** • March performance for time to theatre for fractured neck of femur (# NoF) patients increased, whereby 83% of patients achieved surgery within 36 hours of being fit for surgery and 64% of patients were operated on within 36 hours from admission. • Performance was within process control limits and the upper limit demonstrates the performance target is achievable within current processes. • Overall trauma admissions increased from February 2023 with 359 admissions in March 2024, including 88 with a fractured neck of femur (NoF) (compared to 77 in February 2024). • A Hand Hub has commenced operating 2 sessions per week with 19 patients through the service, releasing 10 main theatre sessions an initiative that we wish to consider for other areas of the trust.
Cancer Standards (1 Assure)	**Strategic goal: To meet the patient national constitutional standards for Planned and Emergency care supporting reducing inequalities in outcome and access and improving productivity and value.** **Assure (1) Final performance against the Cancer Faster Diagnosis Standard (FDS) in February 2024 is 77.8%, achieving the national standard. The Trust also remains on target to meet the standard in March 2024. An improvement in 62 day performance and a reduction in the >62 day back log was also delivered.** • 28-Day Faster Diagnosis Standard - Performance increased in February by 5.3% to a compliant 77.8%, meeting the month end trajectory. Performance remains within the process control limits, which demonstrate the standard can be maintained within the current processes. The main tumour sites seeing a significant improvement in month are Breast, Gynaecology and Skin. 8 out of 14 tumour sites achieved the standard. Colorectal's performance increased by 4.0% in month compared to January, however remains the main tumour site impacting the Trust's overall performance for FDS. Improvement plan is being delivered. • 62-Day Standard - performance in February increased by 2.3% to 65% compared to January and continues to demonstrate normal variation within the process control limits. The main breach reasons were capacity both at the front end of the pathway and for surgical treatments. Capacity for treatments was reduced due to industrial action in the month (February 2024).

- Over 62 Days - The Trust continues to deliver against the regional expectations on reducing the over 62-day backlog. The total number on the PTL over 62 days decreased to 202 in February (34 less compared with January and 33 below the month's trajectory of 235).
- 31-Day standard - The 96% performance target was achieved in February (at 96.1%).

KPI	Target	Nov 23 FINAL	Dec 23 FINAL	Jan 24 FINAL	Feb 24 FINAL	Mar 24 Prov
28 Day Faster Diagnosis Standard	75%	64.3%	66.6%	72.5%	77.8%	76.1%
31 Day Standard	96%	96.4%	96.2%	93.6%	96.1%	95.9%
62 Day Standard	85%	65.8%	64.4%	62.7%	65.0%	65.1%

Improvement actions are detailed within the IPR and include:

- Additional weekend hysteroscopy clinics in Gynaecology throughout Q4 2023/24 and into Q1 2024/25 to sustain the improved performance position.
- Rapid recovery plan in place for Colorectal to mitigate against nursing and medical capacity challenges.
- Elective recovery funding is supporting additional insourcing and waiting list initiative capacity in Dermatology in Quarter 4 2023/24, whilst Tele-dermatology and the pilot AI proposal is operationalised, which was successfully launched in March 2024.

DM01 (Diagnostics report) (1 Advise)

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

Advise (1) The DM01 standard has achieved 89.3% of all patients being seen within 6 weeks of referral; 10.7% of diagnostic patients seen >6weeks in March 2024.

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

March	Total Waiting List	< 6weeks	> 6 weeks	Performance
UHD	12,876	11,493	1,383	**10.7%**

UHD remains one of the top performing trusts for diagnostics in the Southwest region. Nevertheless, there are challenges related to workforce capacity in Echocardiology, Neurophysiology and Radiology (imaging). Mitigating actions are in place to maintain a high level of performance. The presence of a bank holiday in March impacted overall performance.

Improvement actions are being delivered, including the delivery of the Community Diagnostic Centre programme:

- Endoscopy: The InHealth mobile unit was removed in March 2024 as planned. An increase in insourcing is scheduled in Q1 to mitigate this reduction in capacity alongside delivery of productivity improvements.
- Echocardiography: Increase in stress-echo capacity from April.
- Radiology: Commenced AECC Ultrasound at Christchurch (140 patients a week) until end of July 2024.
- Cardiology: additional sessions scheduled
- Mobile CT contract ended March 2024, and replaced with extra weekend sessions at RBH.
- Mobile MRI contract ended March 2024 and replaced with extra weekend and evening sessions at PGH reducing the cost per treatment for endoscopy additional activity.

Health Inequalities (1 Advise)	**Strategic goal: To meet the patient national constitutional standards for Planned and Emergency care supporting reducing inequalities in outcome and access and improving productivity and value.** **Advise (1)** **Waiting list by Index of Multiple Deprivation (IMD)** 8.5% of patients on the waiting list live in the 20% most deprived areas of Dorset. The median weeks waiting at the point of treatment shows no variation between patients from the 20% most deprived group and the rest of the population treated. Analysing the same data by age band identifies children from the most deprived areas wait 1 week longer than the rest of the <18yr old population. **Waiting list by ethnicity:** 11% of patients on the waiting list are from community minority ethnicity groupings. An analysis of the median weeks waiting by ethnicity grouping identifies a 1 week variation between patients within community minority groups and White British populations in Quarter 4. This is an improved position compared to Q3 2023/24. However, the level of variation increases to 3 weeks for <18 year olds from community minority groups. A deep dive into ENT services to understand the variations in 'did not attend' rates by IMD group and ethnicity has commenced to understand the reasons for missed appointments which are a contributing factor to increased waits. **Emergency dept. attendances by Index of Multiple Deprivation (IMD)** Attendances are lowest in deprivation deciles 1-3.
Maternity (1 Advise)	**Advise (1) There are 3 areas currently flagging as red RAG rated:** • 3rd /4th degree tears although within normal variance range • Apgar <7 at 5 minutes-increased over last two months • Prompt Training -below 90% compliance Improvement actions are detailed within the IPR.
Infection Prevention and Control: (1 Assure 2 Advise)	**Quality, Safety, & Patient Experience Key Points** **Strategic goals: To achieve top 20% of Trusts in the country for mortality (HSMR)** **To reduce moderate/severe harm patient safety events by 30% through the development of an outstanding learning culture** **Assure (1) *Clostridioides difficile* Cases** *Clostridioides difficile* cases in March 2024 have increased, which mirrors a national trend. Ward monitoring continues to be completed by the IPC team. **Advise (1)** One case of *Methicillin-resistant Staphylococcus aureus* identified within UHD in March 2024. This was community onset, but hospital acquired – further exploration and review is underway by the Infection Prevention and Control Team. **Advise (2) Hospital Associated cases trend** **HCAI Trends by month** • The team continue to assess themes as part of the PSIR Framework.
Clinical Practice Team	**Clinical Practice Team:** **Advise (1) Moving and Handling - Essential Core Skills**

Organism	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
C Diff	6	8	19	11	4	8	8	4	8	6	9	13
E Coli	7	8	17	14	9	11	11	11	17	17	8	8
MRSA	1	0	0	0	0	0	0	0	1	1	0	1
MSSA	5	6	8	4	4	5	5	4	3	3	6	6

(5 Advise)	The challenges to meet the face-to-face level two training requirements for clinical staff continues. The risk register entry remains at 10 (moderate). The development of an eLearning Level 2 package is being progressed; with filming undertaken in January 2024. There have been unforeseen challenges which the team are working through to get this completed promptly, this continues. **Falls prevention & management**: **Advise (2)** The number of serious falls incidents in month have had a slight decrease six reported; of these three were reported as moderate and three severe falls. These incidents are following the appropriate scoping and investigation process through the patient safety investigation framework. **Tissue Viability:** **Advise (3)** The ability of the service to meet the increased demand remains on the risk register entry 1821 and rated as 9 (moderate), the action plan has been updated. There remains a significant number of complex patients being referred to the service. The TVN team continue with temporary staffing to support this demand and out to recruitment for an additional substantive Band 6 TVN. **Advise (4) Pressure Ulcers:** There were nine new category three pressures ulcers reported in month which are following the appropriate investigation process and learnings identified. To note a specific theme was that a number of patients identified were receiving end of life care. The lead Tissue Viability Nurse continues to work with care groups to review how ward learning is shared though the pressure ulcer screening tool following an incident and further embedding is required alongside the development of ward improvement plans. **Advise (5)** As noted previously a **new National wound care strategy** has recently been published which makes recommendations on reporting including the inclusion of unstageable pressure ulcers as a category three, we therefore may see an increase in pressure ulcer reporting, the TVN team will continue to monitor.
Patient Experience ***(3 Advise)***	**Strategic goal: Every team is empowered to make improvements using patient (or user) feedback, in order that all patients at UHD receive quality care, which results in a positive experience for them, their families and/or carers.** **Patient Experience and Engagement Team Overview:** **PALS and Complaints numbers for March 2024** **Advise (1) The number of open complaints over 55 days** continue to be prioritised within the complaints team and care groups and has continued to decrease with further measures to reduce the number of outstanding complaints commenced. **Advise (2) Friends and Family Test (FFT)** The volume of FFT being received has maintained prior to the Patient Experience Team and BI managing the SMS FFT Service. UHD has seen a sustained high satisfaction score. The Trust's overall positive score has been above the upper control limit for eight consecutive months. **Advise (3) Mixed Sex Accommodation Breaches** There were 2 occurrences of MSA in March 2024 affecting 6 patients overall – continued monitoring of areas is in place with care group matrons.

Nurse Staffing: (2 Advise, 2 Assure)	**Care Hours per Patient Day (CHPPD):** **Advise (1)** March 2024 CHPPD for registered nurses remained stable at 4.5 for Registered Nurses/Midwives, and 8.0 overall (including non-registered staff). **Red Flag Reporting:** **Assure (1)** Fourteen red flags were raised in month for UHD. Of note, no red flags were raised within maternity services. All red flags were mitigated/resolved with no critical staffing incidents. **Workforce Controls:** **Advise (2)** Following extensive training on the tool and accurate capturing of daily acuity and dependency the pandemic heatmap staffing tool has been switched off and allocate SafeCare, linked to allocate eroster, is now in use. **Assure (3)** No impact on care delivery or safety has been noted as part of the workforce controls implemented since January 2024.
Safeguarding: (1 Advise)	**Advise (1) Team Capacity.** There is a vacancy in the children's safeguarding team for a Child Practitioner, creating a 50% vacancy position. The position has been recruited to and the post holder will start in April 2024. A learning Disabilities / Neurodiversity Practitioner commenced in post at the beginning of March 2024.
Workforce Performance:	**Strategic goal: To significantly improve staff experience, engagement and retention**
CPO Headlines:	
HR Operations (2 Advise)	**Advise – Mediation Training -** To support our restorative just and learning cultural approach, mediation skills training will be rolled out across the Trust this year. This training will be aimed at clinical managers and heads of departments to upskill them on how to respond to workplace relationship difficulties/conflicts, to support local resolution. **Advise - Consultant Pay Dispute -** The British Medical Association (BMA) and the Hospital Consultants and Specialists Association (HCSA) have accepted a new pay offer for Consultant staff. This ends their pay dispute with the Government.
Workforce Systems (2 Advise, 1 Assure)	**Advise – Job Planning -** 251 Consultants and admin staff have been trained on recording job plans in Healthrota. Support will continue through April to ensure Care Groups are proficient in using the system. We have set a deadline for all job plans to be uploaded on the system by 30th June 2024. **Advise – Doctors in Training August Rotation -** The timeline for the Doctors in Training (DiT) August rotation has been sent to all rota coordinators to ensure all doctors are on Healthrota by August 2024. **Assure - National Minimum Wage -** The national minimum wage increases to £11.44 an hour from the 1st April 2024. We had one employee whose pay will be uplifted to ensure that they don't fall below the national minimum wage. Students and employees with salary sacrifice agreements are also being assessed with their pay uplifted if required. These employees will be reassessed when the cost of living pay award for 2024 is confirmed.

Resourcing (1 Assure)	**Assure - Nurse Recruitment -** Almost half of the International nurses due to be recruited in this financial year have been offered employment and are undergoing employment checks, with arrivals due May 2024 onwards. As expected, a high proportion are direct applicants, and this will contribute to the required departmental cost improvement plan this year.
Organisational Development ***(4 Advise)***	**Advise – Staff Survey -** National Staff Survey Team level data has been released and will be shared with Care Groups and Directorates in the April. Pulse Survey live during April. **Advise – Freedom to Speak Up -** 412 staff raised concerns with the FTSU team during 2023/4. This is an increase of 48% on the previous 12 months. The common themes are behaviours and attitudes (188 staff; 46%) followed by process and procedures (131 staff; 32%) and then worker safety and wellbeing (76 staff; 18%). Staff use this route more for workplace and relational issues than patient safety. **Advise – Health and Wellbeing -** Over 600 staff members participated in Thrive Live Sessions, in addition there has been over 500 views on Thrive Live Rewind intranet page for accessing recordings. **Advise** - **Reverse Mentoring** – the next cohort is due to commence in May.
Trust Finance Position ***(2 Alert, 3 Assure, 1 Advise)***	**Strategic goal: To return to recurrent financial surplus from 2026/27** **Alert (1): ICS Financial Outturn** Following approval by all organisational Boards; in line with the H2 planning requirements, the Dorset ICS submitted a forecast outturn deficit of £12.3 million. The aggregate reported outturn is a deficit of £14.6 million, being £2.3 million adverse. This places further pressure on the new financial year. **Alert (2): Efficiency Improvement Programme** Efficiency savings of £18.6 million have been achieved against a target £33.3 million. This represents a shortfall of £14.7 million and a recurrent shortfall of £21.4 million. This places considerable financial pressure on the new 2024/25 financial year. **Assure (1): Revenue Position** At the end of March 2024 the Trust has reported a surplus of £0.065 million against a planned break-even position. This is after the receipt of additional contract funding of £6.2 million received in March 2024 from Dorset ICB, and further contract income of £4.5 million from Specialist Commissioners. This has offset energy cost inflation of £5.1 million; and unfunded escalation costs of £6.3 million. Premium cost pay overspends within Care Groups have been off-set by additional bank interest, reduced depreciation charges, and other non pay under spends. **Assure (2): Capital Programme**

	The Trust has reported capital expenditure of £108.2 million, consistent with the capital programme budget, including operating within the operational CDEL target of £25.9 million. **Assure (3): Cash** At 31 March 2024 the Trust is holding a consolidated cash balance of £108.7 million which is fully committed against the future Capital Programme. **Advise (1): Public Sector Payment Policy** The Trust is currently delivering performance of 91.5% against the national standard of 95%. Financial Services continue to work closely with relevant teams to identify further mitigating actions.
Key Recommendations:	Members are asked to note the content of the report
Implications associated with this item:	Council of Governors ☐ Equality and Diversity ☒ Financial ☒ Operational Performance ☒ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☒ Regulatory ☒ Strategy/Transformation ☒ System ☒
CQC Reference:	Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well Led ☒ Use of Resources ☒

Report History: Committees/Meetings at which the item has been considered:	Date	Outcome
Trust Management Group	April 2024	Pending
Quality Committee (Quality)	April 2024	Pending
Finance & Performance Committee (Operational / Finance Performance)	April 2024	Pending

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

University Hospitals Dorset
NHS Foundation Trust



Integrated Performance Report

Reporting month: March 2024
Meeting Month: May 2024

Contents

Achievements

In 2023/24 the achievements to date have been

- NHS E Safe Learning Environment Charter was launched on 7th February as a guide to improve provision for all learners. We are proud that UHD has been sited as best practice in the section regarding raising concerns for our Purple Flag student support initiative. As a result of this with a funding from NHS E we will create a Purple Flag App and will be attending national conferences to 'adopt and spread' nationally.
- Friends and Family Test (FFT) : We are seeing a sustained increase in the number of Family and Friends Tests (FFT) responses being received with more clinical areas now receiving FFT results.
- Fewer patients are waiting for elective care and the referral to treatment time had reduced compared to March 2023.
- No patients are waiting over 2 years for elective treatment and fewer patients are at risk of waiting over 65 weeks. There has been a 99% reduction in the number of patients who were at risk of waiting more than 65 weeks in 2023/24.
- A 24% reduction in the number of patients overdue an elective follow up outpatient appointment
- More than 7 out of 10 patients were seen and either admitted or discharge from our emergency departments in March 2024.
- More patients are receiving same day emergency care.
- UHD is the top performing Trust in the south west for diagnostic (DM01) performance, and the numbers of patients waiting over 6 weeks have reduced.
- All monthly breast screening and bowel screening targets have been successfully met or exceeded at year end.
- The Cancer Faster Diagnosis Standard has been achieved in February and is forecasted to also be achieved in March 2024. The number of cancer waits over 62 days is at the lowest number for 2 years.

Performance at a Glance Indicators (1)

			standard	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
SAFE																		
Quality	Presure Ulcers (Hospital Acquired Cat 3 & 4)			7	5	8	9	5	11	8	7	15	15	14	8	9
	Inpatient Falls (Moderate +)			3	4	2	5	1	3	4	6	3	4	2	11	6
	Medication Incidents (Moderate +)			0	0	0	1	1	1	2	1	3	3	9	4	4
	Patient Safety Incidents (All)			1400	1291	1352	1356	1459	1446	1468	1382	1370	1289	1269	1202	1255
	Hospital Acquired Infections	MRSA		0	1	0	0	0	0	0	0	0	1	1	0	1
		MSSA		1	4	6	8	4	4	5	5	4	1	3	6	6
		C Diff		5	5	8	19	11	4	8	8	4	8	6	9	13
		E. coli		14	5	8	17	14	8	11	11	11	8	17	8	8
EFFECTIVE																		
Mortality	HSMR In Month (UHD)	Latest Dec 23	(source HED)	104.3	114.4	111.9	108.1	109.8	113.6	103.2	114.7	105.1	111.7			
	Patient Deaths in Hospital			259	238	228	215	196	227	200	252	232	281	245	233	215
	Deaths within 36hrs of Admission			32	36	41	34	33	43	25	35	40	45	23	38	32
	Deaths within readmission spell			16	22	22	19	27	31	21	27	20	23	18	26	26
CARING																		
	Complaints Received			86	67	92	91	37	41	47	65	89	81	62	60	66
	Complaint Response Rate (55 Days)			47.4%	53.2%	69.8%	52.9%	23.6%	31.9%	14.3%	20.8%	42.3%	58.2%	56.2%	38.8%	40%
	Friends & Family Test			90.3%	90.9%	91.8%	91.0%	93.8%	94.4%	94.4%	95.1%	94.8%	94.4%	94.1%	94.2%	94%
WELL LEAD																		
Safety	Risks 12 and above on Register			38	40	40	48	42	42	45	42	49	47	43	39	43
	Risks 15 and above on Register			19	20	21	23	20	23	23	22	24	24	22	19	23
	Red Flags Raised*			38	21	43	25	19	13	20	15	13	15	28	13	14
People	Turnover			13.9%	13.8%	13.7%	13.4%	12.9%	12.3%	12.1%	11.7%	11.2%	11.0%	11.1%	11.1%	11.1%
	Vacancy Rate	Reported 1 month in arrears		6.0%	6.0%	7.0%	8.1%	9.1%	8.2%	7.7%	6.9%	6.3%	6.3%	7.1%	9.5%	
	Sickness Rate			4.8%	3.9%	3.7%	3.9%	4.1%	4.1%	4.3%	4.8%	4.6%	4.4%	4.5%	4.4%	4.4%
	Statutory and Mandatory Training			86.98%	87.84%	88.45%	89.41%	89.70%	89.75%	89.25%	88.88%	88.92%	88.93%	88.91%	89.43%	89.0%
	Appraisal Compliance - Values Based			53.56%	1.22%	4.66%	11.97%	23.80%	34.82%	53.33%	60.82%	63.79%	63.77%	64.20%	63.97%	63.7%
	Appraisal Compliance - Medical & Dental			59.52%	60.07%	60.61%	62.03%	60.91%	58.25%	55.9%	57.66%	57.29%	56.14%	59.24%	58.81%	58.5%
	Temporary Hours Filled by Bank			53.5%	57.6%	57.1%	53.1%	53.6%	54.2%	51.0%	51.8%	53.1%	52.4%	53.5%	55.6%	57.6%
	Temporary Hours Filled by Agency			19.2%	20.3%	21.6%	24.4%	26.3%	25.2%	26.8%	26.2%	27.8%	27.0%	24.6%	22.9%	23.2%
	Agency Pay as Proportion of Total Pay			3.6%	5.1%	4.1%	4.6%	4.7%	4.5%	5.0%	5.1%	4.5%	4.9%	5.3%	5.2%	4.4%

Performance at a Glance Indicators (2)

Performance at a Glance - Key Performance Indicator Matrix

		standard	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
RESPONSIVE																
RTT	18 week performance %	92%	53.8%	52.6%	54.3%	55.1%	55.4%	57.0%	57.6%	59.7%	60.8%	59.8%	60.3%	61.3%	62.0%	
RTT	Waiting list size	76,589 (Jan 24)	72,770	74,557	74,500	74,483	75,884	73,727	73,726	70,914	69,158	68,967	67,983	66,909	68,398	RAG rated based on trajectory
RTT	No. patients waiting 52+ weeks	4,054 (Jan 24)	4,100	4,380	4,813	4,574	4,613	4,501	4,426	4,199	4,196	3,879	3,722	2,967	2,767	RAG rated based on trajectory
RTT	No. patients waiting 65+ weeks		1,070	1,249	1,242	1,053	1,122	1,293	1,234	1,331	1,271	1,313	1,220	840	328	
RTT	No. patients waiting 78+ weeks	0	96	112	97	32	34	43	43	47	59	57	86	45	29	RAG rated based on trajectory
RTT	No. patients waiting 104+ weeks	0	0	0	0	0	0	0	0	0	0	0	0	0	0	RAG rated based on trajectory
Theatre	Theatre utilisation (capped) - main	85%	65%	72%	73%	73%	73%	74%	75%	75%	74%	71%	73%	74%	73%	
Theatre	Theatre utilisation (capped) - DC	85%	57%	69%	74%	73%	72%	72%	74%	74%	75%	75%	76%	73%	72%	
Theatre	NOFs (Within 36hrs of admission - NHFD)	85%	67%	54%	33%	37%	37%	31%	47%	43%	56%	60%	73%	62%	62%	
Outpatients	**Outpatient metrics**															
Outpatients	Overdue Follow up Appts		34,302	31,778	31,057	30,594	29,622	27,619	27,946	27,493	26,506	26,733	26,506	25,844	26,075	
Outpatients	% DNA Rate	5%	7.1%	7.6%	6.5%	6.1%	6.2%	6.3%	6.2%	6.3%	5.9%	6.2%	5.9%	5.6%	5.3%	
Outpatients	Patient cancellation rate		9.2%	8.9%	11.3%	11.6%	11.0%	11.3%	11.6%	11.8%	11.2%	12.3%	11.3%	11.1%	10.6%	
Outpatients	% non face to face (telemedicine) attendances	25%	18.5%	18.6%	18.6%	17.5%	17.4%	17.5%	17.1%	17.0%	17.3%	17.4%	17.5%	17.1%	17.2%	
DM 01	**Diagnostic Performance (DM01)**															
DM 01	% of >6 week performance	1%	7.0%	8.4%	6.0%	7.7%	9.4%	13.2%	12.1%	10.4%	9.3%	10.8%	11.8%	8.7%	10.7%	
Cancer	28 day faster diagnosis standard	75%	75.4%	71.2%	70.2%	71.9%	60.1%	54.7%	64.7%	67.0%	64.3%	66.6%	72.5%	77.8%	*76.1%*	*March cancer position provisional*
Cancer	62 day standard	85%	65.4%	67.0%	62.7%	60.2%	63.0%	57.1%	60.2%	68.9%	65.8%	64.4%	62.7%	*65.0%*	*65.1%*	
Emergency Dept	4 hour care standard			56.8%	66.4%	61.7%	60.1%	62.9%	61.2%	61.0%	62.3%	60.8%	61.9%	63.8%	70.2%	
Emergency Dept	Arrival time to initial assessment	15	13.0	16.0	19.0	22.0	24.0	16.0	16.0	21.0	19.0	19.0	20.0	20.0	20.0	
Emergency Dept	Clinician seen <60 mins %		26.1%	31.6%	27.6%	35.6%	20.3%	27.2%	26.1%	27.7%	32.2%	31.9%	31.3%	33.0%	32.0%	
Emergency Dept	Patients >12hrs from DTA to admission	0	211	220	82	13	59	2	-	-	70	294	483	202	207	
Emergency Dept	Patients >12hrs in dept		1238	849	637	504	871	723	857	882	851	1271	1681	927	979	
SWAST	Ambulance handovers		3988	4007	4102	4015	4268	4447	4238	4433	4295	4456	4394	3974	4365	
SWAST	Ambulance handover 30-60mins breaches		829	721	625	684	750	824	874	1046	1139	1248	1238	876	1016	
SWAST	Ambulance handover >60mins breaches		900	698	345	383	615	588	677	805	551	711	733	270	327	
Patient Flow	Bed Occupancy (capcity incl escalation)	85%	94.5%	93.6%	92.3%	94.4%	94.6%	93.5%	95.3%	95.8%	96.7%	95.3%	96.4%	92.4%	93.0%	
Patient Flow	Stranded patients:															
Patient Flow	Length of stay 7 days		543	523	502	480	474	476	500	502	526	534	566	551	528	
Patient Flow	Length of stay 14 days		355	337	322	294	295	308	310	318	331	339	370	363	336	
Patient Flow	Length of stay 21 days	108	255	235	223	199	202	220	211	220	220	231	266	255	235	
Patient Flow	Non-elective admissions		6203	5690	6288	6347	6223	6233	6141	6551	6519	6214	6538	6135	6718	
Patient Flow	> 1 day non-elective admissions		3881	3612	3826	3783	3863	3821	3779	4065	3934	3909	3981	3673	4175	
Patient Flow	Same Day Emergency Care (SDEC)		2316	2078	2458	2560	2358	2410	2310	2393	2458	2157	2391	2295	2395	
Patient Flow	Conversion rate (admitted from ED)	30%	28.30%	29.70%	29.90%	31.60%	28.70%	28.60%	30.70%	32.50%	32.90%	30.50%	28.47%	29.30%	30.70%	

Statistical Process Control (SPC) – Explanation of Rankings

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

Quality Outcomes & Safety Patient Experience

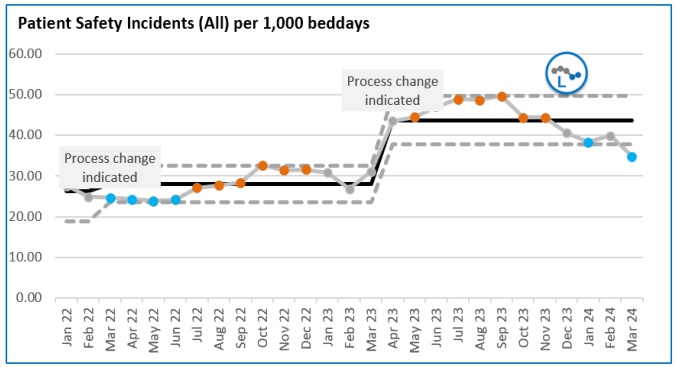
University Hospitals Dorset
NHS Foundation Trust

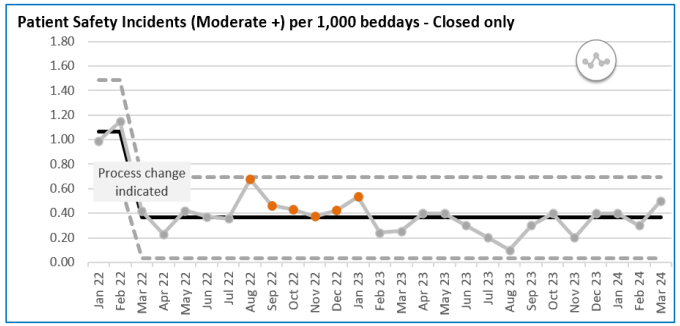
Fiona Hoskins
Interim Chief Nursing Officer
Dr Peter Wilson
Chief Medical Officer

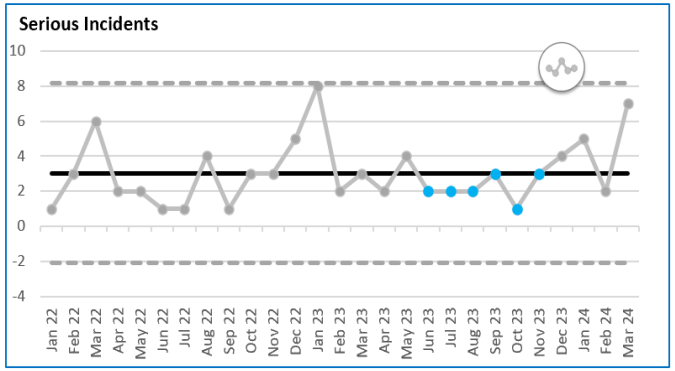
Operational Leads:
Matthew Hodson – Deputy Chief Nursing Officer (IPC, Clinical Practice and Patient Experience)
Fiona Hoskins – Interim Chief Nursing Officer (Deputy Chief NO Safeguarding and Workforce)
Sean Weaver – Medical Director for Quality & Safety
Jo Sims – Associate Director Quality, Governance and Risk
Lorraine Tonge – Director of Midwifery
Mr Alex Taylor – Clinical Director
Sarah Macklin - Care Group Director of Operations, Women's, Children, Cancer and Support Services

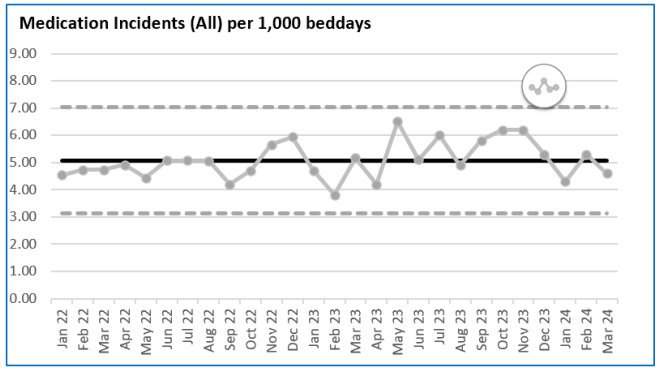
Committees:
Quality Committee

Quality (1) – Safe









Background/target description

To improve patient safety.

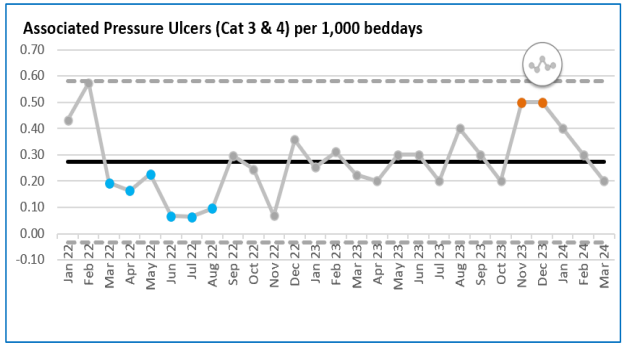
Performance

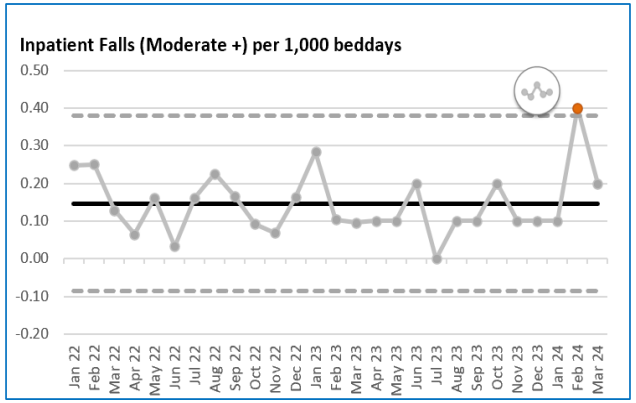
- No significant trends or changes in IPR reported metrics in month (Nov 23 - Mar 24 position).
- Redesign of IPR and Quality Dashboard metrics to report on PSIRF themes and trends in progress.
- Successful transition to new Learning from Patient Safety Events (LFPSE) Forms and national platform on the 30/11/23. LFPSE redefines the definition of a patient safety incident and therefore the Trust reporting profile has changed in the last few months.
- The Quality and Risk Team continue to provide updates on how to report patient safety events.
- The first 2 Patient Safety Investigator training cohorts (4 day course) were provided in Feb 24 and March 24. 30 UHD staff have now received PSII training. A PSIRF implementation plan and PSIRF toolkit is currently being developed.

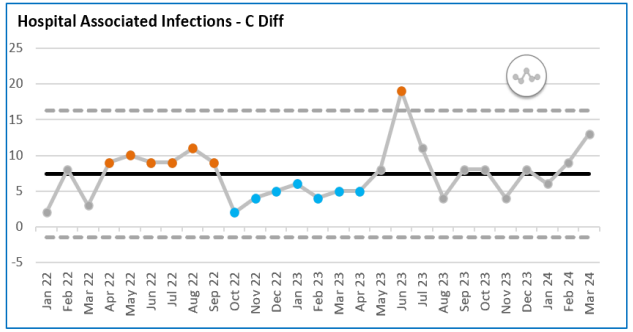
Key Areas of Focus

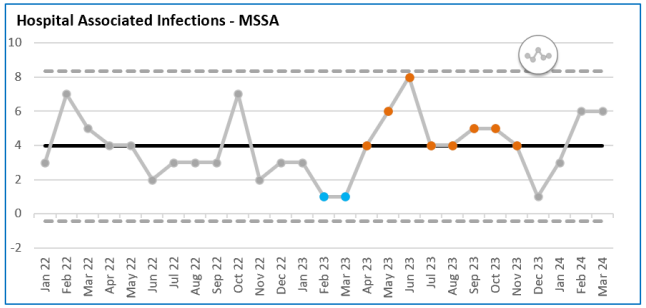
Full report on learning from completed investigations to be included in CMO report to Quality Committee and Board. Learning is also shared via Safety Alerts, SBAR reports, LERN synopsis and the CGG Top 10.

Quality (2) – Safe









Background/target description

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

Performance

Clinical practice:

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

Infection Prevention and Control

- There was one case of *Methicillin-resistant Staphylococcus aureus* identified which was community onset – further exploration and review underway by the IPC.
- *Escherichia coli* blood stream infections remain stable. No immediate themes to assist in identifying further achievement in reduction. The IPC team continue to review cases and monitor.
- *Clostridioides difficile* cases in March 2024 have increased. There have been no specific themes or clinical areas identified or outbreaks. Nationally there continues to be an increase prevalence noted. Ward monitoring continues by the IPC.
- Steady decline in COVID-19 and Influenza A case numbers across March 2024.
- The team continue to assess themes as part of the PSIR Framework, including management of urinary catheters, intravenous cannulae and *Clostridioides difficile* relapses.

Key Areas of Focus

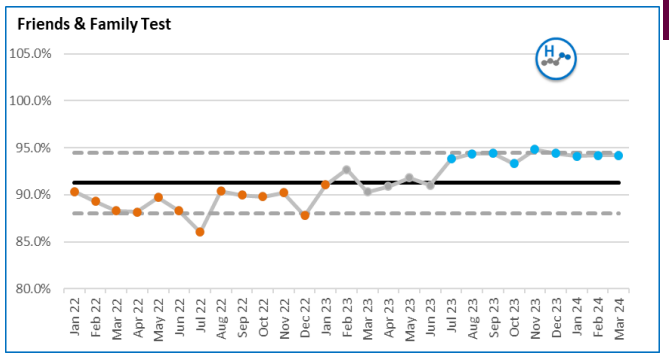
- Continue to work with ward teams on Falls and Tissue viability improvement plans
- Infection Control Team reviewing the venous infusion phlebitis (VIP) assessment tool compliance with care groups.

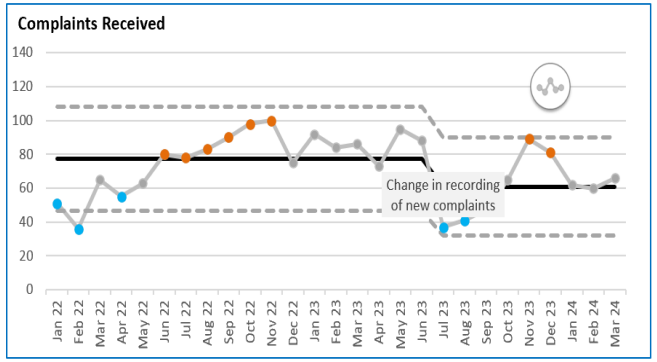
HCAI Trends by month

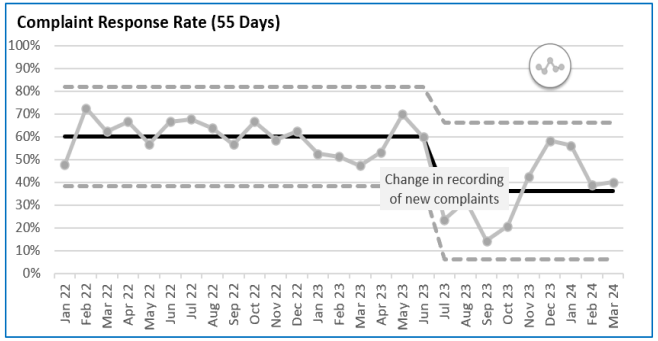
Organism	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
C Diff	8	19	11	4	8	8	4	8	6	9	13
E Coli	8	17	14	9	11	11	11	17	17	8	8
MRSA	0	0	0	0	0	0	0	1	1	0	1
MSSA	6	8	4	4	5	5	4	3	3	6	6

*Categorised as Moderate or Severe

Quality (3) – Caring







PALS and Complaints Data for March 2024:

Overview:

537 PALS concerns raised

- 49 new formal complaints
- 17 Early Resolution complaints (ERC) processed.
- The number of complaints that were responded to and closed in March was 81.

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

The number of open complaints over 55 days continue to be prioritised within the complaints team and care groups and has continued to decrease, as identified in the SPC chart as a special cause variation.

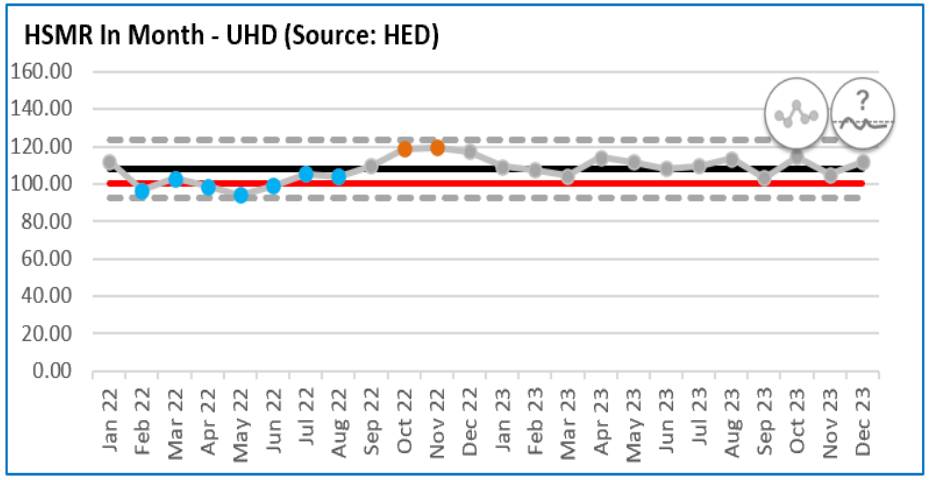
Friends and Family Test (FFT)

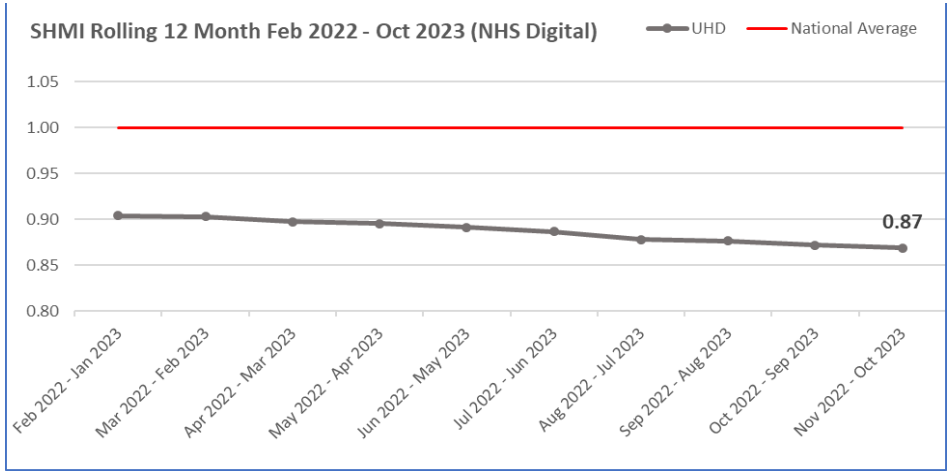
FFT results: FFT responses being received remain steady. More clinical areas are now receiving FFT results. The Trust overall positive score has been above the upper control for eight consecutive months and remains above the average score. Seen in the SPC chart as special cause improved variation. To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

Mixed Sex Accommodation Breaches

There were 2 occurrences of MSA in March 2024 affecting 6 patients overall – continued monitoring of areas continues with care group matrons.

Quality (4) – Effective & Mortality





The headline figure for mortality reporting is UHD trustwide HSMR. This is the key metric for the Quality: Outcomes and Safety central theme of Patient First.

The other main mortality metric is SHMI. This does not alter by data supplier and is set by NHS Digital over the previous year.

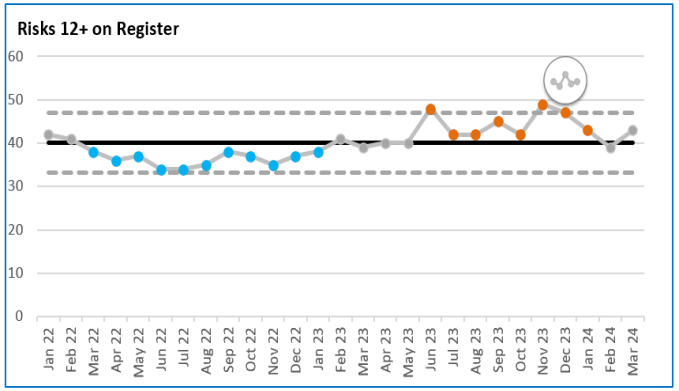
Both are significantly influenced by the fact that we are unusual in having two hospices in our trust. These raise our HSMR as people are dying in our trust rather that outside. The reduce our SHMI as people are not dying in the 30 days after leaving our trust but rather in our trust.

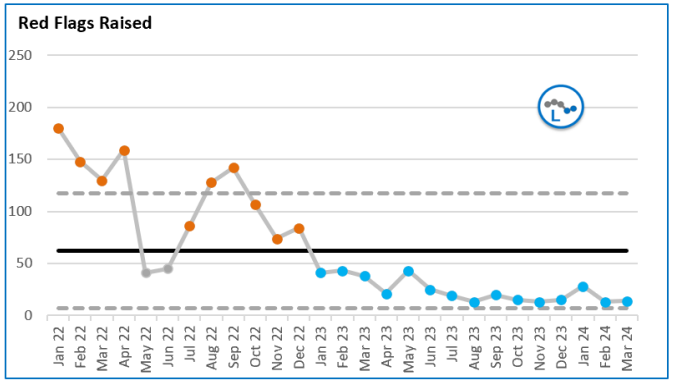
Our rolling HSMR over the last year is 109.47 (Jan 23 – Dec 23). Our SHMI is 0.868 (Nov 22 – Oct 23, Sourced NHS Digital)

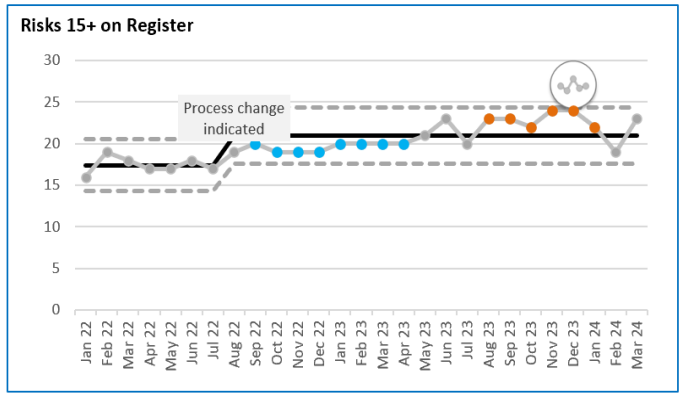
We are learning how to use the HED data most effectively and will be setting up alerts in the next month and also doing a deep dive into our pneumonia data which is our leading cause of death.

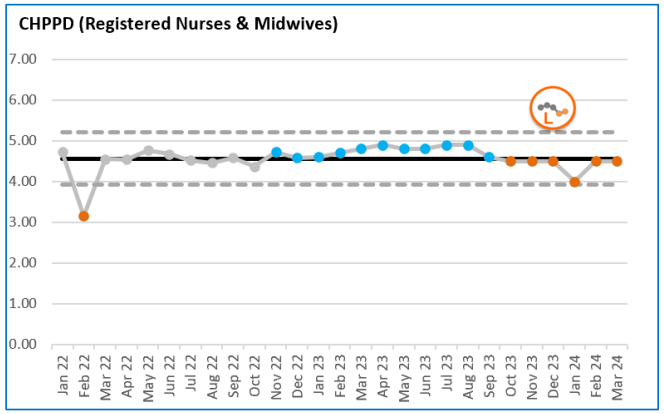
The lack of admin for the learning from death review process has been escalated at SDR as this limits our ability to review and learn from deaths.

Quality (5) – Well Led









Performance

- March 2024 CHPPD for registered nurses and midwives combined is 4.5. Guidance for organisational level CHPPD for registered nurses and midwives advises this should be >3.
- The Red Flag data for March was 14 raised in month (zero for maternity.) No critical staffing incidents were reported during this period indicating that the flags were mitigated, and safe staffing was maintained.

Key Areas of Focus

- Historic (pandemic) Heat map for safe staffing switched off and allocate SafeCare now in use across both sites.

- Separate risk report provide to TMG, QC and Board
- Exec reviews of 12+ risks in progress/ongoing
- Action plan to review and amend Trust Risk management strategy, risk appetite and risk tolerance statements in progress.

Safe Staffing (Rota Fill Rates and CHPPD) - Total (Day & Night Combined) March 2023/24

Hospital Site name	Patient Count	Registered Nurses/Midwives			
		Total monthly planned staff hours	Total monthly actual staff hours	Fill Rate %	CHPPD
Poole Hospital	17344	88213.0	80886.4	91.7%	4.7
Bournemouth & Christchurch	17490	80593.1	76305.0	94.7%	4.4
UHD Total	34834	168806.1	157191.4	93.1%	4.5

Maternity (1)

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

Maternity Perinatal Quality Surveillance Scorecard

Perinatal Quality Surveillance scorecard	Metric	Alert (national standard/ average where available)	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Perinatal	Red flags: 1:1 care in labour not provided	0	0	0	0	1	0	0	0	0	0	0	0	0
	3rd/4th degree tear overall rate	>3.5%	3.1%	2.70%	4.2%	3.9%	4.6%	1.0%	4.5%	3.8%	1.7%	2.2%	2.3%	0.9%%
	Obstetric haemorrhage >1.5L	>2.6 %	2.10%	3.0%%	3.7%	4.4%	3.5%	3.36%	3.3%	2.1%%	5.4%	3.9%	4.8%	3.6%
	Term admissions to NNU	National <6%, Regional <5%	5.9%	6.50%	5.50%	4.30%	4.50%	6.10%	6.80%	5.40%	4.90%	6.10%	4.70%	6.00%
	Apgar < 7 at 5 minutes	<1.2 %	2.3%	0.0%	1.10%	0.70%	0.0%	1.6%	2.8%	2.9%	1.4%	1.9%	0.9%	0.9%
	Stillbirth number	Actual	4	2	1	0	0	2	2	1	0	0	0	0
	Stillbirth number/rate (per 1,000) per quarter	<2.5 /1000			7			2			3			0
Workforce	Rostered consultant cover on Delivery Suite - hours pw	<72	72	72	72	72	72	72	72	72	72	72	72	72
	Dedicated anaesthetic cover on Delivery suite - per week	<58	58	58	58	58	58	58	58	58	58	58	58	58
	Midwife/band 3 to birth ratio (establishment)	01:23	01:21	01:21	01:21	01:21	01:21	01:21	01:21	01:21	01:21	01:21	01:21	01:21
	Midwife/band 3 to birth ratio (in post)	01:23	01:25	01:24	01:24	01:25	01:22	01:22	01:23	01:26	01:22	01:22	01:21	01:21
Feedback	Number of compliments (Smiles via Badgernet)		42	37	41	66	51	32	Moving to new system			40	36	38
	Number of concerns (PALS) negative		0	0	4	3	0	2	1	1	1	0	5	0
	Complaints	3	2	3	2	2	0	0	3	2	2	1	1	4
	FFT Repsonse from November 23		43%	46%	87%	80%	62%	125%	100%	430	276	297	307	no data
Training	UHD Mandatory training - women's health midwives	90%	82%	84%	86%	88%	88%	88%	86%	86%	85%	87%	88%	90%
	PROMPT/Emergency skills all staff groups	90%	82%	82%	84%	86%	not known	85.2%	74%	79%	82%	86%	88%	95%
	K2/CTG training all staff groups	90%	91.76%	96%%	94%	96%	95%	95%	84%	87%	86%	86%	86%	96%
	CTG competency assessment all staff groups	90%	91.76%	96%%	94%	96%%	95%	95%	84%	87%	86%	86%	86%	96%
	Core competency framework compliance - Midwife update	90%	84%	87%	89%	86%	84%	85%	93.50%	90.00%	91.00%	moved to ccf2	moved to ccf2	96%
	Coroner Reg 28 made directly to the Trust	al <6%, Regiona	N	N	N	N	N	N	N	N	N	N	N	N
	HSIB/CQC etc. with a concern or request for action		Y (CQC)	Y(CQC)	Y(CQC)	Y(CQC)	Y(CQC)	Y(CQC)	Y(CQC)	Y(CQC)	Y(CQC)	Y(CQC)	Y(CQC)	Y(CQC)

Data and Target

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

Performance

There are 3 areas currently flagging as red RAG rated:

There are 2 areas currently flagging as red RAG rated:

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

Key Areas of Focus

Obstetric haemorrhage >1.5L: the performance for this metric has been elevated over the past six months. A review has commenced using the Patient Safety Incident Response Framework (PSIRF) a Thematic Review' and the update on the report and the findings will follow

For awareness National rate of PPH is rising due to increasing medicalisation of birth. From the national maternity dashboard, we can see that UHD is not an outlier.

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

Apgar's <7 at 5 min: following a QI project, there has been a reduction in cases in February and March .The cases have been reviewed and were scored and managed correctly.

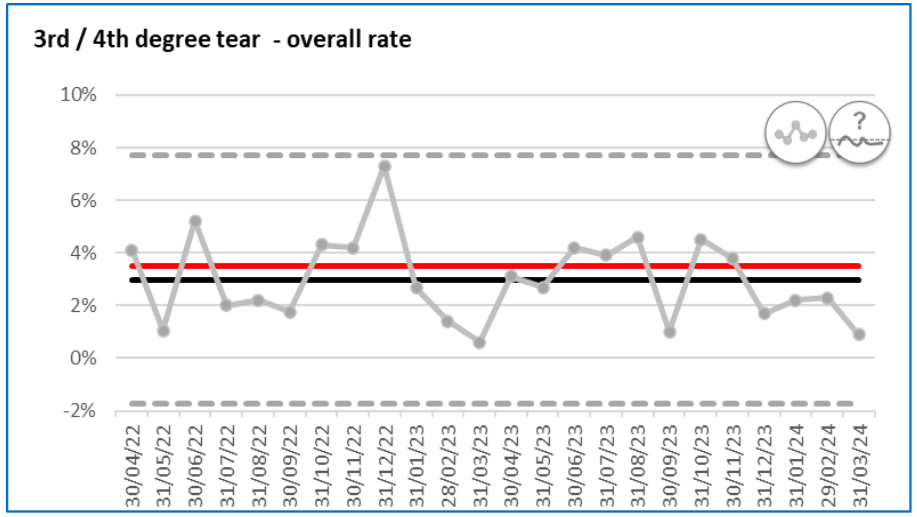
Training: Immediate actions have been taken to improve MDT PROMPT training within the next 12 weeks, (end of March). Overall compliance now end of March 95%. Remaining staff in the medical team were impact by industrial action but plans in place to ensure they are trained as soon as possible.

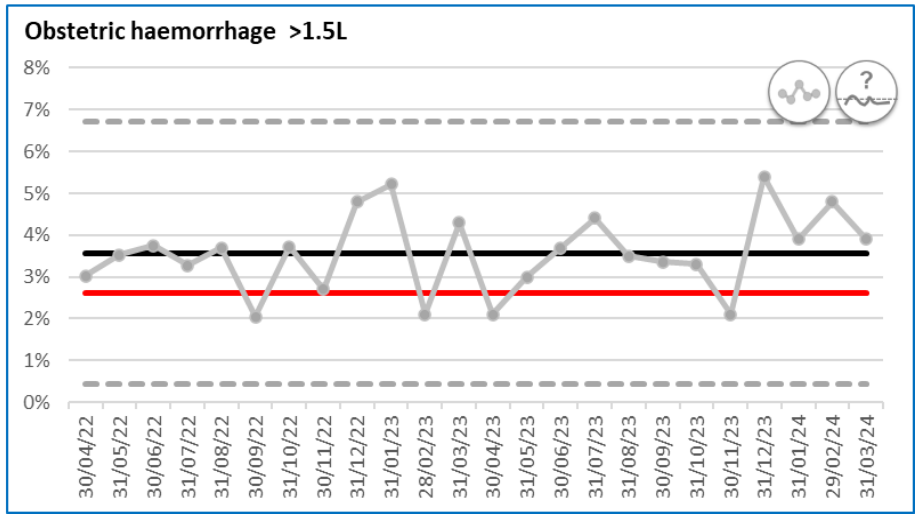
Maternity (SPC)

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

Maternity - Areas of Focus

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
3rd / 4th degree tear - overall rate	Mar 24	0.9%	3.5%			3.0%	-1.7%	7.7%
Obstetric haemorrhage >1.5L	Mar 24	3.9%	2.6%			3.6%	0.4%	6.7%
Term admissions to NNU %	Mar 24	6.0%	6.0%			5.6%	2.5%	8.6%





Maternity (2)

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

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

National position & overview

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

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

MBRRACE reportable cases:

There have been 0 reportable cases for MBRRACE in March

PMRT
There have been 1 cases which had its 2nd reviewed in March following post- mortem results. There was no change in initial grading where learning was identified. This case has been reviewed as a Serious incident and learning report to Trust Board in February.
Key learning and actions were :
Follow up appointments to be booked prior to a woman leaving her appointment Appointments to be sent in a woman's first language
Fundal height measurement to be completed from 24 weeks and plotted on personalized growth chart electronically and align policy
Audit the did not attend process to ensure it is being followed.

MNSI
There were no new cases in March.

Matters for Board information and awareness

Patient Safety Incident Response Framework (PSIRF)

PSIRF is being implemented in maternity and our top 3 areas identified for thematic reviews are
1. Stillbirth
2. Term admissions to NICU - 6 months deep dive presented to ICB and safety champions in November ongoing action plan.
3. PPH greater than 1.5 liters initial quality improvement commenced.

There has been no other reports submitted in March through safety champions/quality committee.

Progress in achievement of Year 5 Maternity incentive scheme

MIS year 5 - All safety standards not met declaration to be submitted by the 1st of February

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

For the standards partially met, there has been further progress made in March

Safety action 4 - Obstetric Staffing needs to provide a robust locum induction as per RCOG standards. We are working with the medical recruitment team to finalise an induction pack (for long term and short-term locums) that is embed guidance from RCOG on the management of the temporary staffing.

An Audit in place to ensure learning is captured if Consultants have not attended as per RCOG guidance roles and responsibilities has commenced.

Neonatal medical team not meeting BAOM standards – long term funding for and additional consultant required.

Safety action 6 - Saving Babies Lives Care Bundle 3 – Quarter 3 assessment with ICB showed 79% compliance, however 50% not met in element 4 fetal monitoring therefore standard not fully met.

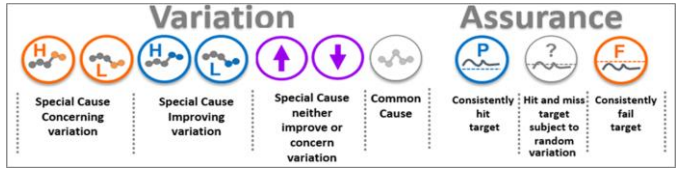
Safety action 8 - In house training, significant improvement in March Overall 95% of staff trained.

MIS year 6 Requirements was launched on 2nd April 2024 and reporting on year 6 standards will commence in April

Performance at a glance
Quality - Key Performance Indicator Matrix

Quality IPR

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Associated Pressure Ulcers (Cat 3 & 4) per 1,000 beddays	Mar 24	0.20	-			0.27	-0.03	0.58
Inpatient Falls (Moderate +) per 1,000 beddays	Mar 24	0.20	-			0.15	-0.09	0.38
Medication Incidents (Moderate +) per 1,000 beddays	Mar 24	0.10	-			0.05	-0.10	0.20
Medication Incidents (All) per 1,000 beddays	Mar 24	4.60	-			5.08	3.12	7.04
Patient Safety Incidents (All) per 1,000 beddays	Mar 24	34.80	-	L		43.72	37.79	49.64
Patient Safety Incidents (Moderate +) per 1,000 beddays - Cl	Mar 24	0.50	-			0.36	0.03	0.69
Serious Incidents	Mar 24	7	-			3	-2	8
Never Events	Mar 24	1	-			0	-1	1
Hospital Associated Infections - MRSA	Mar 24	1	-			0	-1	1
Hospital Associated Infections - MSSA	Mar 24	6	-			4	0	8
Hospital Associated Infections - C Diff	Mar 24	13	-			7	-2	16
Hospital Associated Infections - E Coli	Mar 24	8	-			8	-2	19
HSMR In Month - UHD (Source: HED)	Dec 23	111.70	100.00		?	108.00	92.38	123.63
Mixed Sex Accommodation Breaches	Mar 24	6	-			7	-16	31
Complaints Received	Mar 24	66	-			61	32	90
Complaint Response Rate (55 Days)	Mar 24	40%	-			36%	6%	66%
Friends & Family Test	Mar 24	94.2%	-	H		91.2%	88.0%	94.5%
Patient Deaths in Hospital	Mar 24	215	-			237	168	305
Deaths Within 36hrs of Admission	Mar 24	32	-			36	14	57
Deaths Within Readmission Spell (5 day readmission)	Mar 24	26	-			22	7	36
Risks 12+ on Register	Mar 24	43	-			40	33	47
Risks 15+ on Register	Mar 24	23	-			21	18	24
Red Flags Raised	Mar 24	14	-	L		62	7	118
CHPPD (Registered Nurses & Midwives)	Mar 24	4.50	-			4.56	3.92	5.20
			-					



Our People

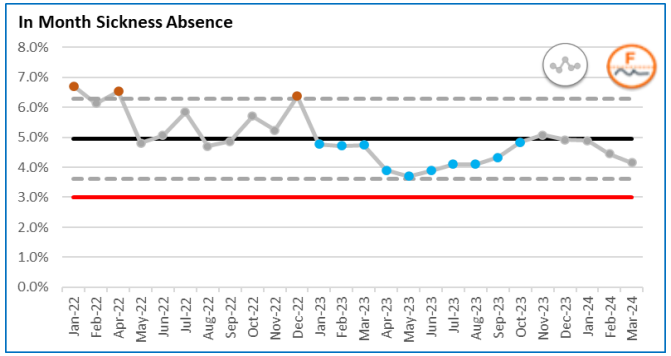
Tina Ricketts
Chief People Officer

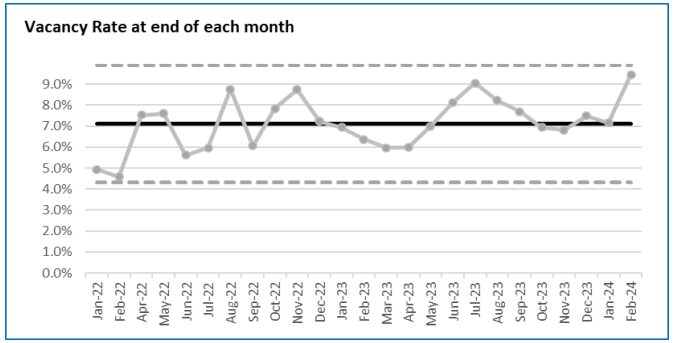
Operational Leads:
Irene Mardon - Deputy Chief People Officer

Committees:
People and Culture Committee

NHS
University Hospitals Dorset
NHS Foundation Trust

Well Led - Workforce (1)





Performance

Sickness Absence and Wellbeing

- In month sickness absence for March 2024 was at 4.2%, this is an improvement on previous month from 4.5%. Latest rolling 12 month rate (as at end of March 2024) is 4.38% which is a very slight improvement on the previous month.
- Anxiety/stress/depression was the top reason for absence in March, significantly higher than other absence reasons (risk 1493).

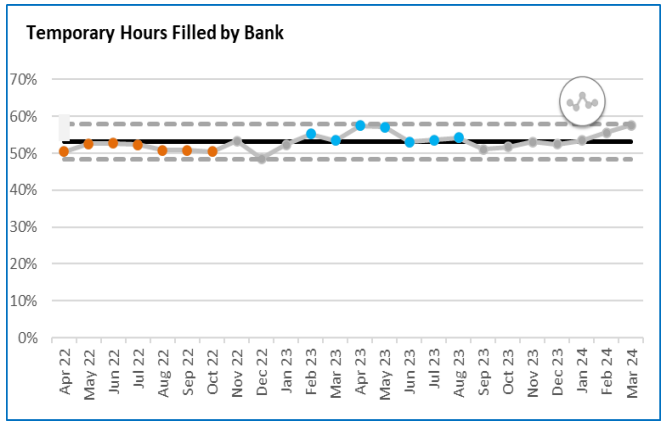
Vacancy Rate

- Vacancy rate is reported a month in arrears to allow for reconciliation with the ledger. Latest vacancy position is 9.5% (as at 29th February 2024), which is an increase from January 2024 at 7.2% (following data adjustments). Our vacancy position has been impacted by the increase in the ward templates following the recent acuity audit.
- In March a total of 180 appointments were made, compared to 168 in the previous month. 171 were to non- medical roles, and 9 were for medical staff. This includes 74 internal non-medical appointments.
- A total of 5,879 applications were received for 264 Jobs advertised. 3333 Applications for 244 Jobs advertised for non-medical roles (average of 13 applicants per vacancy) and 2,546 Application for 20 Jobs advertised for medical roles.. A Junior Fellow in Paediatrics attracted 1193 applicants. These numbers follow a similar trend for the same period last year, and a return to usual high numbers received for medical posts .
- The number of job offers made in March was 191 for non- medical roles, compared to 202 in February, and 12 Medical post offers, compared to 16 the previous month..

Healthcare Support Worker Recruitment

- Healthcare support worker vacancies were reported as 222 WTE at the end of March. The increase of 50 WTE month on month is attributed to the nursing establishment review which has seen additional posts added to the funded establishment.
- For NHS Direct Support reporting we are still using an adjusted figure that allows for 50 WTE of the overall vacant posts being occupied by trainee nurses on apprenticeships, who work clinically as Healthcare Support Workers for 60% of their working week. The pipeline of candidates for those vacancies remains strong, and fortnightly placement meetings focus allocating those applicants to vacant roles to speed up the time to hire.

Well Led - Workforce (2)



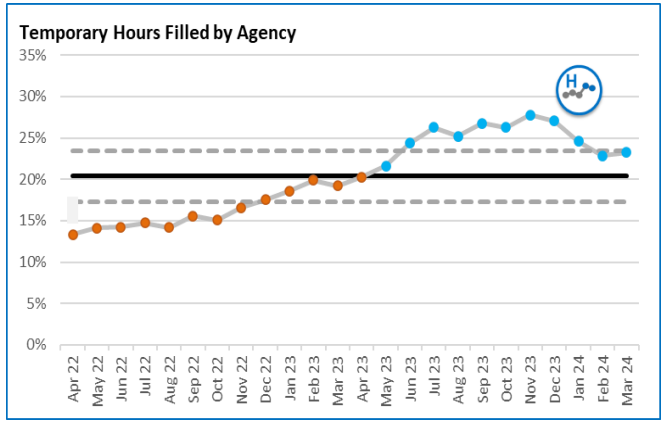
Performance

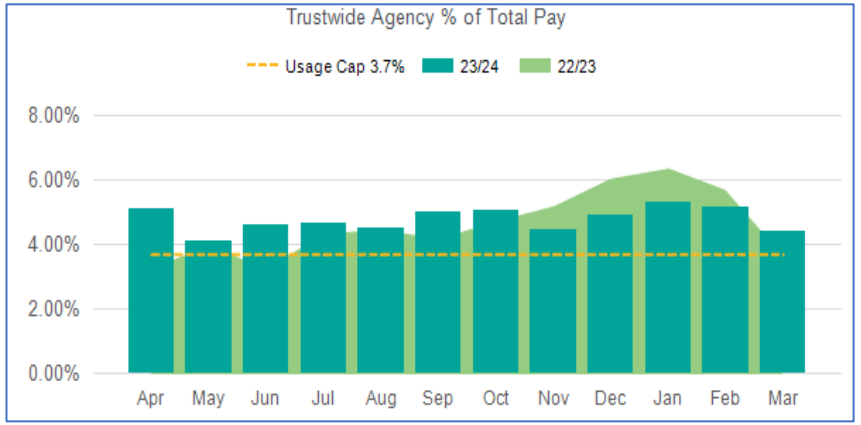
- The Trust implemented the new Nursing rate card in line with the Dorset system approach on 22 March 2024. All suppliers are engaged and are expected to work to the new rates. We have not seen any significant changes in fill rates since this has been implemented.
- Off framework agency usage now sits consistently at 1% which will put us on target to withdraw off framework by 1st July.
- We have seen an overall decrease in agency spend from 5.15% in M11 to 4.40% in M12. The overall trust agency spend for 23/24 year is 4.78%
- Agency spend has decreased in the Medical Care Group from 10.01% to 7.78%, the Surgical Care Group has seen an increase from 3.49% to 3.83%. Women's, Children, Cancer and Support Services Care Group has reduced from 3.37% to 2.28% in M12.
- The number of hours filled by agency staff has reduced again this month

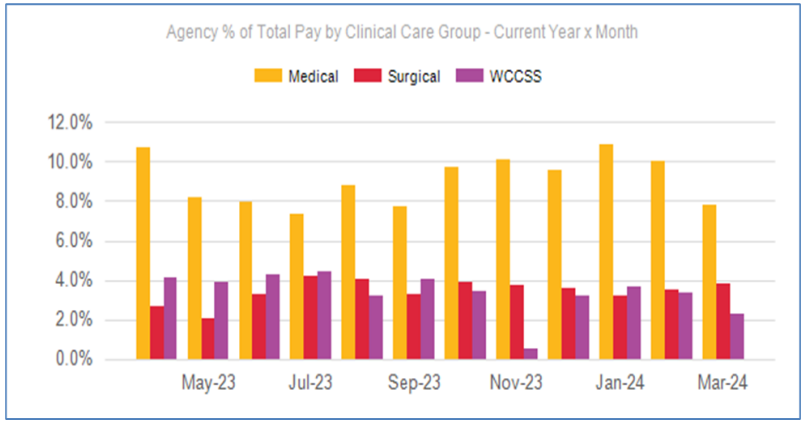
NB: Fill rate for bank and agency spend now measures use across all systems where previously it has only been taken from Allocate (E rostering) - all months have been updated

Key Areas of Focus

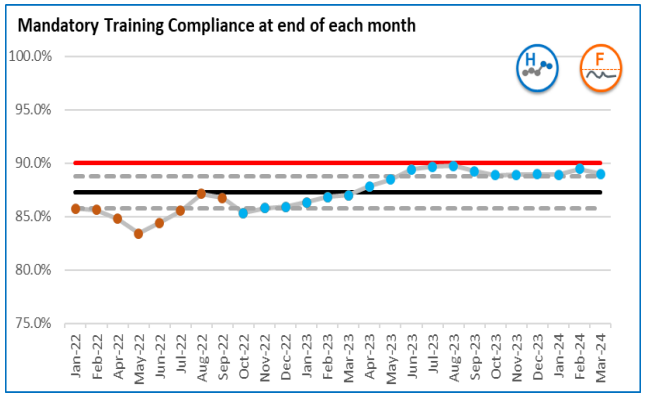
- Risk 1492: Work is in train for further rate reductions, together with removal of Tier 4 agency usage.

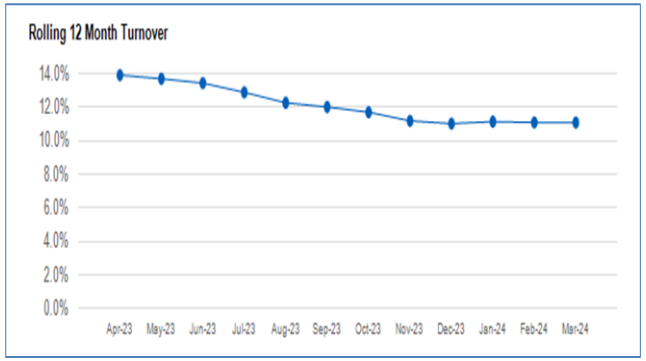


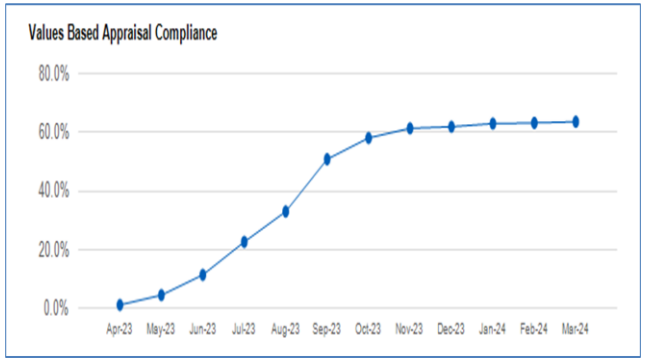


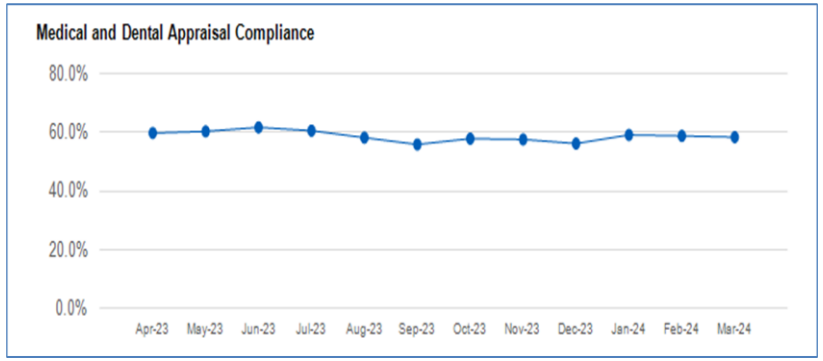


Well Led - Workforce (3)









Performance

- Mandatory Training compliance has increased slightly to 89.0% as at end of March 2024 just under the target of 90%.
- Appraisal compliance for values based as at end of March 2024 is at 63.7% against 59.5% in March 2023. Medical & Dental compliance is at 58.5%.

Turnover

- The rolling 12 month staff turnover rate (excluding fixed term temp) is at 11.1% (as at end of March 2024), which is the same as last month; however, the trend remains downward year to date.
- The Medical and Dental data cleanse project is complete from a staffing perspective, some establishment data is still required from Finance to ensure budgets are up to date in ESR. This final element is due to be completed by 31.3.24.

Appraisal

- The Appraisal paperwork amended to reflect Trust's updated strategic objectives, ahead of launch of appraisal season in April

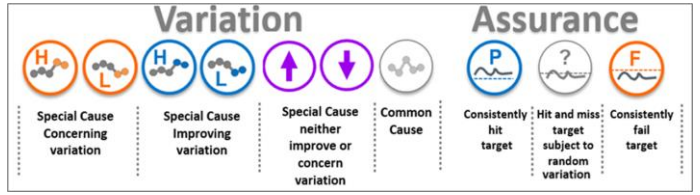
Key Areas of Focus

- Information Governance is currently below the 95% national compliance required .

Performance at a glance
Well Led - Key Performance Indicator

UHD Workforce

KPI	Latest month	Actual	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Vacancy Rate at end of each month	Feb 24	9.5%	-			7.1%	4.3%	9.9%
In Month Sickness Absence	Mar 24	4.2%	3.0%		F	4.9%	3.6%	6.3%
Mandatory Training Compliance at end of each month	Mar 24	89.1%	90.0%	H	F	87.3%	85.8%	88.8%
Temporary Hours Filled by Bank	Mar 24	57.6%	-			53.3%	47.6%	59.0%
Temporary Hours Filled by Agency	Mar 24	23.2%	-			23.2%	19.3%	27.1%
Agency Pay as Proportion of Total Pay	Mar 24	4.4%			?	4.7%	3.1%	6.3%



Population Health and System Working

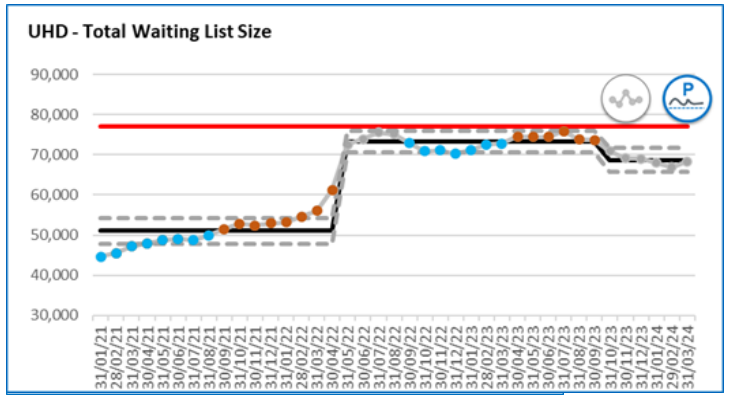
Mark Mould
Chief Operating Officer

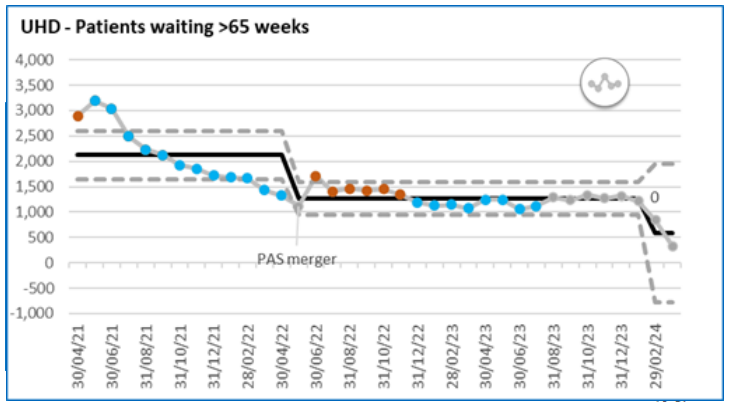
Operational Leads:
Judith May – Director of Operational Performance and Oversight
Alex Lister – Deputy Chief Operating Officer
Abigail Daughters – Group Director of Operations – Surgery
Sarah Macklin – Group Director of Operations – Women's, Children, Cancer and Support Services
Leanna Rathbone – Group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

Committees:
Finance and Performance Committee

NHS
University Hospitals Dorset
NHS Foundation Trust

Responsive – (Elective) Referral to Treatment)





Referral To Treatment	Standard	UHD	pathways with a DTA
18 week performance %	92%	62.0%	
Waiting list size (and trajectory)	76,972	68,398	20%
Waiting List size % variance compared to trajectory		-11.1%	
No. patients waiting 26+ weeks		16,288	33%
No. patients waiting 40+ weeks		7,224	37%
No. patients waiting 52+ weeks (and % of waiting list)	4.0%	2,767	42%
No. patients waiting 65+ weeks (and % of waiting list)	0.5%	328	58%
No. patients waiting 78+ weeks (and % of waiting list)	0.0%	29	76%
No. patients waiting 104+ weeks (and % of waiting list)	0.0%	0	
% of Admitted pathways with a P code		98.27%	

Data Description and Target

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

Performance

- A 6% reduction in the Referral to Treatment (RTT) waiting list size has been delivered since March 2023. Whilst there was an increase in the waiting list in March 2024 compared to February the overall trend represents an improvement and is 7,809 below the operational planning trajectory (76,972).
- RTT performance increased from 61.3% in February to 62.0% in March and the Trust remains above the Southwest Regional average.

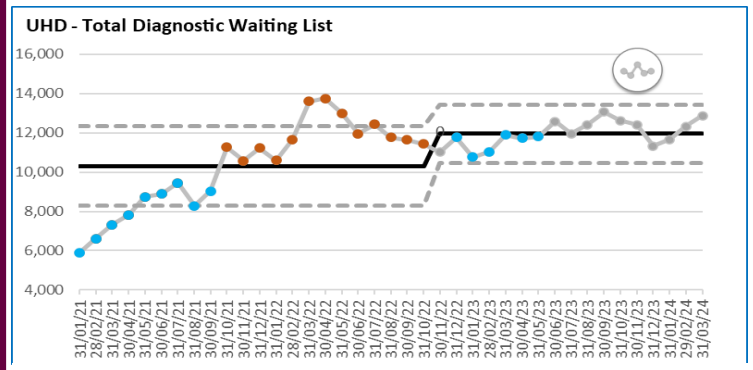
- 29 patients with a wait greater than 78 weeks remained at the end of March 2024. This represents a significant improvement from 45 in February 2024. Capacity, including a bank holiday at the end of the month, and patient choice impacted on the Trust's ability to eliminate 78 week waits.

- >65-week waits also reduced and fell below the recalculated mean, however at 328, the March trajectory was missed (trajectory 279), due to lost activity during industrial action in all but 3 months of the year.

Key Areas of Focus

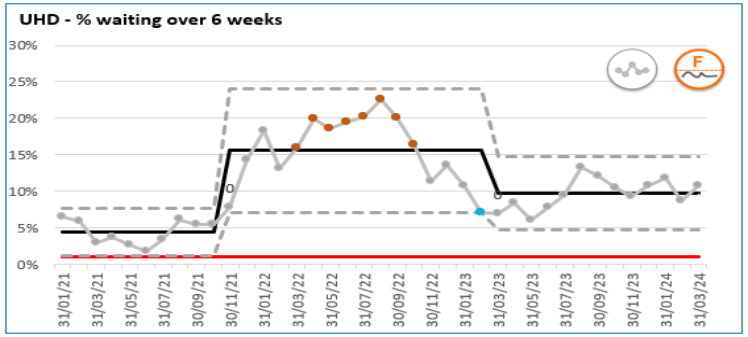
- Delivery of capacity plans to reduce 78 week waits to 0 as soon as possible and eliminate 65 week waits by September 2024.
- Increasing productivity within core capacity. This includes reducing missed appointments (DNAs) and improving theatre and outpatient session utilisation rates.
- Scheduling activity at a level which represents a minimum of 104% against a 2019/20 baseline activity level.
- Prioritising elective recovery funding to building capacity is some specialities to meet demand, including additional capacity in surgery, gynaecology, and dermatology.

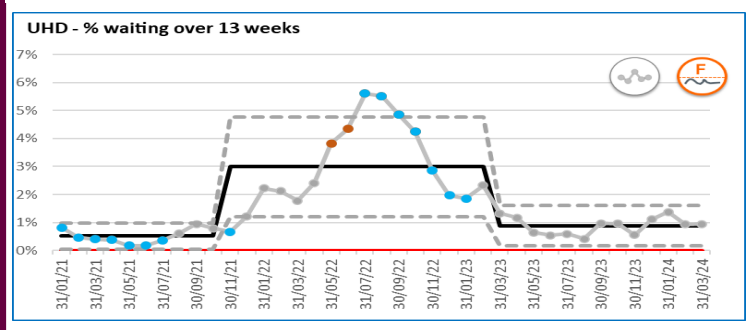
Responsive – (Elective)
Diagnostic Waits



Diagnostic Performance (DM01)

% of >6 week performance (6+ Weeks / Total) 1% 1383/12876 **10.7%**





Data Description and Target

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

Performance

Maintenance of an overall improvement in diagnostics performance (DM01) has been delivered, despite pressures resulting from industrial action and bed occupancy. March 2024 performance reduced to 10.7% compared with 8.7% at the end of February 2024. Performance remains within the upper and lower process control limits; however further improvement is required to meet the 1% target. An increase in the diagnostic waiting list is reflective of increased urgent suspected cancer referrals and elective activity in 2023/24. There are currently 120 patients waiting more than 13 weeks for a diagnostic test (majority cardiac MRI and echocardiography patients)

Endoscopy performance reduced to 12.4% at the end of March (8.7% at the end of February)
There is ongoing use of 18weeks insourcing, the InHealth mobile endoscopy unit and waiting list initiatives (WLIs).

Echocardiography performance has improved to 10.7% in March, from 13.4% in February, predominately due to less inpatient escalation within the cardiology bed base.

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

Neurophysiology performance reduced to 32.5% in March from 24.6% in February.

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

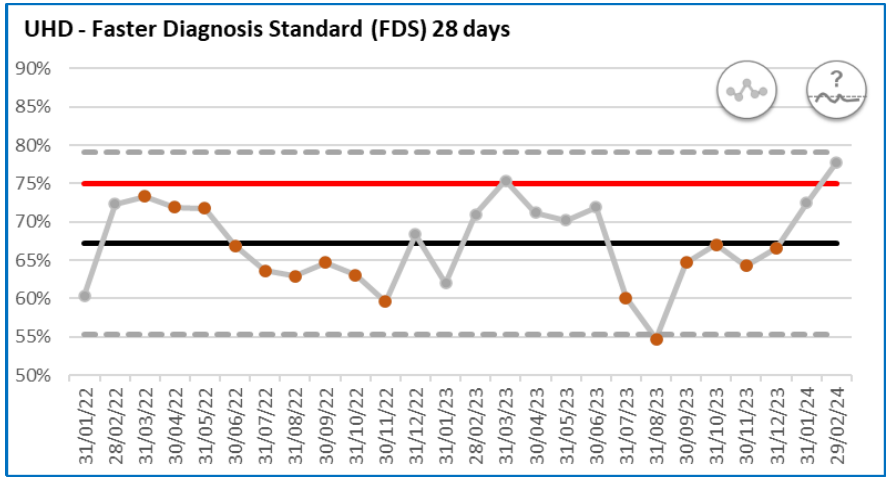
Radiology performance has reduced to 7.6% in March, from 5.9% in February, the target is not being achieved predominately due to the ongoing reduction in cardiologist CT / MRI sessions.

Key Areas of Focus

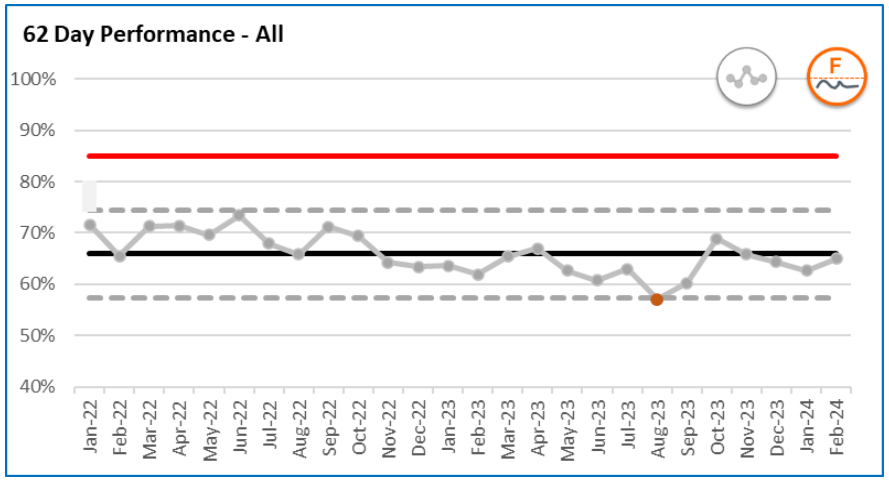
- **Endoscopy:** InHealth mobile unit was removed 31/03/24 as planned. An increase in insourcing is planned to mitigate this reduction in capacity. Dr Doctor is being integrated with e-Camis for Endoscopy for ongoing management of bookings to ensure high utilisation.
- **Echocardiography:** Increase in stress-echo capacity from April.
- **Radiology**: Commenced AECC Ultrasound at Christchurch (140 patients a week) until end of July 2024.
- **Cardiology** have provided some additional sessions with a locum helping to recover the cardiac position (currently 510 patients breaching 6 weeks).
- Ended Mobile CT contract (March 24) and replaced with extra weekend sessions at RBH.
- Ended Mobile MRI contract (March 24) and replaced with extra weekend and evening sessions at PGH.

Responsive (Elective)
Cancer FDS & 62 Day Standard

28 Day Faster Diagnosis Standard (Target 75%)
Finalised UHD February Performance (77.8%)



62-Day Standard (Target 85%)
Finalised UHD February Performance (65.0%)



Data Description and Target

- Percentage of patients informed of diagnosis within 28 days from referral. Faster Diagnosis Standard = 75%
- Percentage of patients who receive their 1st treatment for cancer within 62 days. 62 Day Standard = 85%
- The number of 62-day patients waiting 63 days or more on their pathway – no more than 220 by March 2024.
- The proportion of patients who have a cancer diagnosis, and who have had a decision made on their first or subsequent treatment, who then start that treatment within 31 days.

Finalised February Performance

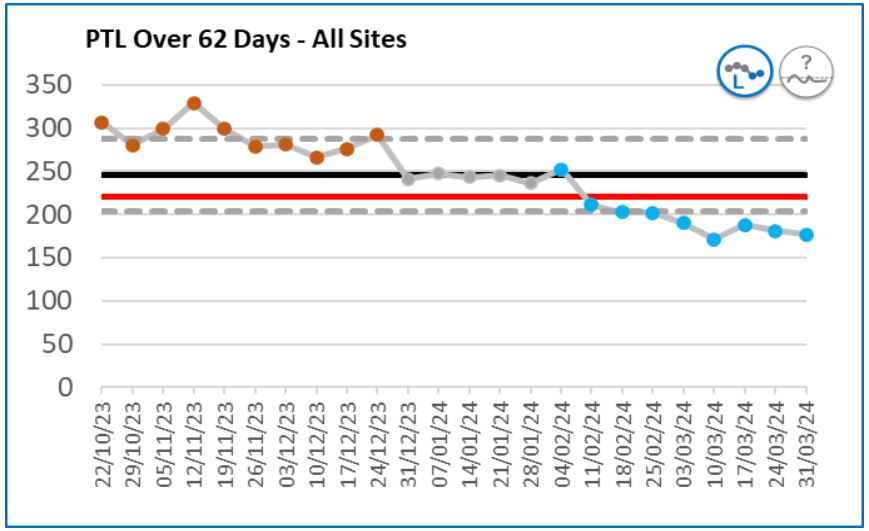
- **28 Day Faster Diagnosis Standard** - Performance increased in February by 5.3% to a compliant 77.8% meeting the month end trajectory. The performance target remains within the process control limits, which demonstrates the standard can be met within the current processes. The main tumour sites seeing a significant improvement in month are Breast, Gynaecology and Skin. 8 out of 14 tumour sites achieved the standard. Performance in Colorectal increased by 4.0% in month compared to January, however, remains the main tumour site impacting the Trust's overall performance for FDS.
- **62 Day Standard** - Performance in February increased by 2.3% to 65% compared to January. It continues to demonstrate normal variation within the process control limits, with the upper process control limit falling below the standard. A change in process therefore is needed to meet the standard. The main breach reasons in February 2024 were capacity both at the front end of the pathway and for surgical treatments. Capacity for treatments was reduced due to industrial action in month.
- **31 Day Standard** - The 96% performance target was achieved in February (at 96.1%).
- **Patient Treatment List (PTL) Over 62 Days** - The total number on the PTL over 62 days decreased to 202 in February (34 less compared with January and 33 below the month's trajectory of 235).

Provisional March Performance (un-finalised)

- **28 Day Faster Diagnosis Standard** – Performance in month is currently 76.1% which is 1.1% above the March trajectory of 75.0% and meets the national standard.
- **62 Day Standard** - Performance in month is currently 65.1%, and this is expected to increase as further treatments are reported.
- **31 Day Standard** - Performance in month is meeting the 96.0% national standard.
- **Patient Treatment List (PTL) Over 62 Days**- The year-end fair share target of 220 has been met at UHD with 177 patients over 62 days (43 below threshold).

Responsive (Elective)
Cancer Over 62 Day Breaches

Over 62 Day PTL (Target February: 235)
Finalised UHD February Performance: 202



High Level Performance Indicators

Cancer Standards	Standard	Final	Provisional
		Feb-24	Mar-24
28 Day Faster Diagnosis Standard	75%	77.8%	76.1%
31 Day Standard	96%	96.1%	95.9%
62 Day standard	85%	65.0%	65.1%

Key Areas of Focus

In 2024/25 the focus for Cancer Performance has returned to the 3 main National Standards (28 Day, 31 Day and 62 Day). UHD however remain committed to maintaining the over 62 day PTL under 220.

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

Colorectal:
- Service to complete an up-to-date capacity and demand model to enable an improved performance position against all standards including over 62 day.
- Ongoing insourcing to manage demand alongside elective long waiters

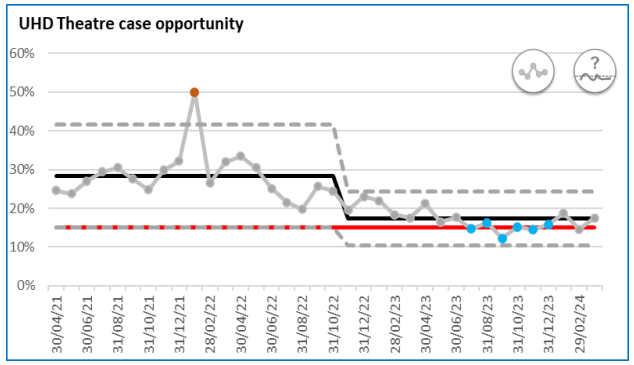
Breast:
- Service to commence MDT transformation Programme with focus on aligning processes in one stop clinics across sites.
- Continued partnership working with Radiology to ensure all one stop clinics are fully supported.

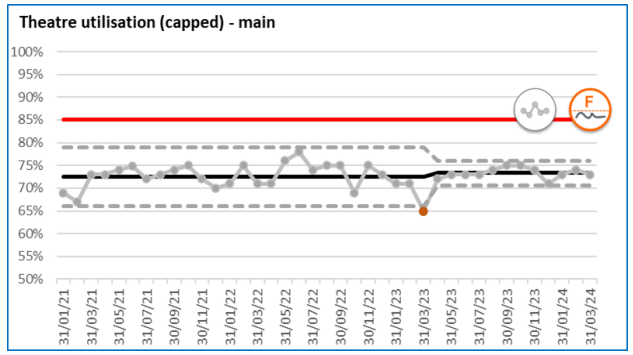
Skin:
- Insourcing solution sourced to provide additional Urgent Suspected Cancer Referral (USCR) capacity in April 2024.
- Impact of the commencement of Tele-Dermatology to be closely monitored in order to inform future capacity requirements in Q2.

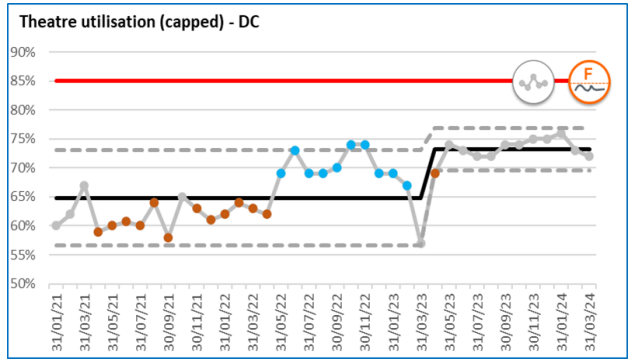
Gynaecology:
- Review and evaluate the post implementation audit of the Post Menopausal Bleeding post HRT pathway to determine its impact on referrals and patient experience.
- Additional hysteroscopy sessions planned in April.

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

Responsive (Elective)
Theatre Utilisation







Data Description and Target

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

Performance

- The SPC chart demonstrates that the case opportunity target can be achieved within the current process and is relatively static against 15% target.
- As shown, capped utilisation within main theatres will not achieve 85% with target sitting above current upper process limit, noting however much less variation and greater control in the process with reported capped @ 77% capped and uncapped at 81.%.
- As of the 28th March the average late start time reduced to 22 minutes (all specialities) a reduction of 3 mins as compared to previous month and ongoing improvement. Three data points away from triggering special cause improvement.
- Capped utilisation within Day Case lists shows some improvement. Process limit still remains below the target, indicating further work is needed to deliver a process capable of sustaining the target utilisation. However, the chart is indicating less variability, some improvement and greater control.
- Ongoing increase in the number of sessions run and associated activity, in line with staff trajectory.
- The focussed work around orthopaedic lists has not translated into sustained improvement. Further work is underway to unlock case opportunity and increase utilisation. Specific areas of focus are booking rates and cancellations.
- Early finishes SPC demonstrating less variability and a more consistent process.

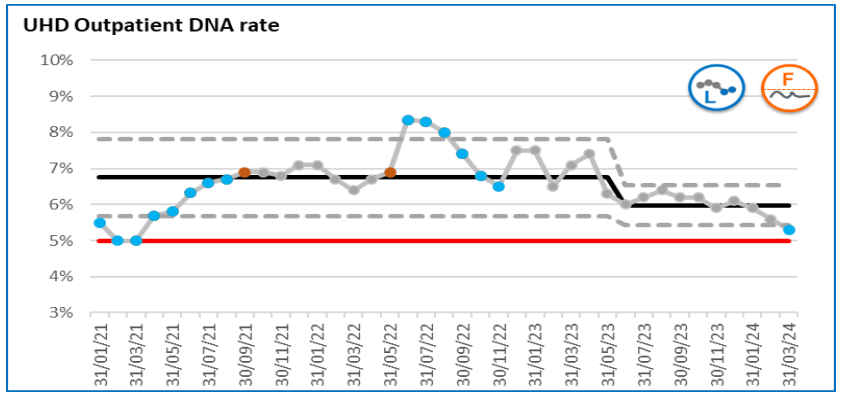
Underlying issues:
- Despite sustained improvement in late starts, Orthopaedic lists remain below 65%. Utilisation % is low due to early finishes and booking processes.

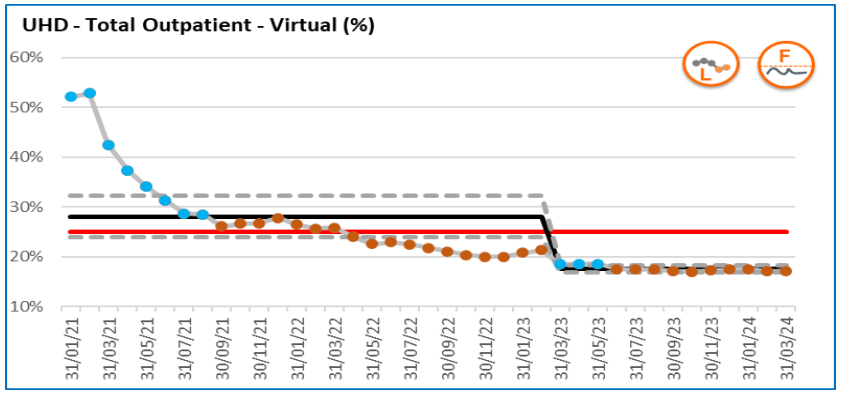
Key Areas of Focus

- Orthopaedic list booking processes including procedure times to address disparity between booked and adjusted utilisation.
- Continued focus on MyPre-Op roll out and the interface to the scheduling tool.
- Live theatre reporting and performance screens.
- On the day theatre process and re-focussing on 'Golden Patient, and a 'Good day in theatres.'
- Continued development and support of new starters.
- Capacity & demand outputs now being rolled out across specialties to not only inform future schedule but also to evidence several areas of template changes to better align to demand. Workshop scheduled for April 17th 2024.
- Data quality and delay reasons to inform improvement work.

Responsive (Elective) Outpatients

Referral Rates (MRR Return)		Standard	This Year	Trust Perf
GP Referral Rate year on year		-0.5%	123692	-2.3%
Total Referrals Rate year on year		-0.5%	187064	-3.4%
Outpatient metrics				
Overdue Follow Up Appointments (Cons-Led Only)				26075
New Attendances				18696
Follow-Up Attendances				28878
% DNA Rate	*(Total DNAs / New & Flup Atts)*	5%	2642 / 47574	5.3%
Hospital cancellation rate	*Hospital Canx / Total Booked Appts)*		12061 / 69698	17.3%
Patient cancellation rate	*'Patient Canx / Total Booked Appts)*		7421 / 69698	10.6%
Reduction in face to face attendances (acute only)				
% telemed/video attendances	*(Total Non F-F / Total Atts)*	25%	8179 / 47574	17.2%





Data Description and Target

- Reduction in DNA rate (first and follow up) to 5%
- 25% of all attendances delivered virtually
- Reduction in overdue follow up appointments

Performance

DNA rate in March is 5.3% which is an improved position and outside normal variation. Planned switch on of text reminders across all clinics is now being staggered, unless a clinically led opt-out rationale is provided by specialty teams. Currently 79.7% of all clinics have text reminders switched on, an increase of 24% from last month. Once the remaining clinics are switched on, this is expected to have a further positive impact on reducing DNAs.

17.2% of attendances were delivered via telemedicine/video in March which has remained static over the past year. Current process control intervals demonstrate the target will not be met unless process improvement is made. Work is underway to ensure all activity is being captured on our patient administration systems, including video consultations. Video consultations went live on the Dr Doctor platform from 1st April 2024.

The number of patients overdue their target date for a follow up appointment increased by 231 in March 2024. A bank holiday at the end of the month is one contributory factor to not achieving an overall reduction.

Key Areas of Focus

- Continue to review clinic utilisation rates and complete template reviews at specialty level and monitor progress. Deadline set of 19th April for this work to be completed.
- Delivery of outpatient productivity improvements, which support a reduction in DNA rates, increased use of Patient Initiated Follow Ups (PIFU) and increased clinic utilisation rates. Process Mining Project commenced for outpatients this month which will provide rich data on areas for improvement.
- Embedding the outpatient performance dashboard (including all Outpatient KPIs) into performance management practices at Care Group and speciality level. Outpatients Care group Forums to commence this month.
- Continue to promote telemedicine/video and the benefits for patients.
- Progress e-outcomes project. Currently delayed while critical testing issues are resolved. Potential workaround with IT Development team under discussion.
- Scoping of clinic room capacity review on Bookwise complete and funding identified. Approvals awaited imminently. Plan to be developed to use Bookwise as the single system for clinic room capacity management within the Trust.
- Continue a review of cancellations less than 6 weeks. Single UHD cancellation process being developed (anticipated go live date 22/4/24) and further work underway to align the SOP with the Access Policy guidelines for cancellations.

Responsive - (Elective) Screening Programmes

Breast Screening

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

BREAST SCREENING	STANDARD	ACHIEVED
Round Length within 36 months	90.00%	99%
Screening to first offered assessment appointment within 3 weeks	98.00%	98%
Screening to Normal Results within 14 days	95.00%	99%
Longest Wait Time (Months)	36	36
UPTAKE – QTR 2 (Oct – Dec 23)	70%	68.4%

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

Performance:
- All monthly targets have been successfully met which is excellent.

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

Actions:
- Trainee mammographers are progressing well and it is hoped they will soon be able to work independently at screening sites around the county.
- Christchurch screening site will be operational from 16th April which will ease pressure on the Bournemouth area .

Bowel Screening

Bowel Screening Standard	Target	Trust March Performance
SSP Clinic Wait Standard (14 days)	95%	100%
Diagnostic Wait Standard (14 days)	90%	99.12%

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

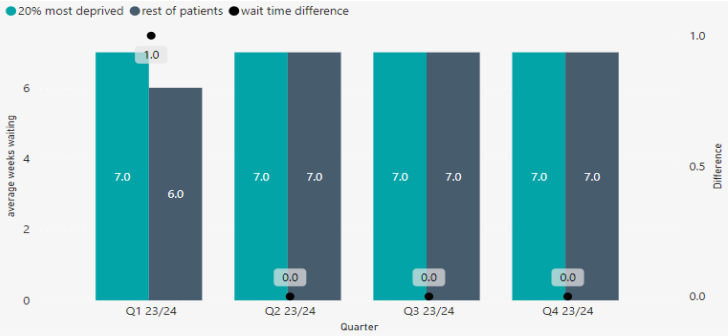
Performance:
- SSP Clinic Wait Standard: This standard continues to be maintained at 100%.
- Diagnostic Wait Standard: This standard was delivered at 99.12% in March 2024.

Underlying issues:
- One screener at DCH is due to leave in April 2024. This reduction in capacity has been partly mitigated but there will be a reduction in capacity. Succession plan being worked through but will take time for aspirant screeners to gain accreditation.
- Replacement capacity for the system potentially joining in June/July.
- Next phase of age extension due April 2024

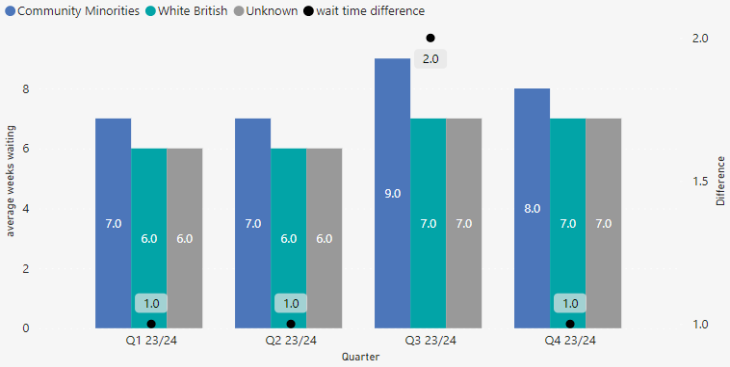
Actions:
- Deliver plans with Dorset County to use additional insourcing capacity in 24/25
- Review insourcing plan for UHD for 24/25 until replacement capacity has been established.
- Support accreditation process for 2 potential new screeners and identify other endoscopists where possible

Health Inequalities

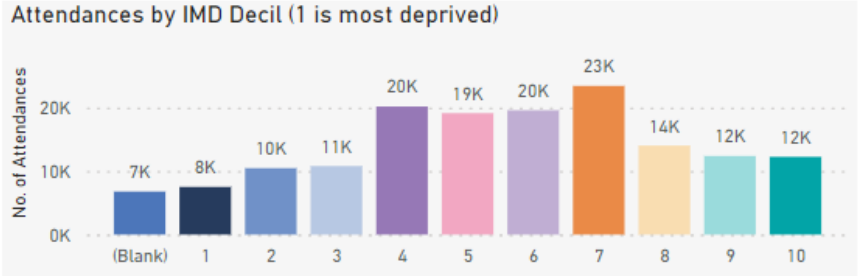
Median Weeks (elective) waiting by Deprivation Group



Median Weeks (elective) waiting by Ethnicity Group



Emergency Department attendances by Deprivation Group



Data Description and Target

Analysis of variation in weeks waiting on an elective waiting list according to the patient's Index of Multiple Deprivation, age and ethnicity grouping to understand areas of variation.
Emergency department admissions by Index of Multiple Deprivation (IMD) decile

Performance

Waiting list by Index of Multiple Deprivation (IMD) Analysing elective waits in Quarter 4, 8.5% of patients on the waiting list live in the 20% most deprived areas of Dorset. The median weeks waiting at the point of treatment shows no variation between patients from the 20% most deprived group and the rest of the population treated. Analysing the same data by age band identifies children from the most deprived areas wait 1 week longer than the rest of the <18yr old population.

Waiting list by ethnicity: 11% of patients on the waiting list are from community minority ethnicity groupings. An analysis of the median weeks waiting by ethnicity grouping identifies a 1 week variation between patients within community minority groups and White British populations in Quarter 4. This is an improved position compared to Q3 2023/24. However, the level of variation increases to 3 weeks for <18 year olds from community minority groups.

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

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

Key Areas of Focus

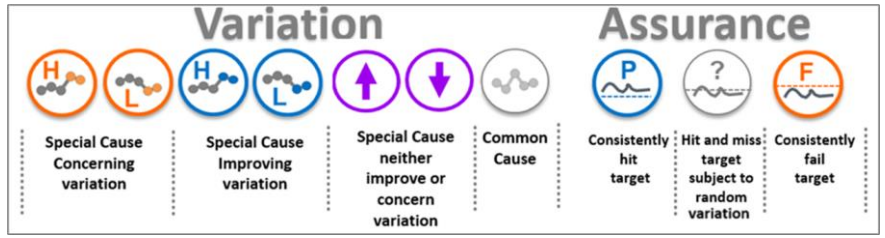
The Trust Health Inequalities group are working to:

- Deliver against the duties outlined within the NHS England's statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006) to collect, analyse and publish information on health inequalities.
- Deliver the Trust's strategic objectives for population health and system working; with a focus on (i) reducing outpatient DNAs and variation according to IMD and ethnicity and (ii) managing High Intensity Users of emergency care.
- Align its health inequalities programme with the ICS key strategic priorities through Patient First.
- Expand the data that's captured on the Dorset DiiS Population Health System to enable further data insights against the Core20Plus5 areas for adults and children.
- Promote awareness raising on health inequalities and population health through education and training opportunities.

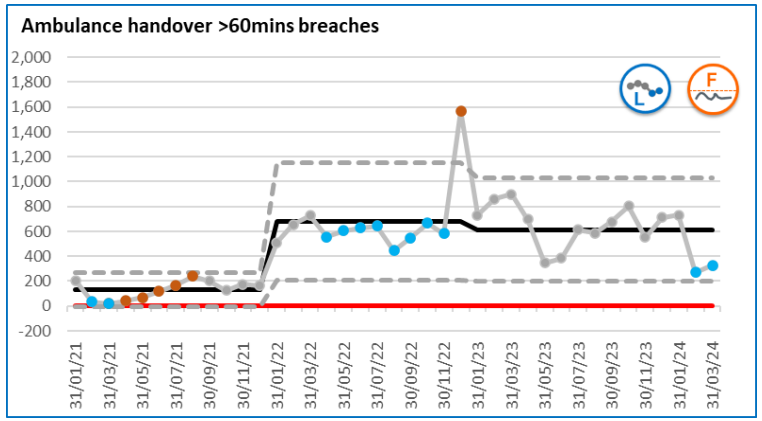
Performance at-a-glance
Responsive (Elective) - Key Performance Indicators Matrix

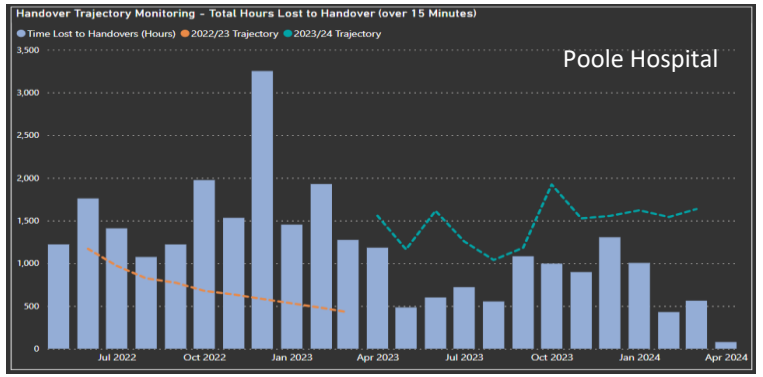
UHD Elective Care

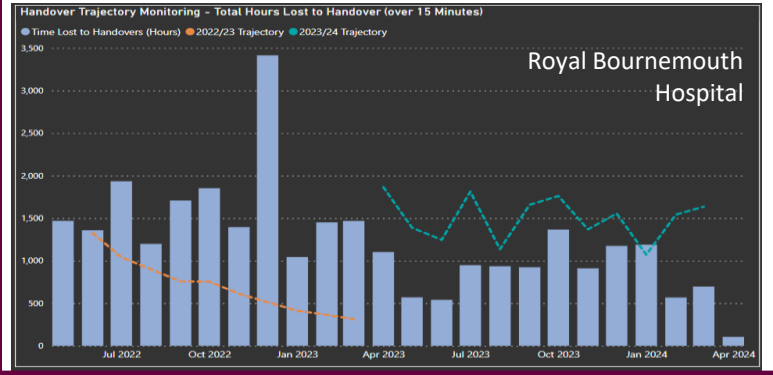
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
UHD - Total Waiting List Size	Mar 24	68398	76972		P	68722	65799	71644
UHD - Patients waiting >104 weeks	Mar 24	0	0		P	0	0	0
UHD - Patients waiting >78 weeks	Mar 24	29	-	L		590	361	819
UHD - Patients waiting >65 weeks	Mar 24	329	-			585	-775	1944
UHD - Patients waiting >52 weeks	Mar 24	2767	-	L		3834	3059	4609
UHD - Patients waiting >52 weeks non admitted	Mar 24	1598	0		F	1414	432	2395
UHD - RTT Performance against 18 week standard	Mar 24	62.0%	92.0%	H	F	59.1%	55.7%	62.6%
UHD - Total Diagnostic Waiting List	Mar 24	12876	-			11959	10475	13442
UHD - % waiting over 6 weeks	Mar 24	10.7%	1.0%		F	9.7%	4.6%	14.7%
UHD - % waiting over 13 weeks	Mar 24	0.9%			F	0.9%	0.2%	1.6%
UHD - Faster Diagnosis Standard (FDS) 28 days	Feb 24	77.8%	75.0%		?	68.8%	59.0%	78.7%
UHD 62 day standard	Feb 24	65.0%			F	63.5%	54.5%	72.6%
Trauma Admissions	Mar 24	359	-			365	304	426
% of NOF patients operated on within 36 hrs of admission	Mar 24	64.0%	85.0%		F	66.3%	49.0%	83.6%
UHD - Total Outpatient - Virtual (%)	Mar 24	17.2%	25.0%	L	F	17.6%	16.9%	18.2%
UHD Outpatient DNA rate	Mar 24	5.3%	5.0%		?	5.5%	4.7%	6.2%
Theatre utilisation (capped) - main	Mar 24	73.0%	85.0%		F	73.3%	70.7%	76.0%
Theatre utilisation (capped) - DC	Mar 24	72.0%	85.0%		F	73.3%	69.6%	76.9%
UHD Theatre case opportunity	Mar 24	17.5%	15.0%		?	17.4%	10.4%	24.3%



Responsive – (Emergency) Ambulance Handovers







Data Description and Target

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

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

Performance

- The total number of Ambulance handovers rose again in March back up to January levels at 4365 vs 3974 in February 2024. There were 141 Ambulances per day which is roughly 4 more than in February across the sites. This was driven by both sites with Bournemouth increasing from 66 to 68 Ambulances a day and Poole 71 to 73 per day.
- However, both sites still received significantly more Ambulances than in March 2023. This is consistent across both sites with approximately 20 additional conveyances a day cross-site.

- After a significant improvement in handover performance for ambulances waiting longer than 60 minutes in February, performance deteriorated slightly in March at 327, but continued to trigger a special cause improving variation. March 24 performance amounts to 7.49% of total handovers vs 6.8% in February 2024 and 23.3% in March 2023.
- Average handover duration was 34 minutes for Bournemouth and 28 minutes for Poole in March 24. This compares to a regional average of approximately 60 minutes.

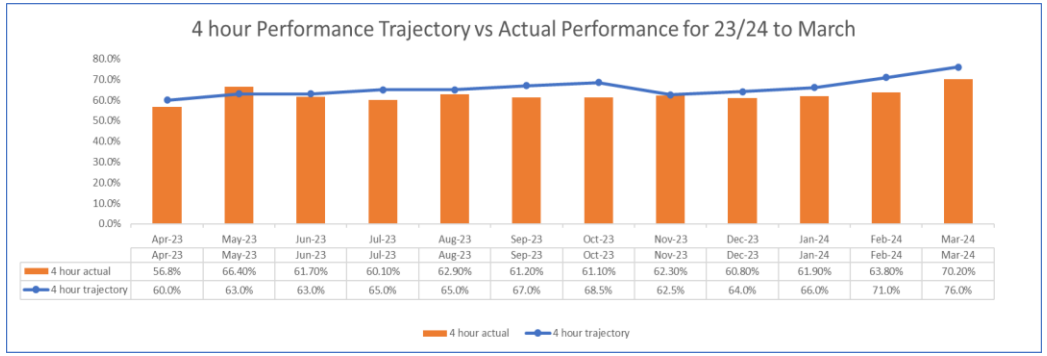
- Based on the 15-minute ambulance handover standard Poole reported a total of 522 hours lost in March vs 432 in February, and RBH reported 682 hours in March vs 571 hours in February.
- In terms of the regional picture, February data shows there were 1,144 total hours lost to handover- this was predominantly driven by UHD.

Key Areas of Focus

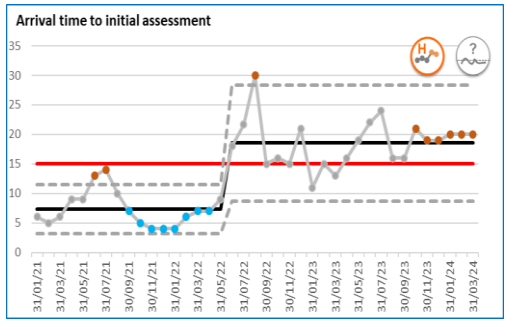
- The Trust risk score relating to Ambulance Handovers remains at 15 with focus on supporting cohorting of patients with SWAST to enable prompt and safe handover.

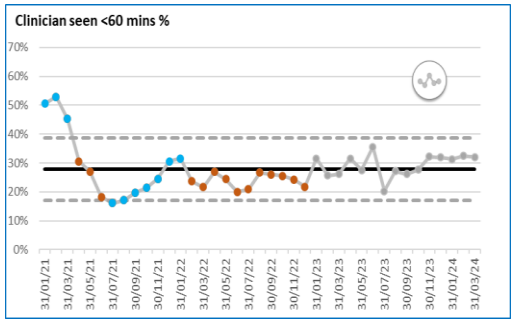
- Whilst capacity has been a challenge intermittently throughout March with a high number of admissions, issues with isolation capacity due to an increased number of patients presenting with COVID/RSV have tapered off.

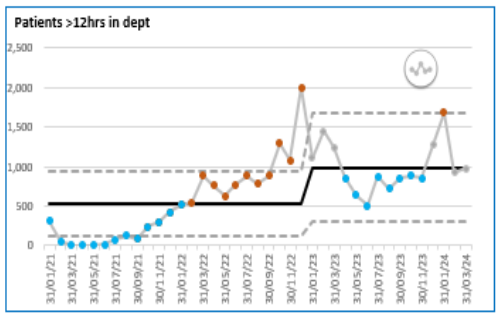
Responsive (Emergency) Care Standards

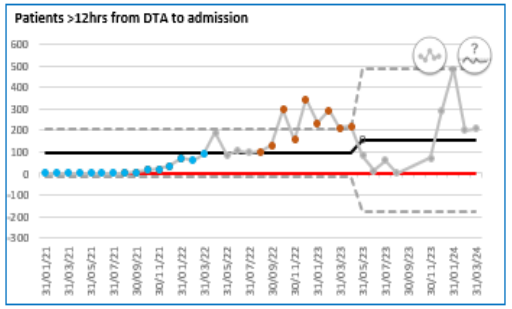


	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
4 hour actual	56.8%	66.40%	61.70%	60.10%	62.90%	61.20%	61.10%	62.30%	60.80%	61.90%	63.80%	70.20%
4 hour trajectory	60.0%	63.0%	63.0%	65.0%	65.0%	67.0%	68.5%	62.5%	64.0%	66.0%	71.0%	76.0%









Data Description and Target

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

Performance

The Trust delivered 70.2% against the year-end target of 76%. Whilst the organisation did not meet its trajectory, this was a significant improvement of 6.4% from February 24 and the fourth consecutive month of continuous improvement.

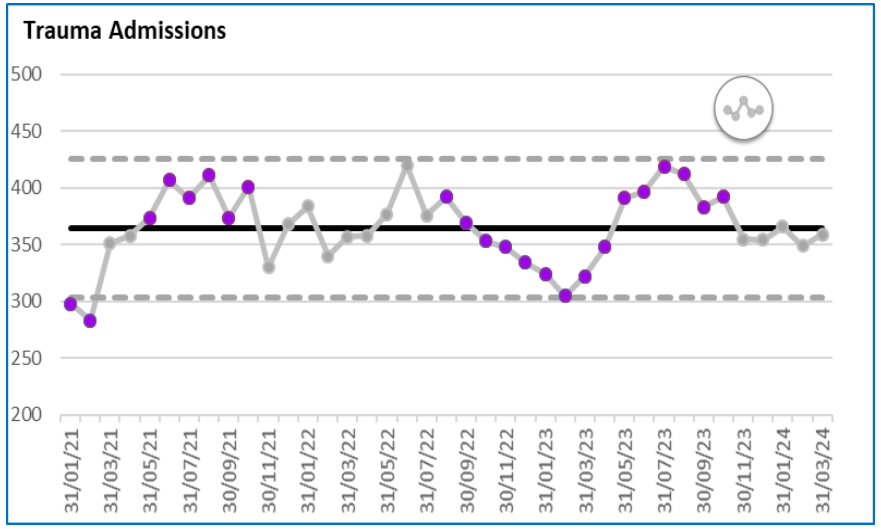
- Total attendances for March slightly increased to 14,610 vs 13,233 in February alongside Ambulance conveyances. There were approximately 470 attendances a day cross site in March vs 456 in February 24. They also remain significantly higher than March 23 which amounted to 441 attendances a day.
- Arrival time to initial assessment continues to remain relatively static for the fourth consecutive month at 20 minutes, however mean time in the department continues to decrease.
- There was a further decrease of 15 minutes in March compared to February giving a total meantime of 286 minutes vs 301 in February. This is a significant improvement from this time last year which saw an average meantime of 358 minutes.
- Arrival time to decision to admit also continues to see incremental improvements and dropped by 10 minutes in March to 252 minutes vs 262 in February and 277 in January.
- Total number of patients waiting more than 12 hours remains static at 979 vs 927 in February. This was mirrored in patients waiting longer than 12 hours following a decision to admit which was 207 in March vs 202 in February.

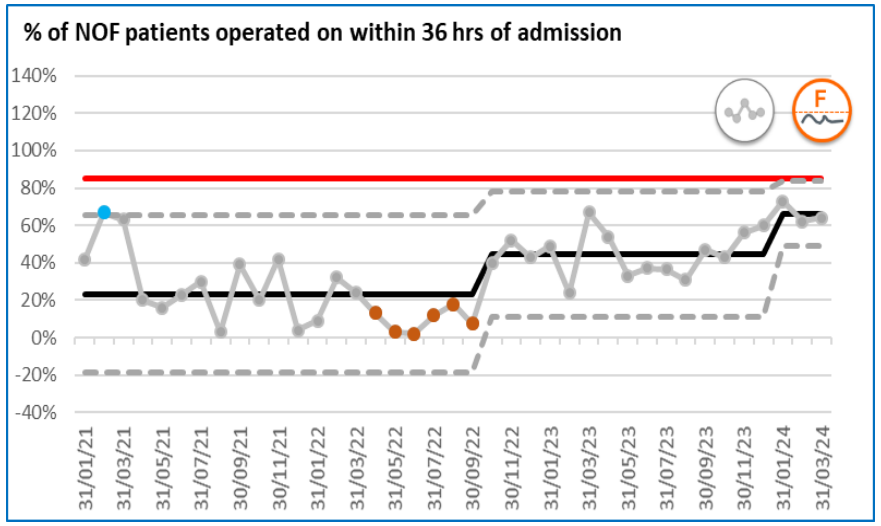
Key Areas of Focus

As a department Non-Admitted performance continues to improve and averaged 73.8 % in March vs 68.5% in February up from 61.5% in January. Performance peaked on the 22nd of March at 89%. Admitted performance has averaged 33.3% in March compared to 26.7% in February and up from 17.3% in January. Performance similarly peaked on the 22nd March at 59.1%.

A review of UTC service provision cross site is on-going with slot utilisation and direct streaming from ED continuing to increase up to 400 per week in March, whilst also maintaining directly bookable and 111 capacity.

Responsive (Emergency)
Trauma Orthopaedics





Data Description and Target

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

Performance

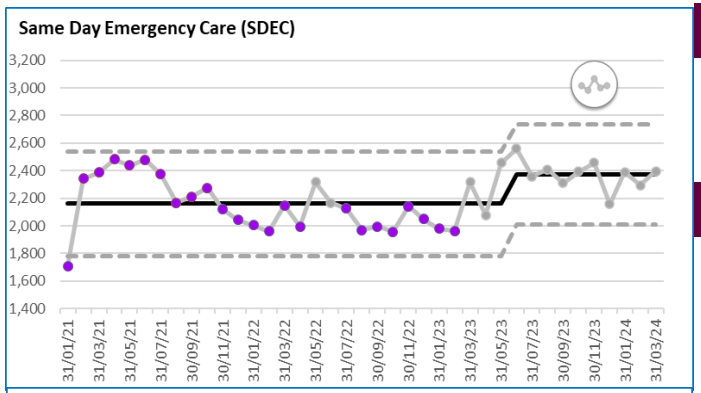
March performance for time to theatre for fractured neck of femur (# NoF) patients: 83% achieving surgery within 36 hours of being fit for surgery and 64% operated on within 36 hours from admission.

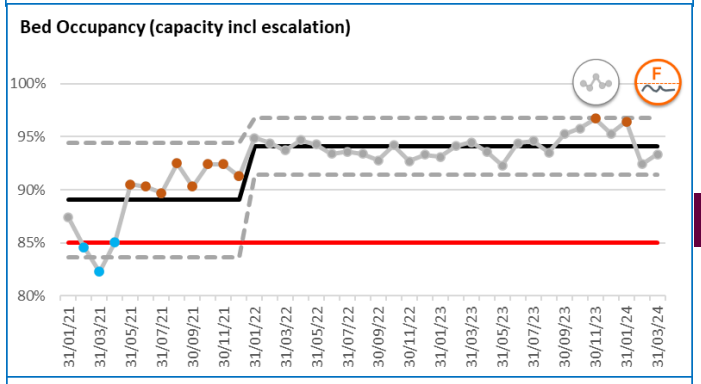
- Overall trauma admissions sustained with 359 in March including 88 with a fractured neck of femur (NoF).
- 14 of the 88 NoF's were unfit for surgery on admission.
- 19 Shaft of femur (SoF) fractures admitted in March with 18 requiring surgery, 8 patients with a # NOF required a THR.
- 15 patients required 2 trips to theatre, equating to an additional 18 theatre cases .
- The barn theatres are working well.

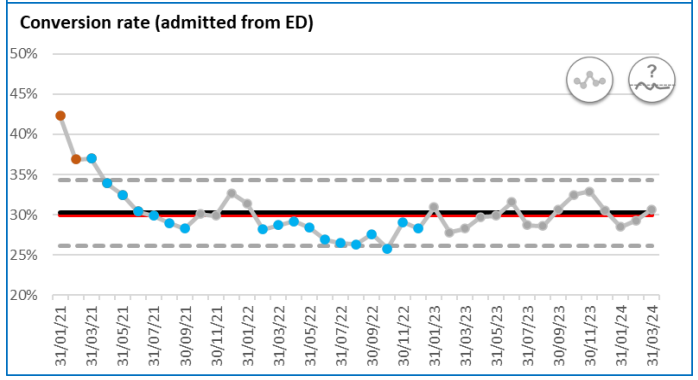
Key Areas of Focus

- e-Trauma , Digital ED link to Virtual Fracture Clinic (VFC) has ceased due to Agyle implementation, which has delayed e-trauma VFC implementation. Risk register updated, contextual link to be implemented, awaiting feedback from IT.
- Hand Hub continues to be a success operating 2 sessions per week with 19 patients through the service releasing 10 main theatre sessions
- Trauma outliers continue to remain low.
- Increase in medical outliers impacting admitting capacity, with complex medical conditions as their admitting priority
- Reduced availability of orthogeriatric input due to reallocation of resources to OPS.

Responsive – (Emergency) Patient Flow







Data Description and Target

88% bed occupancy would support flow and delivery of rapid progression from the Emergency Department within an hour of being clinically ready to proceed. The ICB operational plan uses 92% occupancy as its ambition.

Performance

Bed occupancy remained high in March at an average of 1059 adult beds occupied, 4 more than in February, which is 97.6% of planned beds open (1085).

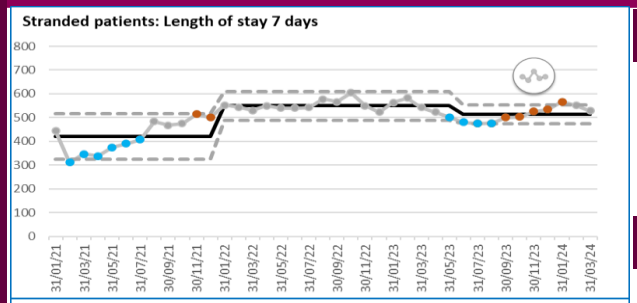
The average number of escalation beds open in March saw an increase to just under 75, which is 5 more than the February average. There were significant delays with patients waiting for beds at times in ED, with an average of 19 per day waiting for beds every morning.

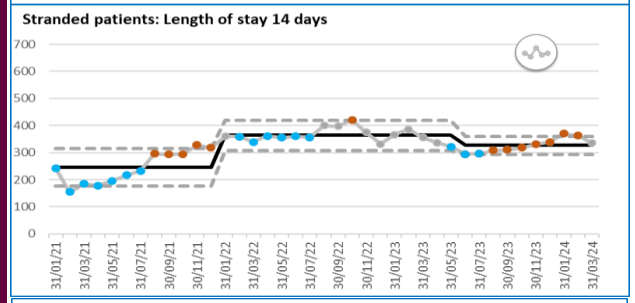
No Criteria to Reside (NCtR) continues to impact occupancy and escalation. NCtR again decreased as an average in March to 209 – however as previously reported this is not linked to increased pathway 1-3 (complex) discharges.

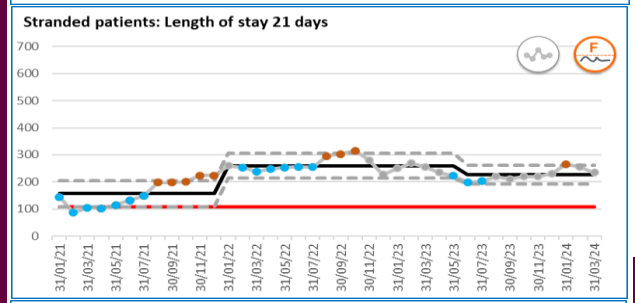
Key Areas of Focus

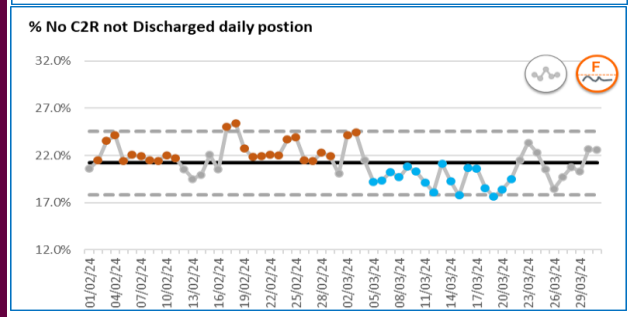
- In March all partners in the ICB received a letter from the ICB COO asking for immediate focus on 5 key actions aimed at improving pathways for patients ready to leave hospital. This is being progressed at a Place level with UHD working closely with BCP. This work is expected to gain momentum through April.
- UHD continues to 'hold the line' on not reopening SDEC care spaces that have been released from bedded capacity in February. It was necessary to escalate into one bay on TIU in February to mitigate risk in the Emergency Department overnight, this area has now been de-escalated and is subject to the same conditions if being considered to be used for beds (an NHSE reportable event or risk to patient safety) and can only be approved by a Director.
- Virtual Ward is a significant success. On average there were 81 patients per week being admitted, with over 1300 Occupied Bed Days recorded in March
- Same Day Emergency Care (SDEC) continues to make progress but is not achieving the 12 hours per day, 7 days a week standard in all areas. This is a core element of the UHD recovery plan, with Care Groups clear on the work required.

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









Data Description and Target

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

The proportion of delays in discharge for whom the patient has no criteria to reside. Target to reduce the number of patients with No Criteria to Reside (NCtR) by 50% by the end of Q2 substantially missed, currently no ICS baseline or trajectory has been established for 24/25.

Performance

21+ day length of stay position shows wards are far from the target of a maximum of 108 patients. In March the average number was 235, which is an improvement of 20 compared to February.

UHD has been consistently showing as an outlier in the South-West with a higher percentage of bed base occupied by patients with NCtR. March has seen UHD at c21% of beds occupied by NCtR with the number of patients remaining to an average of 209 in March. Analysis of the discharge profile for March shows that the improvement has not been achieved by higher numbers of discharges with support. This number remains challengingly low at an average of 16 a day, falling to an average of 6 at weekends. Further analysis of those discharged home with support (pathway 1) confirms that 40% of those discharged are supported by a service directly provided or commissioned by UHD, rather than community health or social care providers.

UHD has completed our capacity de-escalation plan in March. The number of escalation beds in use increase from 69 in February to 82 at the end of March. We have however re-established services on both sites including the medical Same Day Emergency Care Services (SDEC) and the Poole Treatment Investigation Unit (TIU). As part of 24/25 operational planning UHD is being asked to establish 40 additional core beds. These will largely be drawn from current escalation capacity and will feature in the UHD Capacity Plan.

In terms of the new Discharge Ready Date metric this is currently captured for c71.7% of patients as at 9th April 2024, In month UHD has commenced sharing the EDD data in discharge planning data shared with partners daily.

Key Areas of Focus

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

As part of the UHD Capacity plan patients who have been in hospital longer than 21 days with a criteria to reside will be reviewed and tracked.

Progressing work with care groups towards using EDR as the discharge planning date for P1/2 patients, this data is now included in daily sharing with system partners. Focused work completed in Trauma is being rolled out to older persons medicine in April with ambition to reduce LoS by 5-8 days for this group of patients, and reduce process steps

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

UHD Elective Care

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
UHD - Total Waiting List Size	Mar 24	68398	76972	L	P	72087	69076	75097
UHD - Patients waiting >104 weeks	Mar 24	0	0		P	0	0	0
UHD - Patients waiting >78 weeks	Mar 24	29	-	L		590	361	819
UHD - Patients waiting >65 weeks	Mar 24	329	553	L	F	1121	709	1532
UHD - Patients waiting >52 weeks	Mar 24	2767	-	L		3834	3059	4609
UHD - Patients waiting >52 weeks non admitted	Mar 24	1598	0	L	F	2814	2078	3550
UHD - RTT Performance against 18 week standard	Mar 24	62.0%	92.0%	H	F	59.1%	55.7%	62.6%
UHD - Total Diagnostic Waiting List	Mar 24	12876	-			11959	10475	13442
UHD - % waiting over 6 weeks	Mar 24	10.7%	1.0%		F	9.7%	4.6%	14.7%
UHD - % waiting over 13 weeks	Mar 24	0.9%			F	0.9%	0.2%	1.6%
UHD - Faster Diagnosis Standard (FDS) 28 days	Feb 24	77.8%	75.0%		?	68.8%	59.0%	78.7%
UHD 62 day standard	Feb 24	65.0%			F	63.5%	54.5%	72.6%
Trauma Admissions	Mar 24	359	-			365	304	426
% of NOF patients operated on within 36 hrs of admission	Mar 24	64.0%	85.0%		F	66.3%	49.0%	83.6%
UHD - Total Outpatient - Virtual (%)	Mar 24	17.2%	25.0%	L	F	17.6%	16.9%	18.2%
UHD Outpatient DNA rate	Mar 24	5.3%	5.0%	L	F	6.0%	5.4%	6.5%
Theatre utilisation (capped) - main	Mar 24	73.0%	85.0%		F	73.3%	70.7%	76.0%
Theatre utilisation (capped) - DC	Mar 24	72.0%	85.0%		F	73.3%	69.6%	76.9%
UHD Theatre case opportunity	Mar 24	17.5%	15.0%		?	17.4%	10.4%	24.3%

Sustainable Servicers

Pete Papworth
Chief Finance Officer

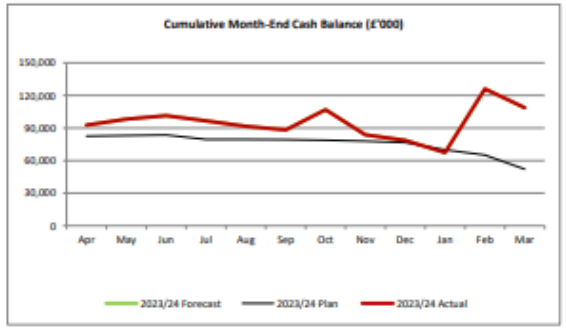
Operational Lead:
Andrew Goodwin, Deputy Chief Finance Officer

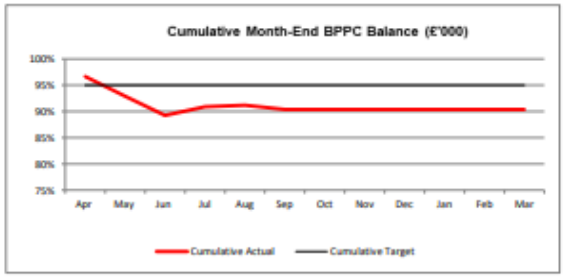
Committees:
Finance and Performance Committee

NHS
University Hospitals Dorset
NHS Foundation Trust

Finance

FINANCIAL INDICATORS	Year to date		
	Budget £'000	Actual £'000	Variance £'000
Control Total Surplus/ (Deficit)	(0)	65	65
Capital Programme	108,241	108,241	0
Closing Cash Balance	52,056	108,725	56,669
Public Sector Payment Policy	95.0%	91.5%	(3.5)%





Commentary

At the end of March 2024 the Trust has reported a surplus of £0.065 million against a planned break-even position. This is after the receipt of additional ICS funding of £6.2 million received in March 2024, and further contract income of £4.5 million from Specialist Commissioners. This has offset energy cost inflation of £5.1 million; and unfunded escalation costs of £6.3 million. Premium cost pay overspends within Care Groups have been off-set by additional bank interest, reduced depreciation charges and other non pay under spends.

Efficiency savings of £18.6 million have been achieved against a target £33.3 million. This represents a shortfall of £14.7 million and a recurrent shortfall of £21.4 million.

Following approval by all organisational Boards; in line with the H2 planning requirements, the Dorset ICS submitted a forecast outturn deficit of £12 million within this, the Trust is required to deliver a break-even financial outturn supported by further efficiency savings, increased ERF Income, and additional ICB funding support resulting from ICB specific and ICS-wide efficiencies. The aggregate reported outturn is a deficit of £14.6 million, being an adverse variance to plan of £2.6 million.

The Trust has capital expenditure of £108.2 million, consistent with the capital programme budget, including operating within the operational CDEL target of £25.9 million.

As at 31 March 2024 the Trust is holding a consolidated cash balance of £108.7 million which is fully committed against the future Capital Programme.

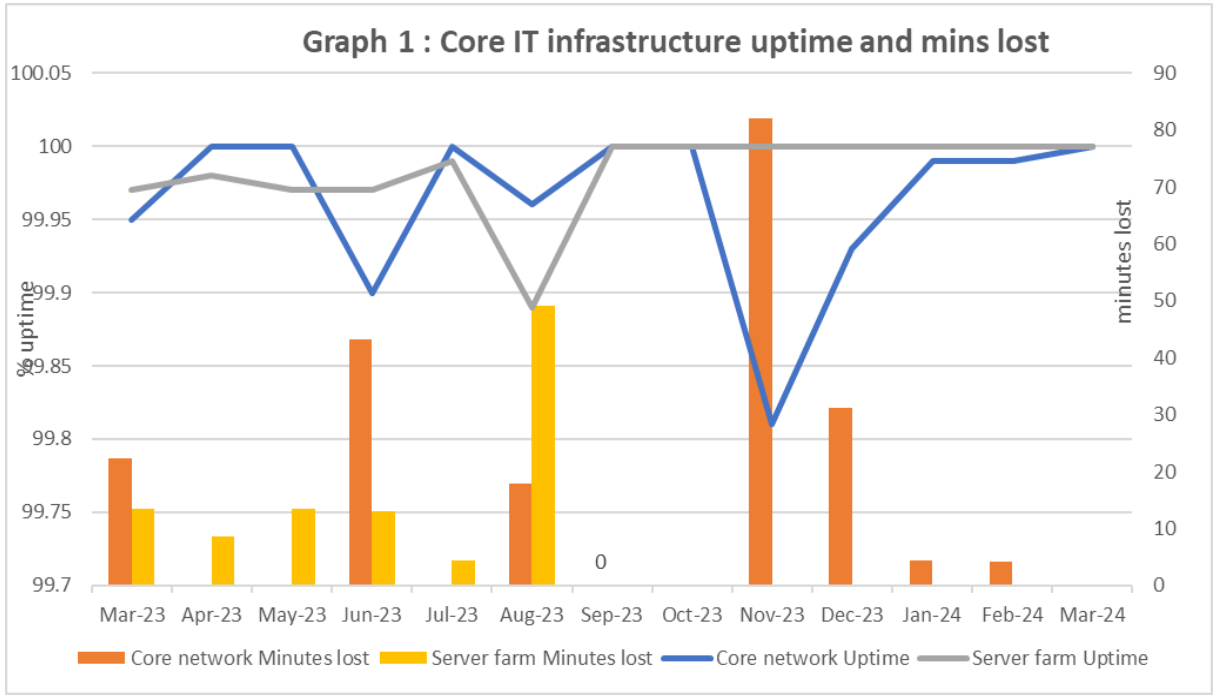
In relation to the Public Sector Payment Performance the Trust is currently delivering performance of 91.5% against the national standard of 95%. Financial Services continue to work closely with relevant teams to identify further mitigating actions

Digital

Pete Papworth
Chief Finance Officer

NHS
University Hospitals Dorset
NHS Foundation Trust

Information Technology



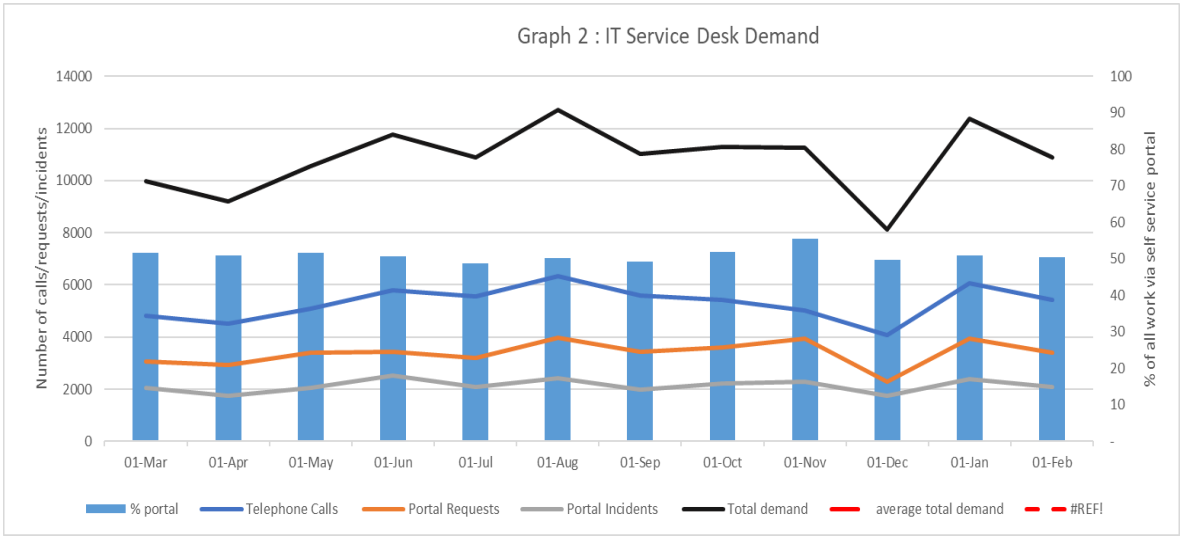


Table 1: Cyber Security - Obsolete systems

	Supported	Obsolete	Mitigated	Unsupported
Windows Desktops	98.5%	1.5%	0.0%	1.5%
Windows Servers	76.5%	23.5%	18.1%	5.5%

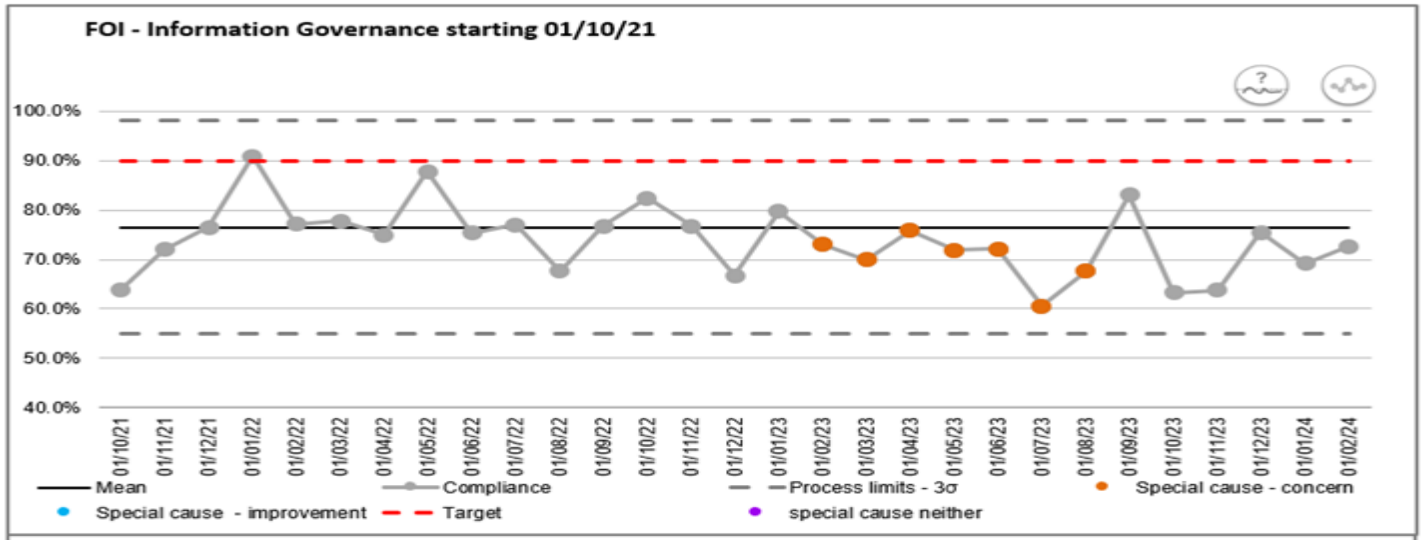
Commentary

Graph 1: Zero minutes lost due to IT infrastructure downtime during March.

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

Table 1: The percentage of servers now supported reduced significantly in November due to the end of mainstream support for Windows Server 2012. The vast majority are being mitigated or planned in early 2024.

Information Governance



Commentary

Statistical Process Control chart for the UHD Freedom of Information Act Compliance. A special cause reduction in performance was noted earlier in the year and the recovery of this is being monitored by the Information Governance Steering Group.

Progress continues to be made in refreshing the Information Asset compliance documentation, with a target completion date of the end of April.

All Active Assets

Status	Total	%
Draft Only (Pending Updates)	15	5.12%
Awaiting IAO Review/Approval	74	25.26%
Awaiting IG Review/Approval	58	19.80%
DSPT Compliant (2023/24)	146	49.83%
Total	293	

Health Records

Table 8 UHD Scanning Bureau Stats March 2024

Images / Patients	Poole	RBH	Total
Hugh Symons Scanned - Notes - Images	110,572	394,022	**504,594**
Hugh Symons Scanned Loose Paper - Images	-	8,666	**8,666**
Scanned In House - Notes - Images	181,519	157,806	**339,325**
Scanned in House - Loose Paper - Images	-	208	**208**
Case Note Tracking Errors Found	122	45	**167**
Incorrrect Uploaded Notes - Patients	-	-	**-**
Incorrect Filing in Notes - Patients	104	167	**271**
Number of Blank Outpatient Case Notes Prepared / Delivered / Returned / Shredded	2,301	1,219	**3,520**

Table 9 SUBJECT ACCESS REQUESTS

Table 9 Subject Access Requests

Compliance by Date of Receipt - Stats (Home)			
Month	**Total**	**Compliant**	**Breach**
2024 (01) January	290	285	5
2023 (12) December	222	218	4
2023 (11) November	241	239	2

Commentary

Table 8 Shows the scanning statistics and record errors found in this process. Within this, an image is one side of a single piece of paper. Incorrect filing in patients notes represents a single mis-file within a patient record.

Table 9 Subject Access Requests continue to increase in complexity putting pressure on compliance with the national standards.

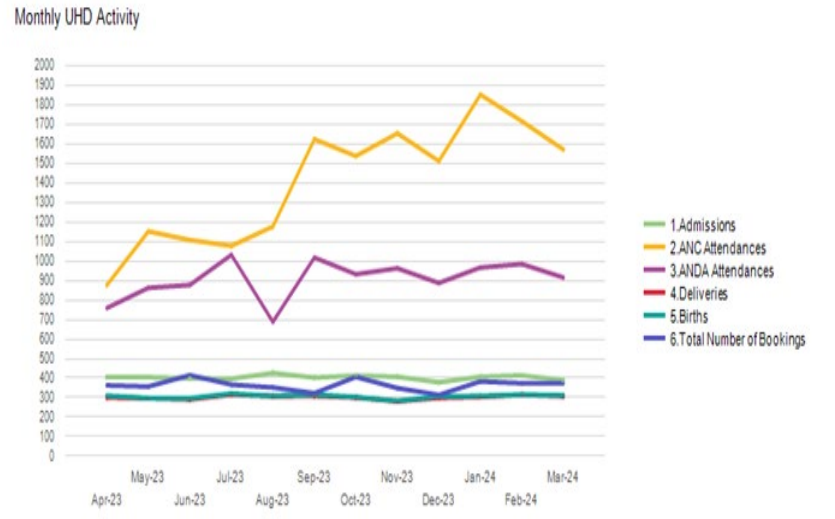
University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 01 May 2024

Agenda item: 6.3.1

Subject:	Maternity Safety Champions Report
Prepared by:	Lorraine Tonge Director of Midwifery Kerry Taylor, Head of Midwifery Alex Taylor, Clinical Director
Presented by:	Lorraine Tonge, Director of Midwifery

Strategic themes that this item supports/impacts:	Systems working and partnership ☒ Our people ☒ Patient experience ☒ Quality: outcomes and safety ☒ Sustainable services ☒ Patient First program ☒ One Team: patient ready for reconfiguration ☐
BAF/Corporate Risk Register: (if applicable)	Medical staffing
Purpose of paper:	Review and Discussion
Executive Summary:	Highlights from the maternity safety champions report will be used in conjunction with IPR slides attached to give the board a summary of the key areas of focus for maternity. **Activity:** 

Advise

Antenatal clinic attendances trend continues to be high in March 2024 compared to April 2023. Changes in policy and care pathways account for the rise however a review of antenatal pathways is underway, and consideration is being given to services that could be offered as an outpatient service to maintain sustainability and quality of care.

Perinatal quality surveillance –

Table of the number of new MNSI cases at UHD for the last 12 months:

Month	Apr 23	May 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
New Cases	1	0	0	0	0	0	1	0	1	1	2	0

Advise

There were 2 HSIB (MNSI) cases reported in February.

- A baby that who went for therapeutic cooling following an 11-minute shoulder dystocia – No omissions in care identified.
- An indirect maternal death following a subarachnoid haemorrhage early pregnancy (IUD occurred prior to maternal death). This case is also MBBRACE reportable.

Training-

Advise

Improvement this period with MDT PROMPT training overall staff groups at 95% in March however the medical team remain under the 90% target - plans in place to address this and expected to reach target by June.

Assure: CTG training at 96%.

Assure: NLS training at 95%

Assure: Midwife core competency at 96%

Assure: Development of maternity education team is underway to deliver core competency framework 2 from April 2024.

Advise: MIS year 6 standards were published on the 2nd of April 2024 we will be moving to the new reporting for training in April.

Safe staffing –

Assure:

Midwifery vacancies at 2 % in March. Focus is now on retention supporting our staff and preparing for the move in 2025.
MSW vacancy at 12% awaiting new starters which have been appointed. Vacancy will then reduce to 3%.

Advise

That Consultant Obstetric medical staffing 1.7WTE vacancies at 14 % continues and challenges remain.

There has also been changes in the Neonatal consultant workforce which are being addressed and will be monitored due the impact it could have on maternity services.

Advise:

Status	Jul 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Resolved	55	48	61	46	27	24	29	48	51
Open	0	1. Awaiting transfer to LW at time of report writing	0	0	0	0	0	0	0
Raised in error	0	0	2	2	1	3	4	9	0

Red flags in Feb - March showed there were 48 - 51 incidences 47 + 43 of these incidences were delays in Induction of labour.

There was 100% - 1:1 midwifery care provided in labour.

There were six occasions of Opel 3, and one occasions of Opel 4 due to neonatal capacity. One baby was transferred to DCH during this time to enable reopening of maternity.

Service user voice:

Assure

In February we received our CQC patient survey 2023 which showed us 28% improvements from 2022 survey and significant improvements in many areas.

Our best and bottom scores where:

5 Best Scores:	5 Bottom Scores:
Discharge was not delayed (Postnatal).	Partner unable to stay overnight.
Supported and encouraged with feeding baby.	Provided with information on feeding baby during pregnancy.
Pain managed after birth.	Given information and advice on induction of labour.
Involved in decision for induction of labour.	Provided information on where to have baby.
Received help when needed.	Midwives and Doctors were not aware of medical history during antenatal period.

An agreed action plan is in place working with our MNVP on improvements throughout 2024.

Advise:

There are 4 new complaints with communication remaining the main theme. The Matrons continue to work with clinicians to learn from this feedback.

There was no clinical negligence claim settlements in March.

Audits:

Advise

<u>Saving babies lives</u>

Saving babies lives to reduce stillbirths audit quarter 3 was assessed by the ICB. The outcome of 79% compliance was achieved overall which is a significant improvement from quarter 1 which was only 43% compliance.

However, 50 % compliance was not achieved in all 6 elements. Element 4 relating to CTG monitoring demonstrated through audits that peer reviews of CTG's were not being done to the required standard.

Immediate action has been taken to address this safety concern. In quarter 4 we are now expected to meet the standard and assessment will be on the 30th of April.
We have also changed the way in which we are classifying CTGS in March in line with NICE guidelines and it is expected that this change will demonstrate improvement.

Alert
Interpreting service 2nd audit demonstrated poor recording of using interpreting service.

Ongoing work continues to make improvements.

From safety walkabouts with NED and CNO staff showed how they are using their laptops to call language line when caring for parents.

The next audit will not be expected until September completion of pregnancy occurs however, we will continue to monitor compliance with the changes made through matrons' rounds.

The improvement plan has also been expanded to include leaflets, information, and appointments in first language and a trigger on badger net system.

Risk –
Advise:
Highest maternity risk at 12 medical staffing which has reduced due to improvement in junior doctors Rota and implementing two tier system.

Assure:
Reduced risk midwifery triage staffing.
Maternity support program
Assure:

This full plan is being aligned to patient first and contains:

- MSSP exit criteria.
- MIS
- 3-year delivery plan with Mat Neo insight improvement plan
- Maternity CQC action plan
- Maternity self-assessment
- CQC Annual patient feedback action plan
- Staff survey and Score action plan

These will be monitored monthly and overall compliance of improvements reported from April.

Alongside the improvement plan there is additional action plans which are monitored and reported through governance:

- ATAIN action plan.
- PMRT action plan
- Learning from litigation

Maternity incentive scheme year 5 –

Alert:
We have been unable to achieve all 10 safety actions. 3 standards not met are however continuous improvement since January reporting,

Action 4 – Medical workforce - Ongoing audits in place.

Action 6 -Saving babies lives V3.- further improvement seen in quarter 3 expected to meet standard when assessed for quarter 4.

Action 8 – Overall Prompt improved,
Training compliance and core competency framework version 2 to implement. Challenge with increase in training days and increase in trainers required.

MIS year 6 requirements was published 2nd April 2024, and we will report on these new standards from April**.**

Ockendon insight 3-year delivery plan
Assure:
We have received the insight report and recommendations. An action plan has been developed and reviewed monthly at the assurance meetings. All action in progress and on track.

CQC action plan –
Assure:
Many of our action this month have been identified as sustainable and standards maintained. Improvements seen in medical triaging at 81% (overall target 85%)

Overall prompt MDT training above 90% at 95% however medical obstetric team still requires improvement.

Maternity safety dashboard:

Maternity Perinatal Quality Surveillance Scorecard

Perinatal Quality Surveillance scorecard	Metric	Alert (national standard/ average where available)	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Perinatal	Red flags: 1:1 care in labour not provided	0	0	0	0	1	0	0	0	0	0	0	0
	3rd/4th degree tear overall rate	>3.5%	3.1%	2.70%	4.2%	3.9%	4.6%	1.0%	4.5%	3.8%	1.7%	2.2%	2.3%
	Obstetric haemorrhage >1.5L	>2.6 %	2.10%	3.0%%	3.7%	4.4%	3.5%	3.36%	3.3%	2.1%%	5.4%	3.9%	4.8%
	Term admissions to NNU	National <6%, Regional <5%	5.9%	6.50%	5.50%	4.30%	4.50%	6.10%	6.80%	5.40%	4.90%	6.10%	4.70%
	Apgar < 7 at 5 minutes	<1.2 %	2.3%	0.0%	1.10%	0.70%	0.0%	1.6%	2.8%	2.9%	1.4%	1.9%	0.9%
	Stillbirth number	Actual	4	2	1	0	0	2	2	1	0	0	0
	Stillbirth number/rate (per 1,000) per quarter	<2.5 /1000			7			2			3		
Workforce	Rostered consultant cover on Delivery Suite - hours pw	<72	72	72	72	72	72	72	72	72	72	72	72
	Dedicated anaesthetic cover on Delivery suite - per week	<58	58	58	58	58	58	58	58	58	58	58	58
	Midwife/band 3 to birth ratio (establishment)	01:23	01:21	01:21	01:21	01:21	01:21	01:21	01:21	01:21	01:21	01:21	01:21
	Midwife/band 3 to birth ratio (in post)	01:23	01:25	01:24	01:24	01:25	01:22	01:22	01:23	01:26	01:22	01:22	01:21
Feedback	Number of compliments (Smiles via Badgernet)		42	37	41	66	51	32	Moving to new system			40	36
	Number of concerns (PALS) negative		0	0	4	3	0	2	1	1	1	0	5
	Complaints	3	2	3	2	2	0	0	3	2	2	1	1
	FFT Repsonse from November 23		43%	46%	87%	80%	62%	125%	100%	430	276	297	307
Training	UHD Mandatory training - women's health midwives	90%	82%	84%	86%	88%	88%	88%	86%	86%	85%	87%	88%
	PROMPT/Emergency skills all staff groups	90%	82%	82%	84%	86%	not known	85.2%	74%	79%	82%	86%	88%
	K2/CTG training all staff groups	90%	91.76%	96%%	94%	96%	95%	95%	84%	87%	86%	86%	86%
	CTG competency assessment all staff groups	90%	91.76%	96%%	94%	96%%	95%	95%	84%	87%	86%	86%	86%
	Core competency framework compliance - Midwife update	90%	84%	87%	89%	86%	84%	85%	93.50%	90.00%	91.00%	moved to ccf2	moved t ccf2
	Coroner Reg 28 made directly to the Trust	al <6%, Regiona	N	N	N	N	N	N	N	N	N	N	N
	HSIB/CQC etc. with a concern or request for action		Y (CQC)	Y(CQC)	Y(CQC)	Y(CQC)	Y(CQC)	Y(CQC)	Y(CQC)	Y(CQC)	Y(CQC)	Y(CQC)	Y(CQC)

Alert:

- PPH >1.5
- Atain (February)
-

Ongoing QI improvements taking place.

Assure

Improvement in 3rd and 4th continues.
Improvement in overall MDT Prompt and training.

Background:

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

Key Recommendations:

To note report.

Implications associated with this item:

Council of Governors	☐
Equality, Equity, Diversity & Inclusion	☐
Financial	☒
Health Inequalities	☒
Operational Performance	☒
People (inc Staff, Patients)	☒
Public Consultation	☐
Quality	☒
Regulatory	☒
Strategy/Transformation	☐
System	☐

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

Report History: Committees/Meetings at which the item has been considered:	Date	Outcome
Maternity quadrumvirate Safety champions meeting Directorate meeting Care group Board Quality Committee	26/04/2024	Noted and approved through Governance processes.

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

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 01 May 2024

Agenda item: 5.2

Subject:	Mortality Report
Prepared by:	Sean Weaver, Medical Director for Quality and Safety
Presented by:	Peter Wilson Chief Medical Officer

Strategic themes that this item supports/impacts:	Systems working and partnership ☐ Our people ☒ Patient experience ☒ Quality: outcomes and safety ☒ Sustainable services ☐ Patient First programme ☒ One Team: patient ready for reconfiguration ☐
BAF/Corporate Risk Register: (if applicable)	BAF Risk 5 – Risk of not improving hospital mortality and being in the top 20% of trusts in the country for HSMR in the next 3 years
Purpose of paper:	Assurance
Executive Summary:	The HSMR for October from our new data supplier HED is 114. The SHMI for the year to October from NHS Digital is 0.87. We have changed our data supplier which has altered how our HSMR is calculated and this is higher than what we have seen with Telstra data over the same periods. Our SHMI remains good and both will need to be interpreted and trends noted and acted on. We have been working with the coding team to increase depth of coding and accuracy of capturing palliative care coding.
Background:	Regular mortality review and report.
Key Recommendations:	Future work regarding learning from deaths and triangulation of all data is described.
Implications associated with this item:	Council of Governors ☐ Equality, Equity, Diversity & Inclusion ☐ Financial ☐ Health Inequalities ☐ Operational Performance ☐ People (inc Staff, Patients) ☐ Public Consultation ☐

	Quality Regulatory Strategy/Transformation System	☒ ☐ ☐ ☐
CQC Reference:	Safe Effective Caring Responsive Well Led Use of Resources	☒ ☐ ☐ ☐ ☐ ☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Quality Committee	26/04/2024	Meeting not yet taken place at the time of submission.

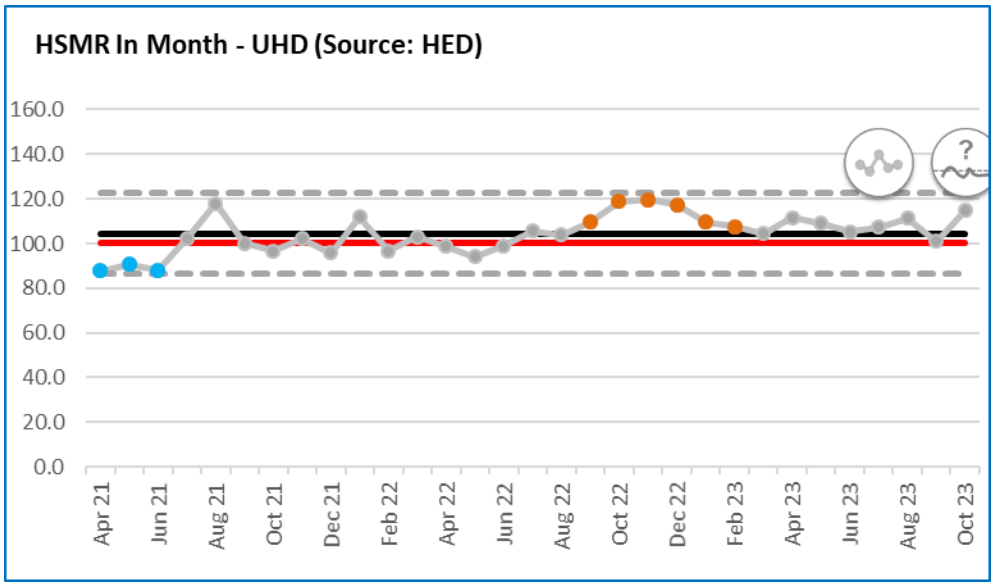
Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality Patient confidentiality Staff confidentiality Other exceptional reason	☐ ☐ ☐ ☐

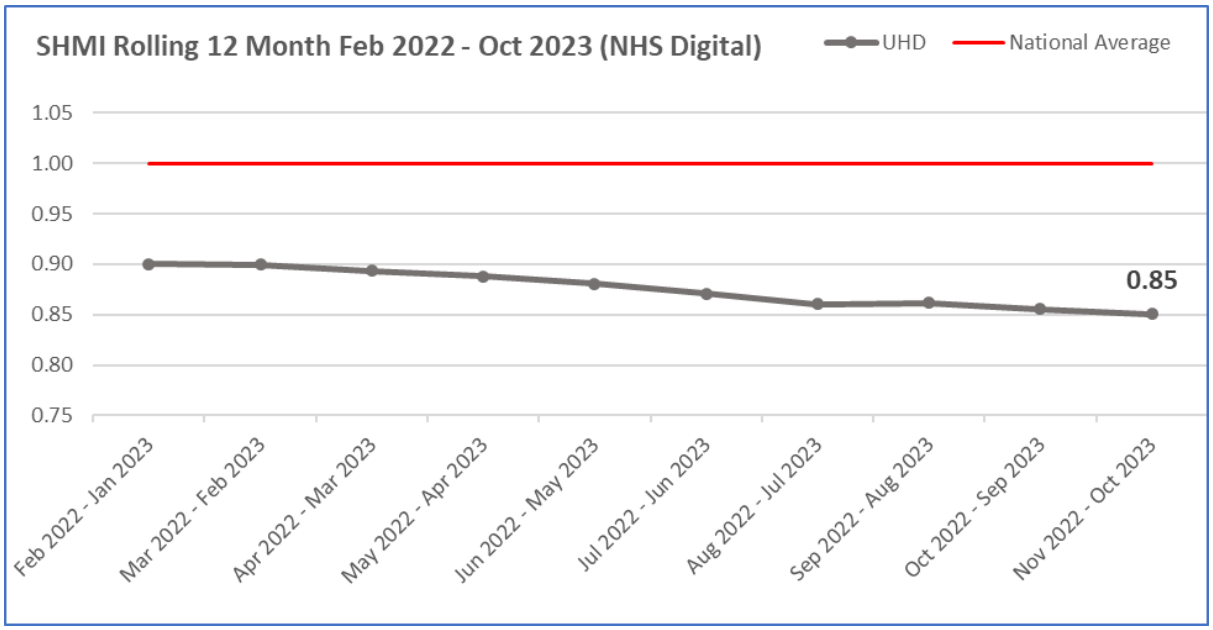
Mortality Report – March 2024

Headline Data

HSMR (HED) for January 2024 – 100.5 - Improving

SHMI (NHS Digital) rolling for year to December 2023 – 0.85





Headline Data and Change of Data Supplier

We have changed our data supplier from Telstra Health to HED. Generally this is a positive step. HED give us a greater ability to interrogate our data and also immediate access to patient level data. They calculate HSMR differently and with a different population. This has resulted in our HSMR generally being higher – October 114. The SHMI which is delivered by NHS Digital and is set and continues to drop and is 0.87.

The change in our HSMR from previously is a step due to the change of provider. The graph above is from solely HED data and does not show any new or unknown trends. HSMR is our headline metric for patient first. It is the more challenging of the two main measure of mortality due to the influence of having two hospices in our trust. SHMI Is set by NHS Digital and our persistent and onward trend with our SHMI is downward. This is influenced in a beneficial way by our hospices. Our rolling HSMR is 110 and drops to 93 when our hospices are removed. Our SHMI is 0.87 and rises to 1 when our hospices are removed.

We have a plan to set up alerts with HED and are doing a deep dive of pneumonia data given that it is the biggest cause of death in the trust and concerns about inconsistent practice have been raised by the medical examiner.

Coding

We are working with the coders to ensure that we are accurately capturing our data, especially for patients receiving palliative care who significantly influence our mortality statistics.

Our coding timeliness has changed meaning that our closed data is one month behind the latest data. This is causing some initial issues with the reporting of alerts and this should be resolved by next month.

The coders have fed back on clinical tips to help to improve coding and these are being shared with CGG

Moving Forward

We are keen to maximise the learning from death particularly in specialities where by their nature more people die – palliative care, Older Peoples Services and Oncology. There is ongoing work to review cases where there is likely to be most learning whilst still reviewing 30-50% of deaths. We are also aligning that to work that already takes place in certain specialities such as oncology.

We are keen to triangulate all the learning from incidents, feedback from patients/relatives/staff, and audit, as well as learning from death, to continually improve the care our patients our patients receive and keep our mortality as low as possible.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 01 May 2024

Agenda item: 6.4.2

Subject:	Guardian of Safe Working Hours Report for UHD: Annual Report for January – December 2023
Prepared by:	Mike Vassallo, Guardian of Safe Working Hours Paul Froggatt, Guardian of Safe Working Hours Julie Mantell, Medical Education Manager
Presented by:	Mike Vassallo, Guardian of Safe Working Hours Paul Froggatt, Guardian of Safe Working Hours

Strategic themes that this item supports/impacts:	Systems working and partnership	☐
	Our people	☒
	Patient experience	☐
	Quality: outcomes and safety	☒
	Sustainable services	☐
	Patient First programme	☐
	One Team: patient ready for reconfiguration	☐
BAF/Corporate Risk Register: (if applicable)	N/A	
Purpose of paper:	Assurance	
Executive Summary:	**Royal Bournemouth Hospital** 1. The total number of exception reports submitted during the year was 335, a decrease of 46% from the previous year. This is contributed to by improved staffing in highly reporting areas as well as the industrial action which is likely to have caused a reluctance and despondency about exception reporting. 2. The majority of exception reports related to hours of working accounting for 80%. 3. Almost all these exceptions were settled by agreeing overtime payments. 4. There has also been a reduction in the number of immediate patient safety issues raised during 2023. The prevailing theme for immediate patient concerns was mostly related to the capacity to manage unwell patients when staffing levels were low. All ISCs were raised to the directorates. 5. The data below highlights an increase of 35% in the number of locum shifts requested from 2022 to 2023 from 6568 to 8869.	

	6. This year the joint Junior Doctor Forum has been established and is now running regularly hosted alternately at Poole and Bournemouth Bi monthly. 7. During 2024 the Guardian of safe working for each site with continue promoting Exception reporting at every induction and will continue working with Junior doctor representatives to support them in their work in the Trust. The Trust will also move exception reporting to Health Rota from August 2024. **Poole Hospital** 1. Significant increase in reporting especially in general and older people's medicine and oncology. 2. Majority of reports relate to hours worked. 3. ISCs were addressed through supervisors, GoSW and where indicated directorate CD. 4. Continued support for reporting from the guardian and individual supervisors.
Background:	The Guardian post was created as part of the 2016 Junior Doctor contract, to ensure hours worked, and levels of supports, are safe for doctors and patients, based on exception reports.
Key Recommendations:	Continue to support the process of exception reporting and therefore identifying problems early. 1. The Trust to appoint to vacant posts using this funding and to monitor further exceptions against the vacancy rates and other data within this report. 2. Option to offer BMA rate for extra contractual work.
Implications associated with this item:	Council of Governors ☐ Equality, Equity, Diversity & Inclusion ☐ Financial ☒ Health Inequalities ☐ Operational Performance ☐ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☒ Regulatory ☒ Strategy/Transformation ☐ System ☐
CQC Reference:	Safe ☒ Effective ☐ Caring ☐ Responsive ☐ Well Led ☒ Use of Resources ☐

Report History: Committees/Meetings at which the item has been considered:	Date	Outcome
People & Culture Committee	10/04/2024	Report reviewed and noted.

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

University Hospitals Dorset
NHS Foundation Trust

Guardian of Safe Working Annual Report

University Hospitals Dorset – RBH and Poole

Annual Report – Year 1 January 2023 – 31 December 2023

Contents:

Executive Summary

Poole Hospital

For the last calendar year there has been a significant increase in the number of exception reports (ERs) at the Poole site. This has also occurred during a period which has included a hitherto unprecedented level of industrial action by doctors in training. The vast majority of reports relate to the hours worked (89%)

I think there have been both general and specialty specific drivers underlying this increase; in both exception reports and those identified as immediate safety concerns (ISCs).

In the general sense doctors in training are becoming much more familiar with and willing to submit exception reports regarding their working hours, such that we may now be getting a more full and accurate representation of the hours that doctors in training are working.

In turn their supervisors are also becoming more attuned to the way in which exception reporting can be used as a tool to identify gaps within human resource allocation and rota planning. In addition, at each new induction of doctors to the trust I emphasise the rationale behind reporting and the way in which it can help to transform and improve the working environment.

A specialty specific driver has occurred in Oncology – there was a significant increase in reporting (ERs and ISCs) when there was a change in the pathway for acute oncology admissions with Poole also taking the admissions from Dorset County Hospital. However this lead to a discussion with the clinical director for oncology with subsequent improved human resources and a reduction in the reports with no further ISCs.

Further notable increases have occurred in both general medicine and older peoples services (OPS) which are reflective of the increasing workload that these specialties are coming under.

As Professor Vassallo mentions below there is now a UHD junior doctors forum which serves both sites. In addition, a new reporting software will be introduced later in year which will also be the platform for bespoke rotas for doctors in training.

Royal Bournemouth Hospital

The year January 2023 – December 2023 has been characterised by Junior doctors' industrial action. It is very likely that this has impacted significantly on the metrics reported in this report

The total number of exception reports submitted during the year was 335. This showed a decrease of 46% from the previous year. The biggest changes were in General Medicine with a decrease of 58% and in Older Person Services with a decrease of 63%. It is not possible to be definitive about the causes for this drop but a lot of work has been put in place to improve staffing in these areas and this would have contributed to this drop as well as the industrial action which is likely to have caused a reluctance and despondency about exception reporting

The majority of exception reports raised relate to hours of working accounting for 80% of the total reports raised compared to 73% in 2022. Almost all these exceptions were settled by agreeing overtime payments.

There has also been a notable reduction in the number of immediate patient safety issues raised during 2023. The prevailing theme for immediate patient concerns was mostly related to the capacity to manage unwell patients when staffing levels were low. All ISC were raised to the directorates

The data below highlights an increase of 35% in the number of shifts requested from 2022 to 2023 from 6568 to 8869. Whilst in 2022, 56% of shifts requested were worked, in 2023 62% of the requested shifts were worked in comparison. Emergency Medicine, General Medicine and General Surgery have remained the departments with the most shifts requested, equating to 93% of the total shifts requested in 2023 and 96% in 2022.

This year the joint Junior Doctor Forum has been established and is now running regularly hosted alternately at Poole and Bournemouth Bimonthly

During 2024 The Guardian of safe working for each site with continue promoting Exception Reporting at every induction and will continue working with junior doctor representatives to support them in their work in the Trust. The Trust will also move exception reporting to Health Rota from August 2024.

University Hospitals Dorset: Poole Hospital

High Level Data

The table below provides a breakdown of the total number of exception reports received during the period 1st January 2023 to 31st December 2023 with comparison to 2022:

Department	Sum of Total Exceptions Submitted 2022	Sum of Total Exceptions Submitted 2023	Increase/ Decrease
Acute	1	2	↑
Cardiology	29	3	↓
Dermatology	1	0	↓
Emergency	30	4	↓
ENT	0	10	↑
Gastroenterology	33	4	↓
General Medicine	72	142	↑
General Practice	0	0	↔
General Surgery	22	29	↑
Haematology/Oncology	43	103	↑
Neurology	5	8	↑
O&G	1	1	↔
OPS	110	161	↑
Paediatrics	4	5	↑
Respiratory	11	26	↑
T&O	5	2	↓
TOTAL	**367**	**500**	↑ **36%**

Source Allocate (Table 1)

There was an overall increase of 36% in the number of exception reports raised compared to the last calendar year, with notable increases in the following departments:

- ENT – increasing from 0 to 10
- General Medicine – 97%
- Haematology/Oncology – 139%
- OPS – 46%
- Respiratory – 136%

Total Specialty Exceptions

The general trend year on year has seen a rise in the number of exceptions raised within General Medicine, Haematology and OPS. The highest contributing departments have remained constant which could be due to several reasons including low workforce numbers and open culture of reporting which provides opportunities to improving standards that provide a good learning environment for doctors in training.

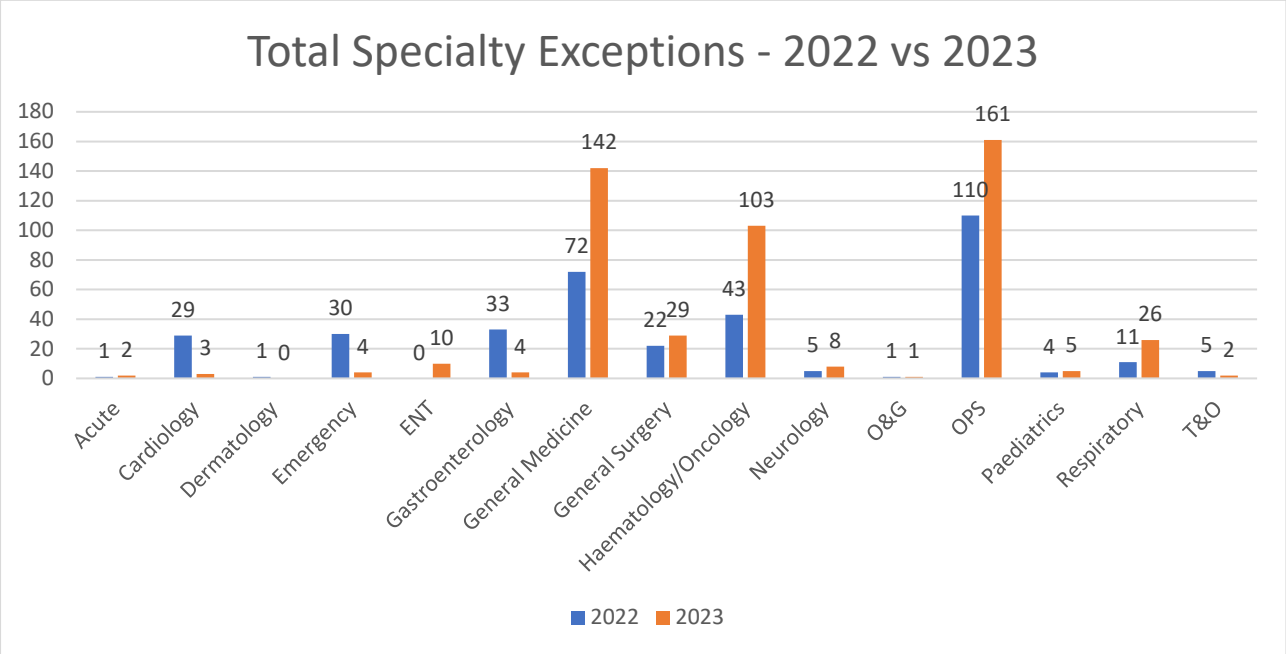


Figure 1

The majority of reports relate to hours of working accounting for 89% of the 2023 reports received compared to 84% in 2022. There has been a significant rise in the number of immediate patient safety issues raised.

	2022	2023	Change
Total number of exception reports received	367	500	36%
Number relating to hours of working	309	444	44%
Number relating to educational opportunities	6	14	133%
Number relating to shift pattern of work	19	13	- 31%
Number relating to service support available to the doctor	8	8	-
Number relating to unable to take a natural break	25	21	- 16%
Of which related to immediate patient safety issues	10	16	60%

Source Allocate (Table 2)

Table 3 provides a comparison breakdown of the resolutions which were raised in 2022 and 2023. With 200 overtime payments and 246 Time Off In Lieu (TOIL).

	2022	2023	Change
Total number of exceptions where TOIL was granted	187	246	31%
Total number of overtime payments	134	200	49%
Total number of work schedule reviews	0	2	-
Total number of reports resulting in no action	23	31	35%
Total number of outcomes agreed and not recorded	21	10	-52%
Cancelled exceptions	0	0	-
Exception created in error	2	2	-
Total number of resolutions	367	491	34%
Total pending outcomes - As of 05.01.24	0	9	-

Source Allocate Table 3

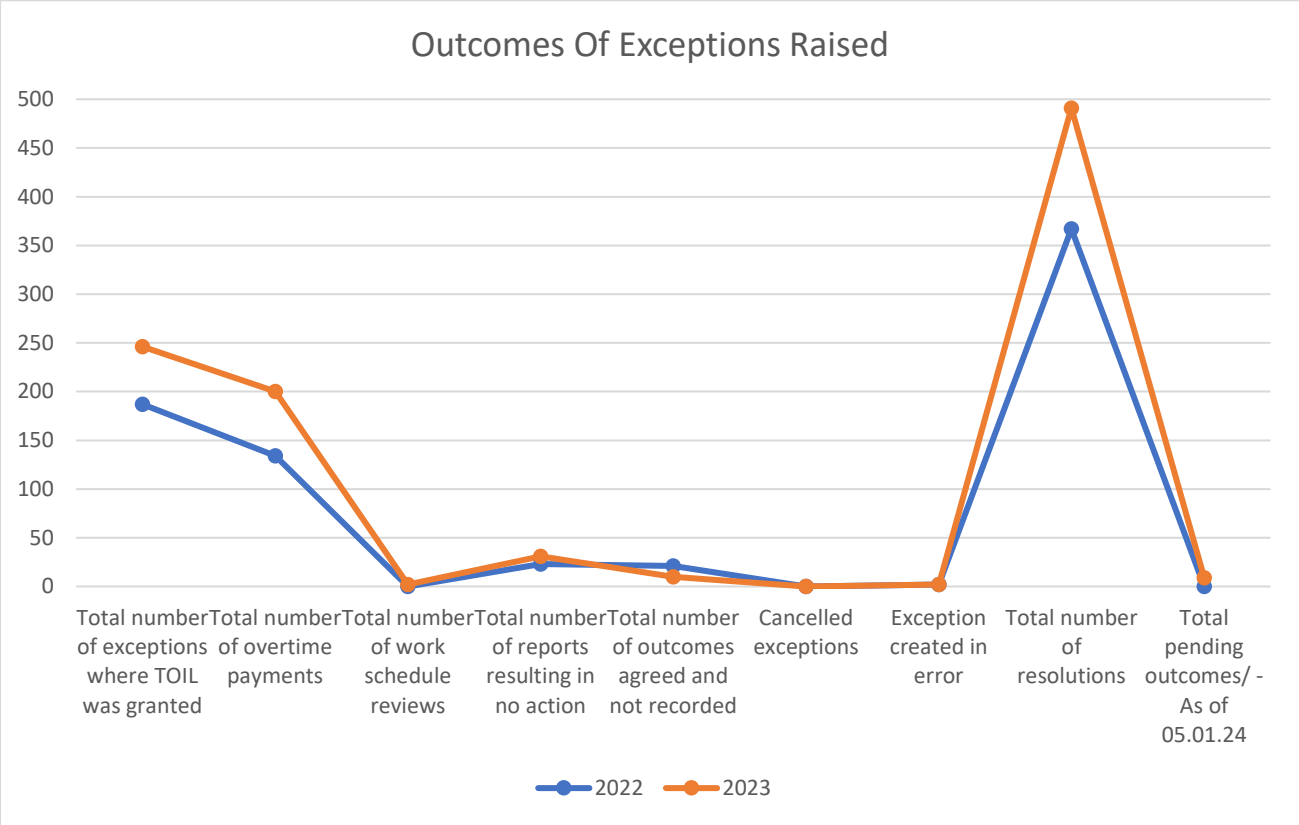
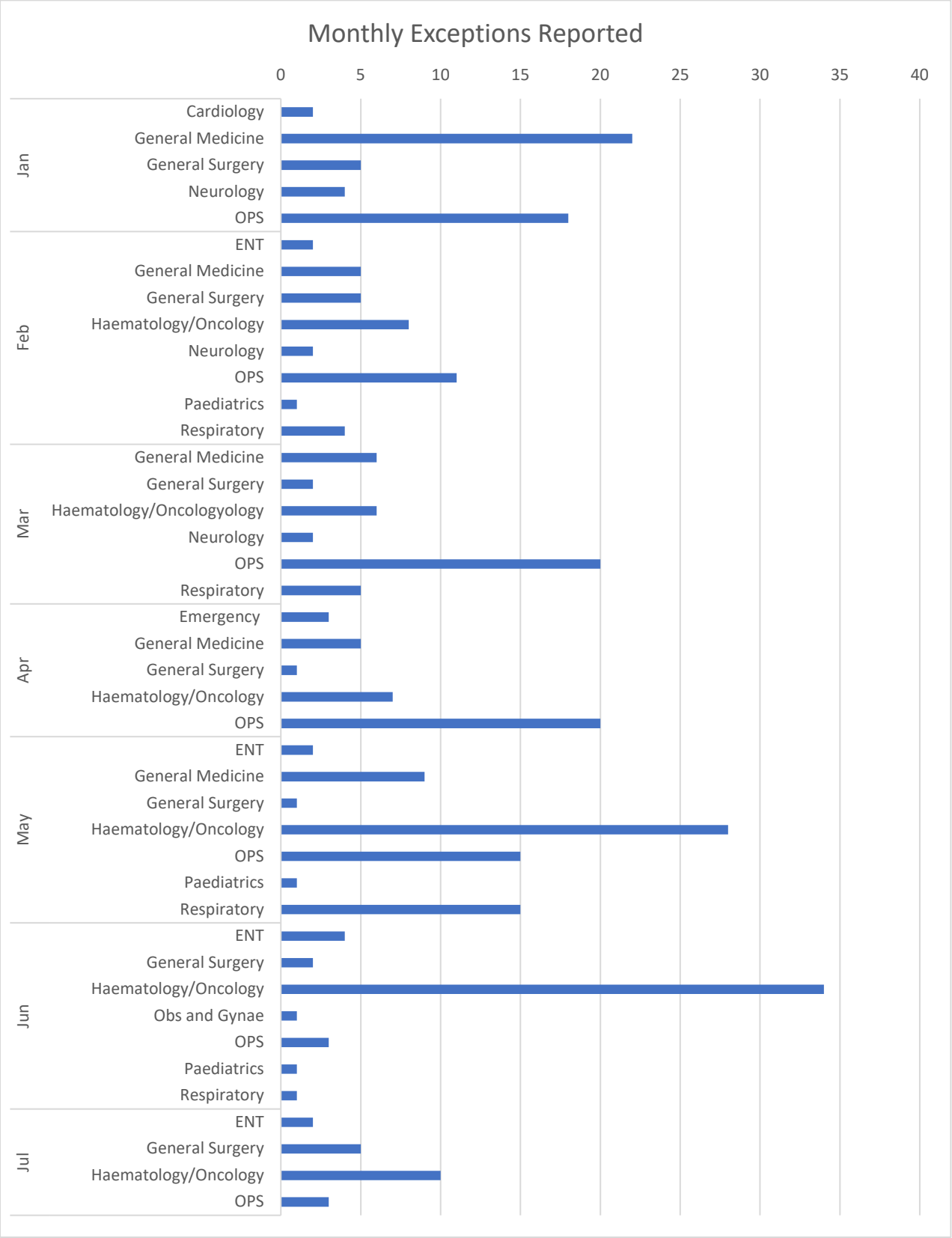


Figure 2

Monthly Exception Breakdowns by Specialty

Figure 3 below breaks down the exception reports further into reported by specialty by month, allowing insight into periods throughout the year which have seen significant peaks in reporting. For example, May and June which saw the highest number of

Haematology/Oncology reports. Whilst OPS is the only department in which there has been reports made during every month of the year.



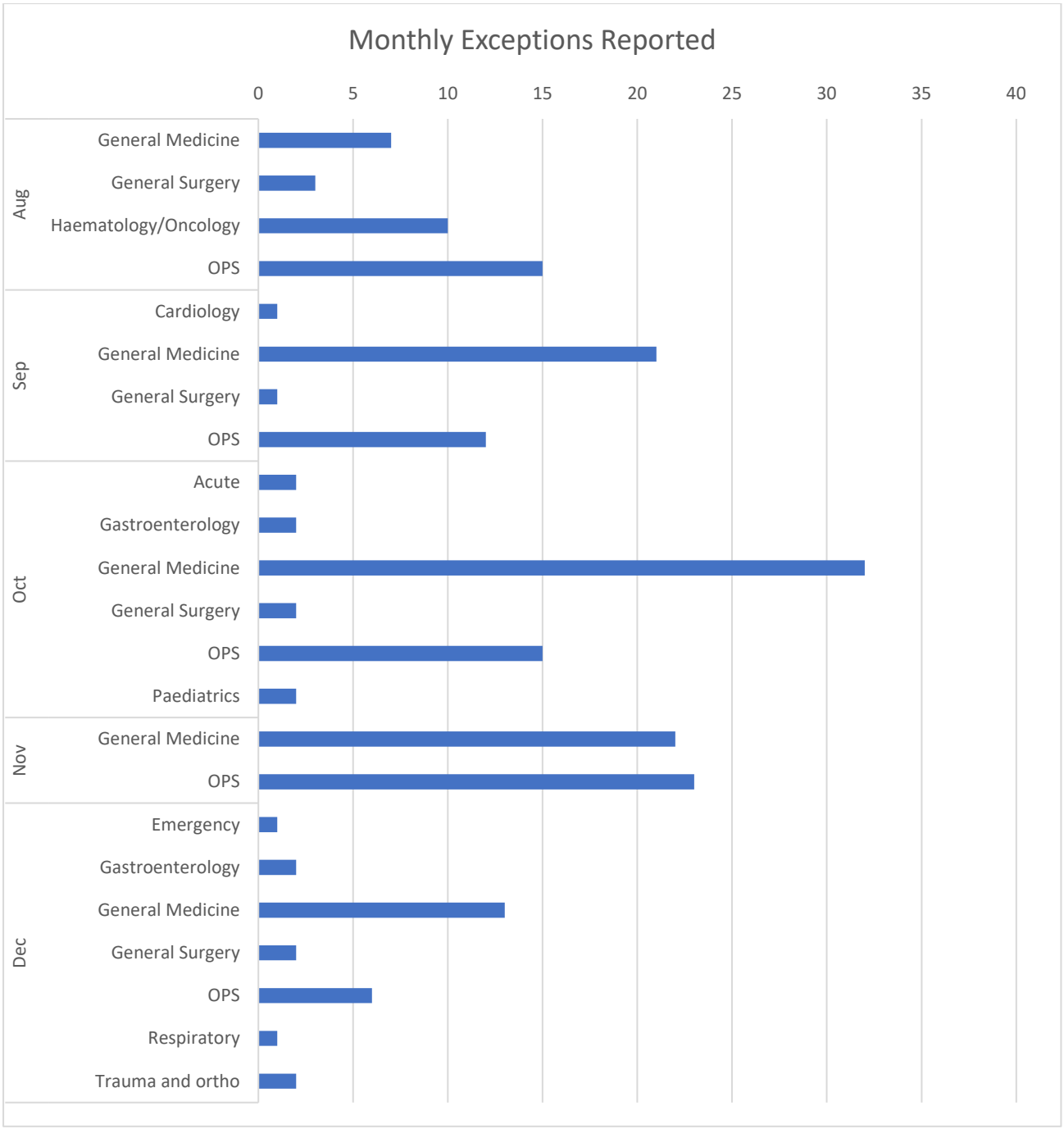

Monthly Exceptions Reported
0
5
10
15
20
25
30
35
40
Aug
General Medicine
General Surgery
Haematology/Oncology
OPS
Sep
Cardiology
General Medicine
General Surgery
OPS
Oct
Acute
Gastroenterology
General Medicine
General Surgery
OPS
Paediatrics
Nov
General Medicine
OPS
Dec
Emergency
Gastroenterology
General Medicine
General Surgery
OPS
Respiratory
Trauma and ortho

Figure 3

Reporting Grades for Period 1st January 2023 – 31st December 2023

Grade	Jan – Mar	Apr – Jun	Jul – Sep	Oct - Dec	Total
FY1	51	32	42	91	216
FY2	41	74	31	10	156
GPST1/2	0	0	0	0	0
ST/CT 1/2	26	30	16	22	94
ST3+ / CT3	10	17	1	4	32
Trust SHO	2	0	0	0	2

Source Medical Staffing Table 4

Table 4 provides an overview of the different grades of staff exception reporting for 2023, with a comparison for 2022 detailed in figure 4 below.

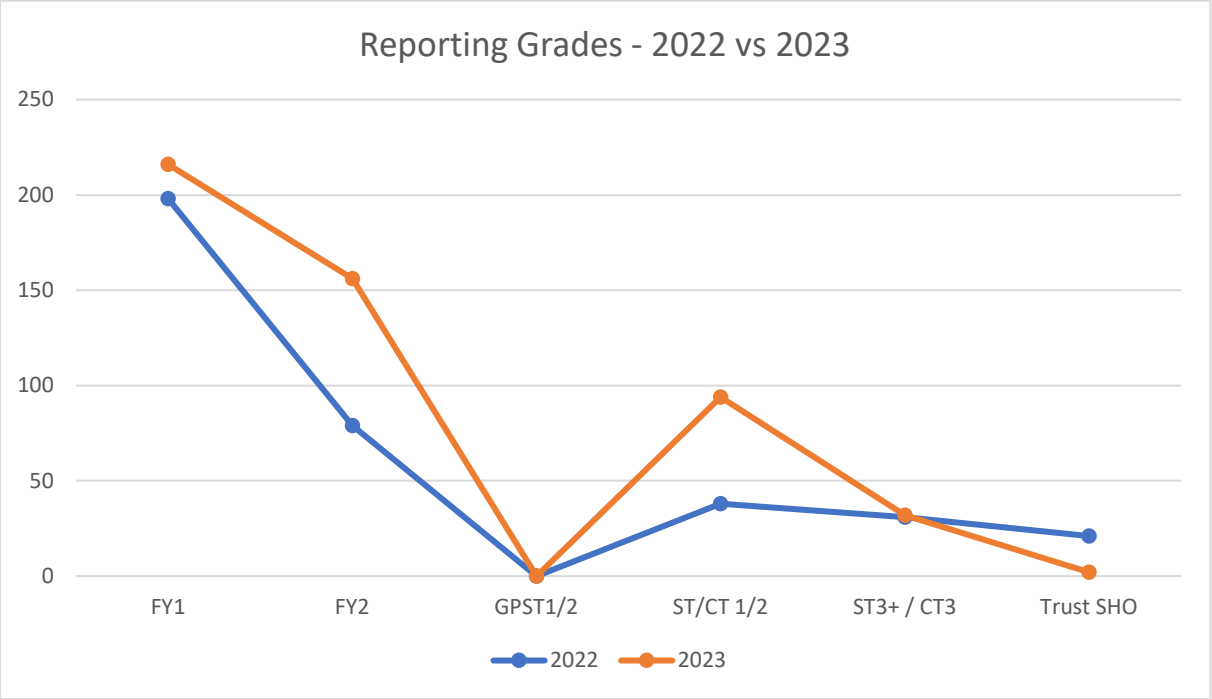
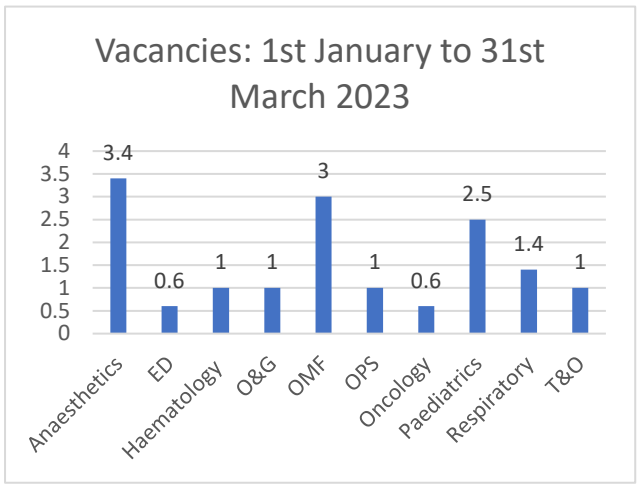
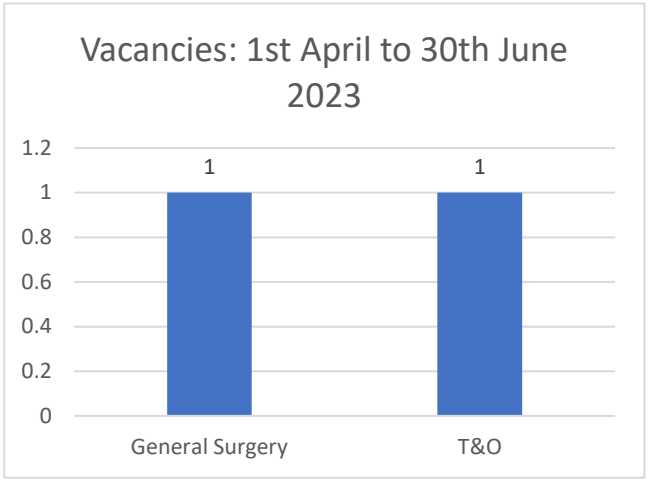


Figure 4

Vacancies Overview for 1st January 2023 to 31st December 2023





Source Medical Staffing Figure 5

Due to a lack of available data, we are unable to provide a vacancy comparison between 2022 and 2023.

Locum Shift Requests by Reason 1 January to 31 December 2023

The tables below provide an overview of the pressures of workload for our junior doctors.

The data below highlights an increase of 18% in the number of shifts requested from 2022 to 2023 from 8687 to 10,251. Whilst in 2022, 69% of shifts requested were worked, in 2023 66% of the requested shifts were worked in comparison.

Notable increases include an increase of 1151% from 39 to 488 shifts requested for Less Than Full Time Cover, an increase of 1340% for Escalations and an increase of 59% for Sickness shift cover. As expected, the most significant decrease was for Coronavirus shift cover, decreasing by 98%.

Reason	Number of Shifts Requested 2022	Number of Shifts Worked 2022	Number of Shifts Requested 2023	Number of Shifts Worked 2023
7 day Pilot	31	15	22	4
Acuity	153	153	0	0
Adhoc	496	496	993	993
Annual Leave	301	186	294	238
Civil Duty	0	0	2	0
Coronavirus	1388	652	23	10
Deanery Vacancy	709	475	694	427
Escalations	32	27	461	198
LTFT Cover	39	31	488	302
Maternity/Paternity Leave	45	34	102	62
Service Demand (e.g winter pressures)	431	312	958	649
Sickness	496	260	788	458
Study Leave	97	58	153	76
Trust vacancy	3714	2837	4497	2958
Urgent Clinical Need	753	485	763	428
Waiting List Initiative	2	2	13	11
Total	**8687**	**6023**	**10251**	**6814**

Source UHD Bank Staff Office Table 5

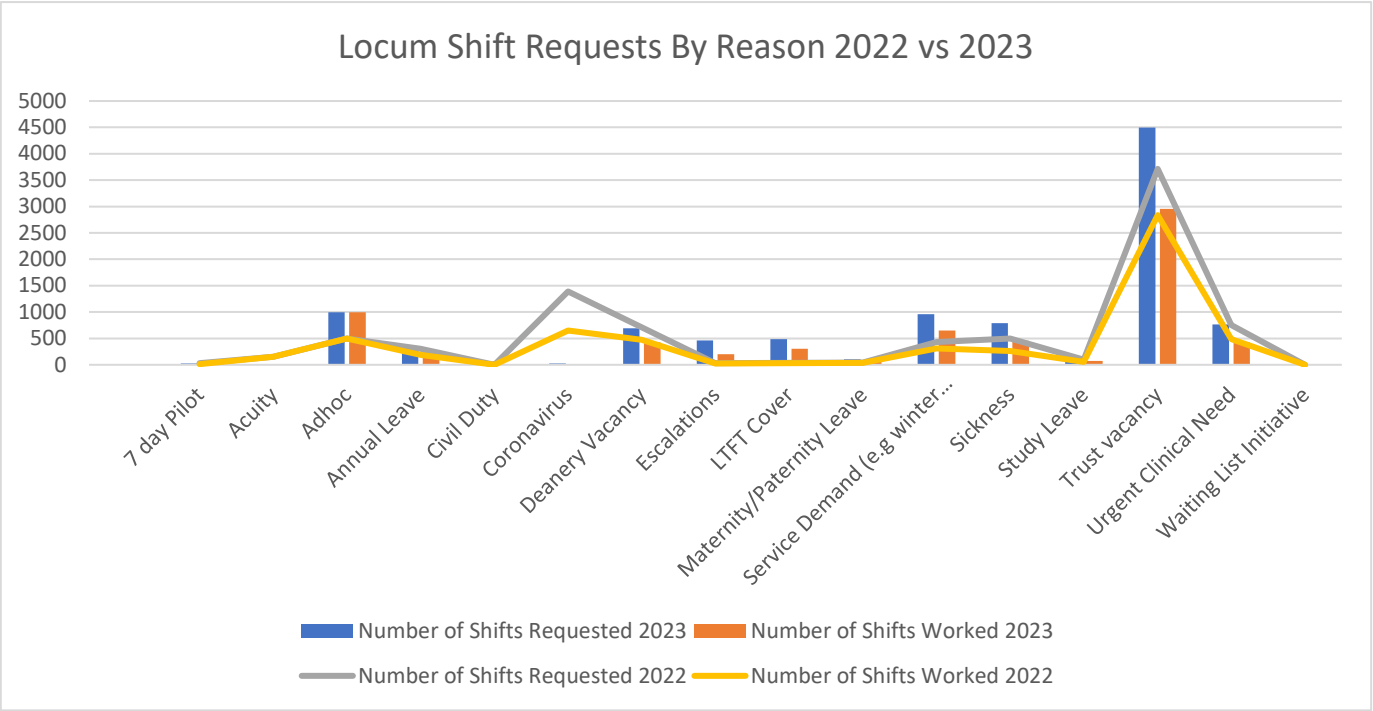


Figure 6

Locum Shift Requests by Specialty for Period 1st January to 31st December 2023

Highlighted are the total number of shifts requested from specialties and how many of these were worked. In comparison with 2022, please see figure 7.

Specialty	Number of Shifts Requested 2022	Number of Shifts Worked 2022	Number of Shifts Requested 2023	Number of Shifts Worked 2023
Anaesthetics	0	0	5	5
Emergency Medicine	2362	1339	3304	1690
ENT	222	146	418	298
General Medicine	2893	1743	2532	1625
General Surgery	265	187	216	111
Intensive Therapy	0	0	1	1
Maxillo Facial	1	1	110	100
Obstetrics and Gynae	227	184	302	222
Oncology	254	183	284	185
Orthopaedic Surgery	2434	2207	2646	2357
Paediatrics	340	231	430	217
Psychiatry	6	6	0	0
Urology	0	0	1	1
TOTAL	**9004**	**6227**	**10249**	**6812**

Source UHD Bank Staff Office Table 6

Emergency Medicine, General Medicine and Orthopaedic have remained the departments with the most shifts requested, equating to 83% of the total shifts requested in 2023 and 85% in 2022.

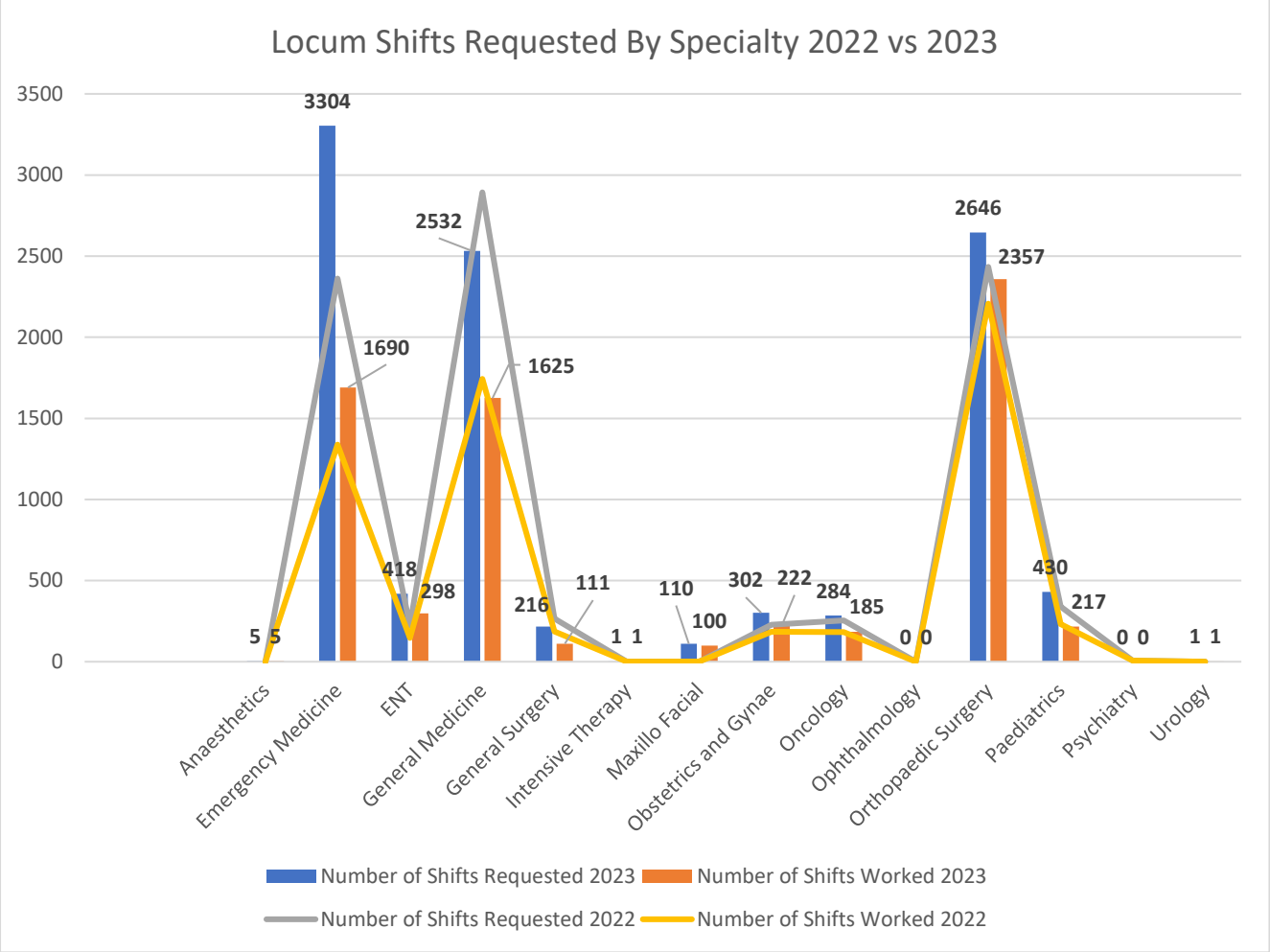


Figure 7

The figure below depicts the Locum Shift Requests by Specialty during 2023 broken down into their respective quarterly requests:

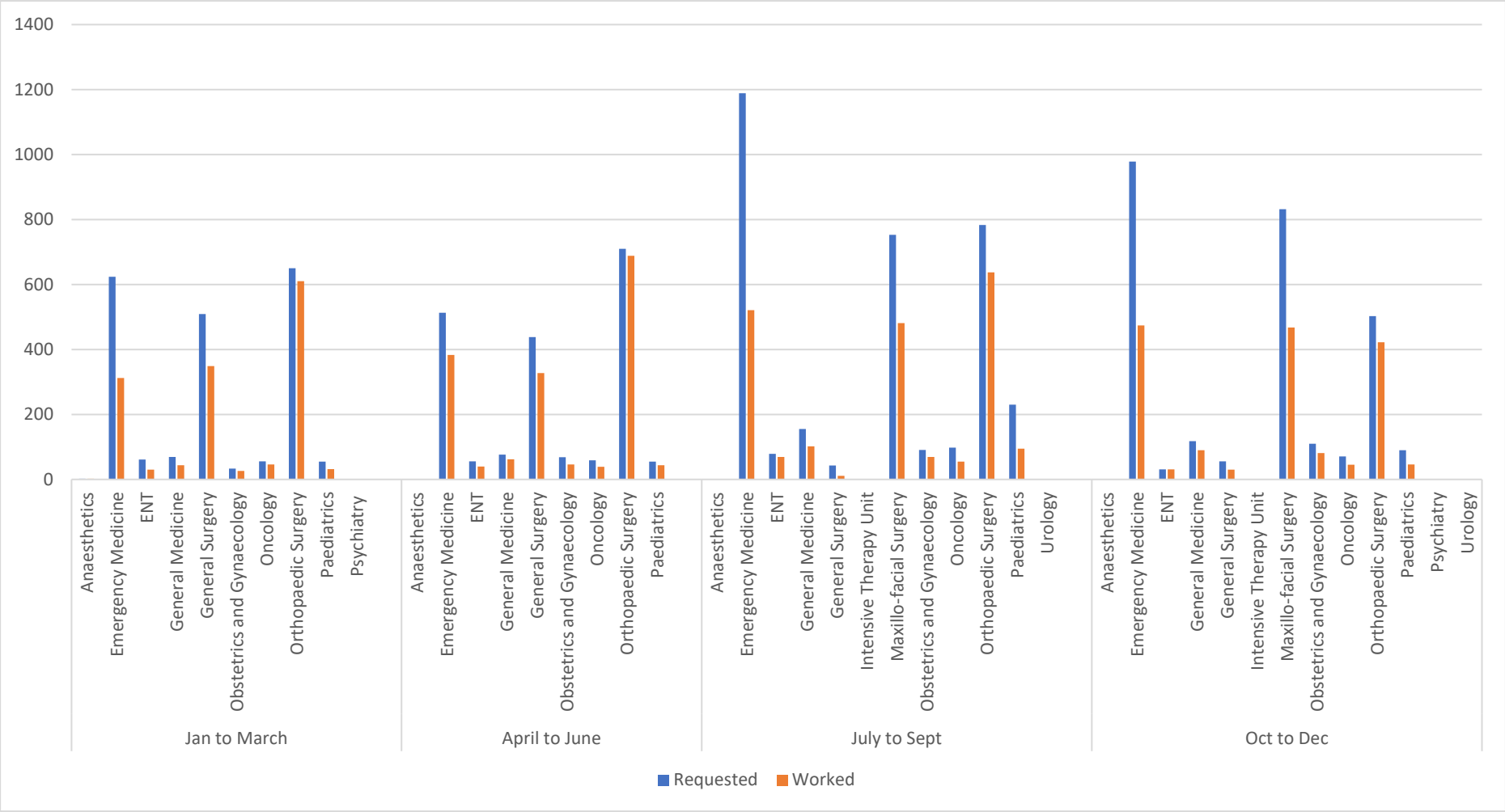


Table 7

University Hospitals Dorset: Bournemouth Hospital

High Level Data

The table below provides a breakdown of the total number of exception reports received during the period 1st January 2023 to 31st December 2023 with comparison to 2022:

	Sum of Total Exceptions Submitted 2022	Sum of Total Exceptions Submitted 2023	Increase/ Decrease
Acute	12	33	↑
Anaesthetics	1	0	↓
Cardiology	29	17	↓
Dermatology	0	1	↑
Diabetes and Endo	4	0	↓
Emergency	11	12	↑
Gastroenterology	75	22	↓
General Medicine	239	101	↓
General Practice	0	4	↑
General Surgery	76	48	↓
Haematology/Oncology	16	0	↓
O&G	0	1	↑
Ophthalmology	15	15	↔
OPS	121	45	↓
Respiratory	8	18	↑
Urology	7	6	↓
Vascular	6	12	↑
TOTAL	**620**	**335**	↓ 46%

Source Allocate Table 8

There was a significant decrease in the number of exceptions raised during this year, a decrease of 46% has been noted.

The following departments have seen the most significant changes:

- Acute Medicine – Increase of 175%
- Cardiology – Decrease of 41%

- Gastroenterology – Decrease of 70%
- General Medicine – Decrease of 58%
- OPS – Decrease of 63%

There has been a significant decrease in the number of exceptions reported in 2023 in comparison to 2022. The below breakdown shows that 38% of the total reports were made in the first three months of 2023 compared to 21% in 2022. Of note, in the final quarter of 2023 compared to 2022 reporting there was a 75% decrease, this may be due to the industrial action activity which took place during this time period.

Month Reported	2022	2023
Jan – Mar	138	128
Apr – Jun	95	80
Jul – Sept	138	65
Oct - Dec	249	62

Source Allocate Table 9

Total Specialty Exceptions

As stated previously, there has been a significant reduction in reporting across many departments compared to 2022 which can be seen below. Most notably there has been a decrease of 58% in the General Medicine reports and 63% in the OPS department.

Figure 8

The majority of exception reports raised relate to hours of working accounting for 80% of the total reports raised compared to 73% in 2022. There has also been a notable reduction in the number of immediate patient safety issues raised during 2023.

	2022	2023	Change
Total number of exception reports received	620	335	- 46%
Number relating to hours of working	455	269	- 41%
Number relating to educational opportunities	54	22	- 59%
Number relating to shift pattern of work	18	16	- 11%
Number relating to service support available to the doctor	45	12	- 73%
Number relating to unable to take a natural break	48	16	- 66%
Of which related to immediate patient safety issues	37	8	- 78%

Table 10

Table 11 provides a comparison breakdown of the resolutions which were raised in 2022 and 2023. With 280 overtime payments and 3 Time Off In Lieu (TOIL).

	2022	2023	Change
Total number of exceptions where TOIL was granted	9	3	- 67%
Total number of overtime payments	483	280	- 42%
Total number of work schedule reviews	10	0	-
Total number of reports resulting in no action	93	33	- 65%
Total number of outcomes agreed and not recorded	17	6	- 65%
Cancelled exceptions	0	0	-
Exception created in error	8	3	- 62%
Total number of resolutions	620	325	- 48%
Total pending outcomes/ - As of 05.01.24	0	10	-

Source Allocate Table 11

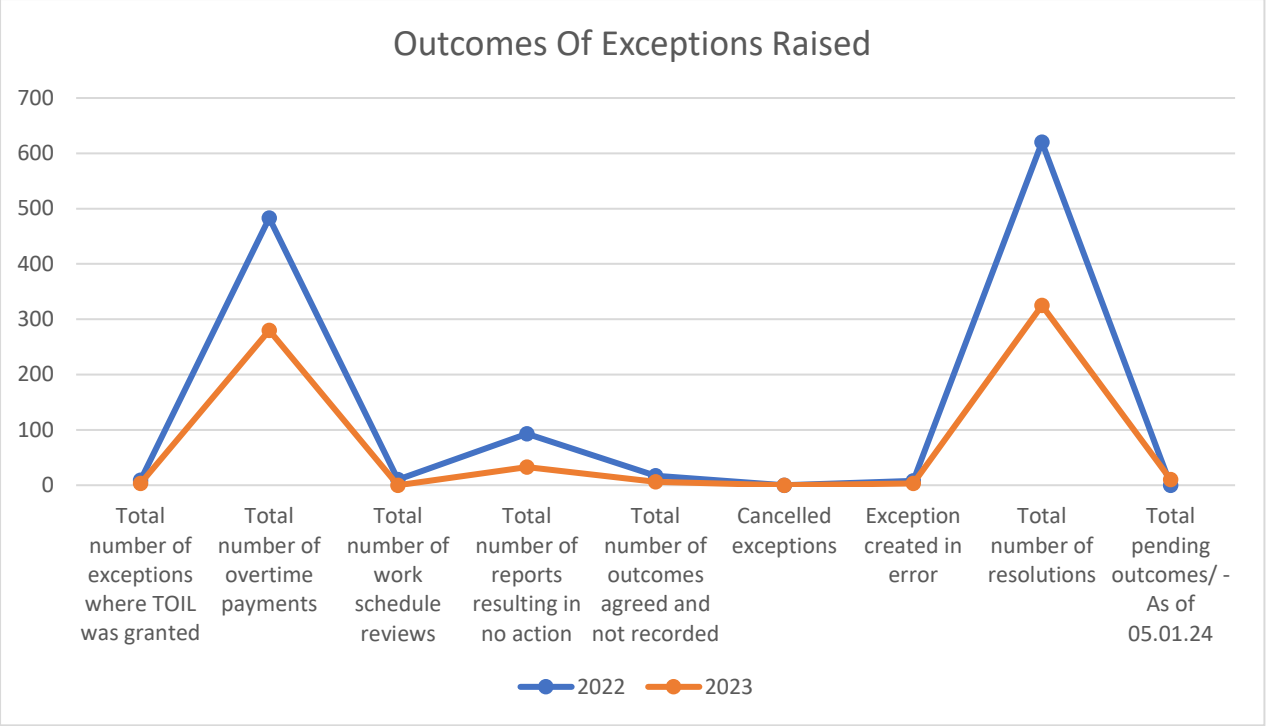
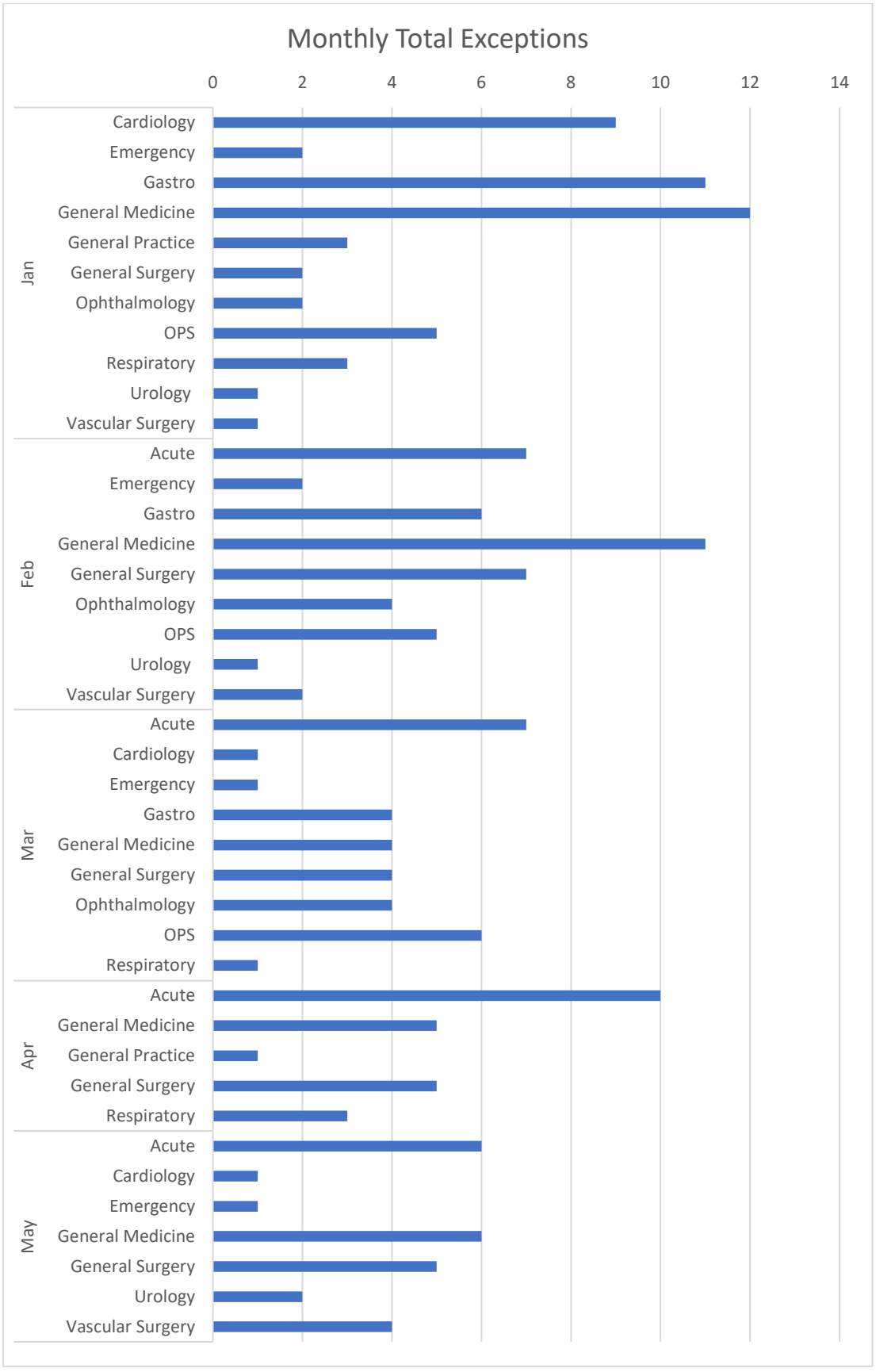


Figure 9

Monthly Exception Breakdowns by Specialty

Figure 10 below breaks down the exception reports further into reported by specialty by month, allowing oversight of particular periods throughout the year which may have seen significant peaks in reporting. General Medicine is the only department in which there has been reports made during every month of the year.


Monthly Total Exceptions
0
2
4
6
8
10
12
14
Jan
Cardiology
Emergency
Gastro
General Medicine
General Practice
General Surgery
Ophthalmology
OPS
Respiratory
Urology
Vascular Surgery
Feb
Acute
Emergency
Gastro
General Medicine
General Surgery
Ophthalmology
OPS
Urology
Vascular Surgery
Mar
Acute
Cardiology
Emergency
Gastro
General Medicine
General Surgery
Ophthalmology
OPS
Respiratory
Apr
Acute
General Medicine
General Practice
General Surgery
Respiratory
May
Acute
Cardiology
Emergency
General Medicine
General Surgery
Urology
Vascular Surgery

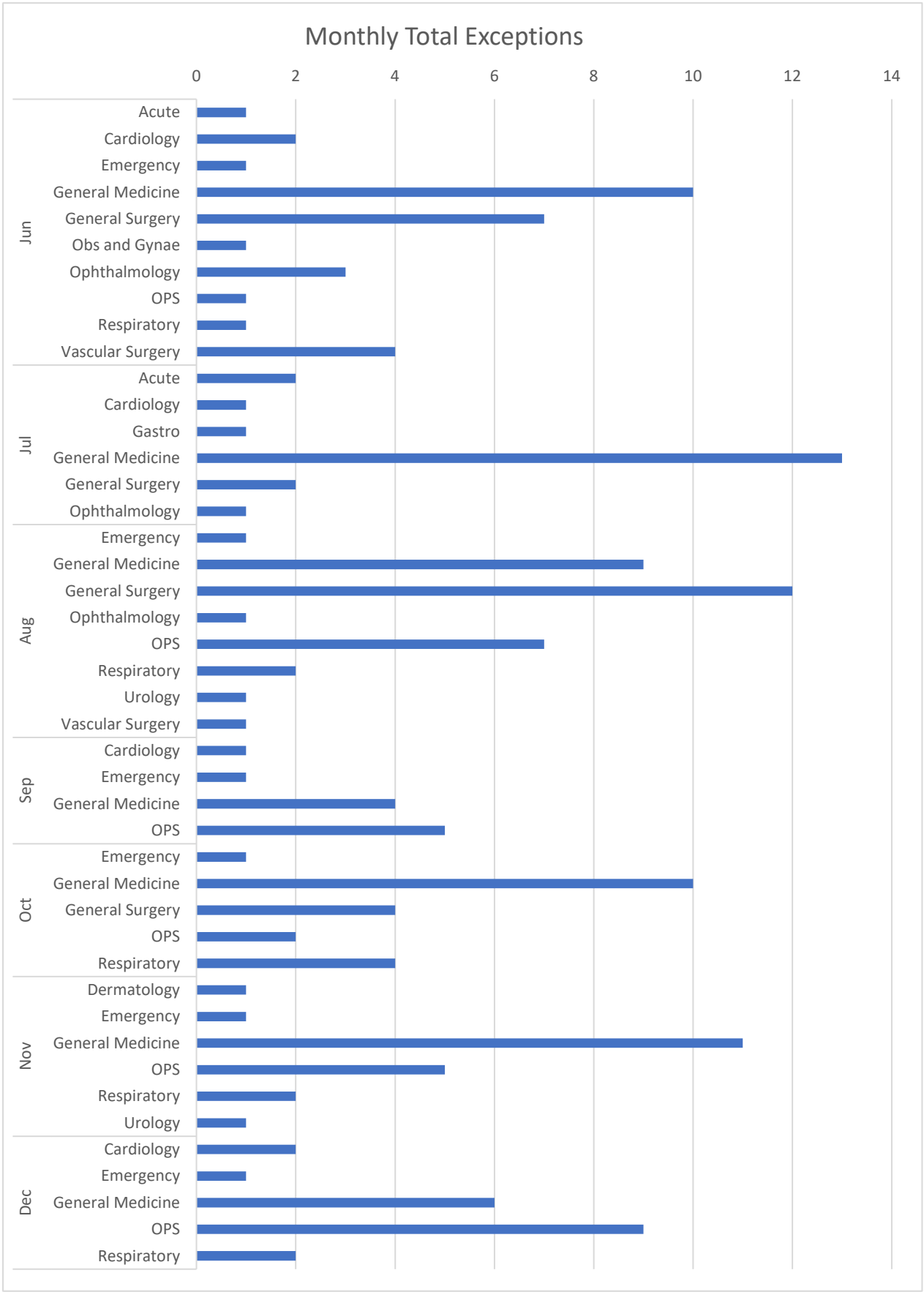

Monthly Total Exceptions
0
2
4
6
8
10
12
14
Jun
Acute
Cardiology
Emergency
General Medicine
General Surgery
Obs and Gynae
Ophthalmology
OPS
Respiratory
Vascular Surgery
Jul
Acute
Cardiology
Gastro
General Medicine
General Surgery
Ophthalmology
Aug
Emergency
General Medicine
General Surgery
Ophthalmology
OPS
Respiratory
Urology
Vascular Surgery
Sep
Cardiology
Emergency
General Medicine
OPS
Oct
Emergency
General Medicine
General Surgery
OPS
Respiratory
Nov
Dermatology
Emergency
General Medicine
OPS
Respiratory
Urology
Dec
Cardiology
Emergency
General Medicine
OPS
Respiratory

Figure 10

Reporting Grades for Period 1st January 2023 – 31st December 2023

Grade	Jan – Mar	Apr – Jun	Jul – Sept	Oct - Dec	Total
FY1	64	46	34	21	165
FY2	35	14	17	20	86
GPST1/2	0	0	0	0	0
ST/CT 1/2	20	11	7	15	53
ST3+ / CT3	9	6	7	5	27
Trust SHO	0	3	0	1	4

Source Medical Staffing Table 12

Table 12 provides an overview of the different grades of staff exception reporting for 2023, with a comparison for 2022 detailed in figure 11 below.

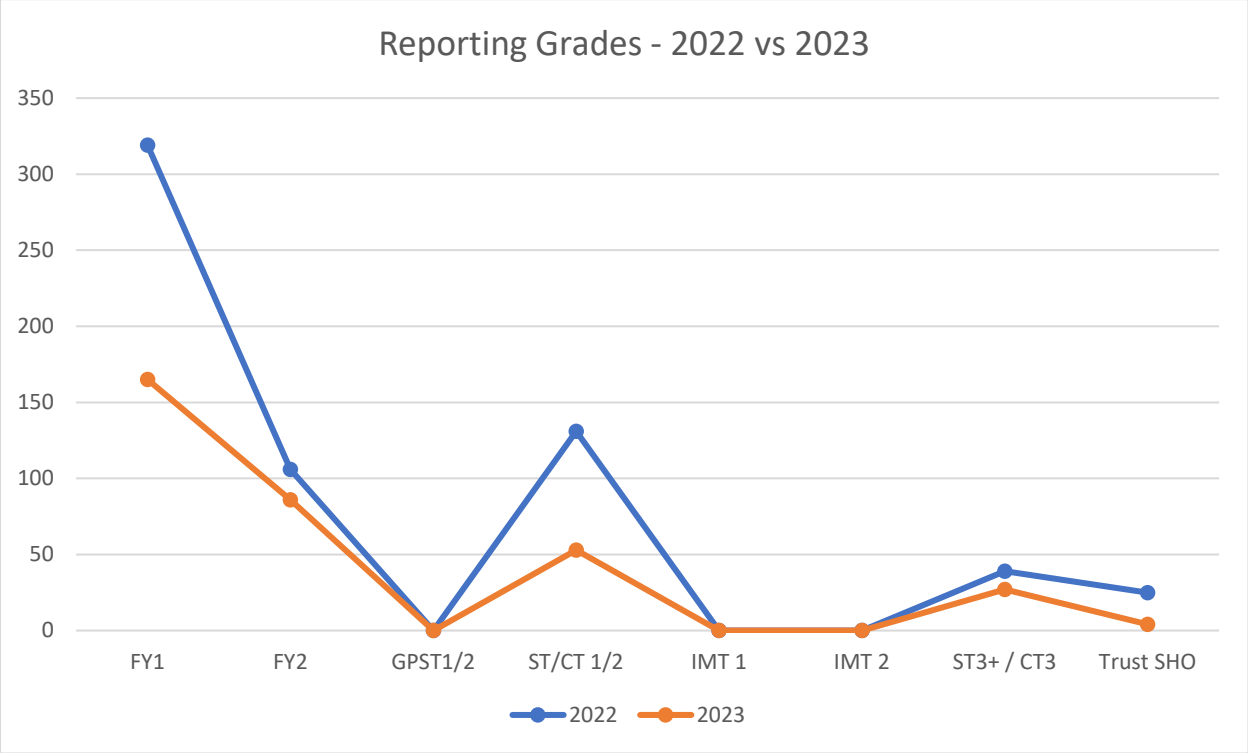
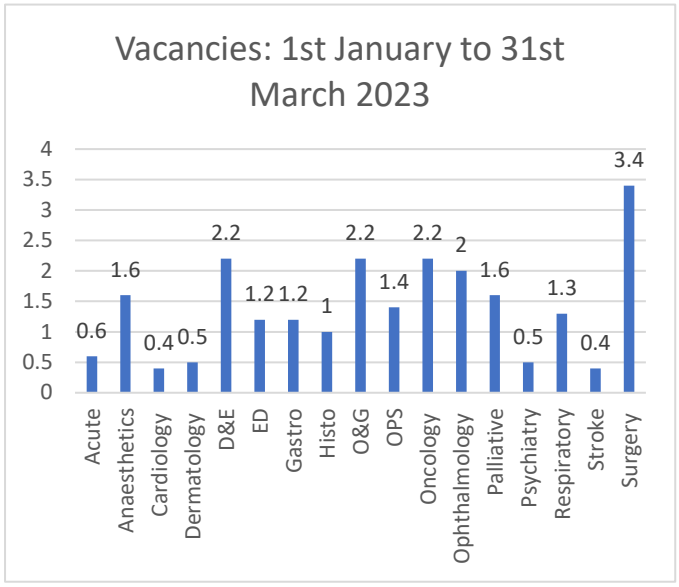
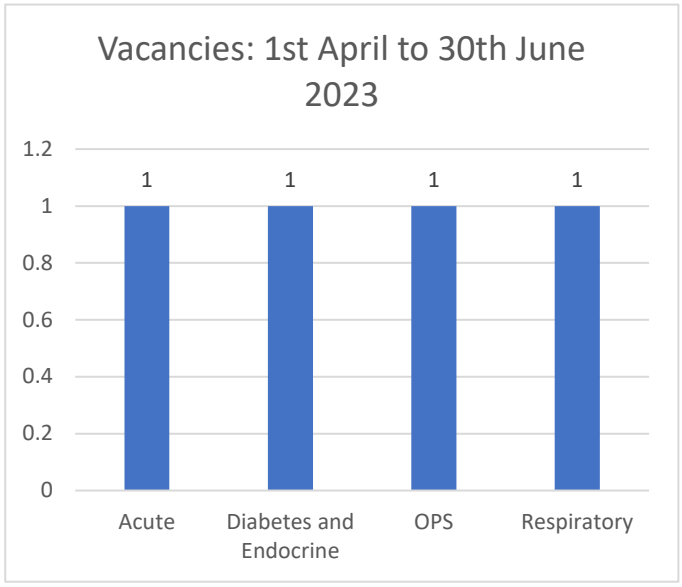


Figure 11

Vacancies Overview for 1st January 2023 to 31st December 2023





Source Medical Staffing Figure 12

Due to a lack of available data, we are unable to provide a vacancy comparison between 2022 and 2023.

Locum Shift Requests by Reason 1st January to 31st December 2023

The tables below provide an overview of the pressures of workload for our junior doctors.

The data below highlights an increase of 35% in the number of shifts requested from 2022 to 2023 from 6568 to 8869. Whilst in 2022, 56% of shifts requested were worked, in 2023 62% of the requested shifts were worked in comparison.

Of note, increases include Study Leave shifts, from 5 to 57 at 1040%, the 7 day pilot from 6 to 143 an increase of 2283% and Urgent Clinical Need from 11 to 261 a 2273% increase. As expected, the biggest decrease were the Coronavirus shifts, decreasing from 61 to 1, a 98% decrease.

Reason	Number of Shifts Requested 2022	Number of Shifts Worked 2022	Number of Shifts Requested 2023	Number of Shifts Worked 2023
7 day Pilot	6	3	143	55
Acuity	32	32	0	0
Adhoc	239	239	1105	1105
Annual Leave	78	70	275	164
Civil Duty	0	0	0	0
Coronavirus	61	50	1	0
Deanery Vacancy	477	268	335	205
Escalations	357	114	414	195
Leave - Emergency	1	1	1	1
LTFT Cover	2	2	159	48
Maternity/Paternity Leave	5	2	0	0
Service Demand (e.g winter pressures)	1386	466	1560	1082
Sickness	521	227	642	433
Study Leave	5	2	57	37
Trust vacancy	3374	2196	3904	2034
Urgent Clinical Need	11	2	261	116
Waiting List Initiative	13	13	12	11
Total	**6568**	**3687**	**8869**	**5486**

Source UHD Bank Staff Office Table 13

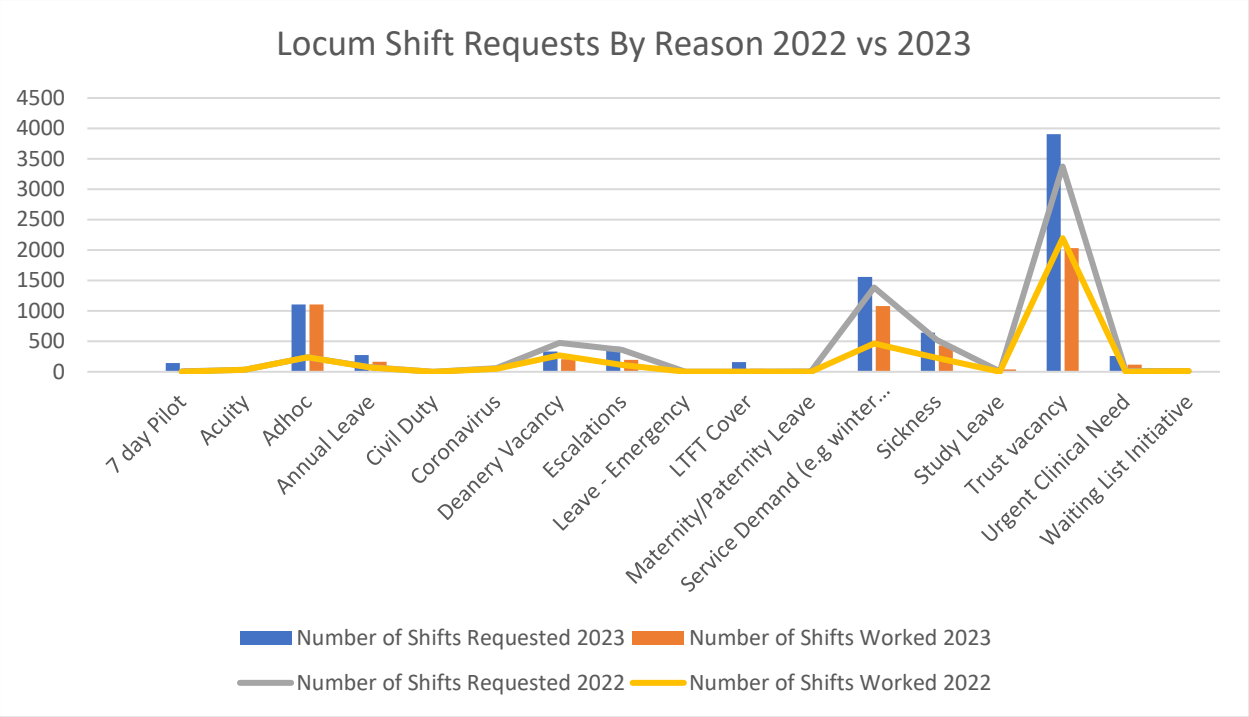


Figure 13

Locum Shift Requests by Speciality for Period 1st January to 31st December 2023

Highlighted are the total number of shifts requested from specialties and how many of these were worked. For comparison with 2022, please see figure 14 for comparison with 2022.

Specialty	Number of Shifts Requested 2022	Number of Shifts Worked 2022	Number of Shifts Requested 2023	Number of Shifts Worked 2023
Anaesthetics	28	26	55	46
Dermatology	3	3	0	0
Emergency Medicine	2420	1618	3349	2259
General Medicine	3405	1628	3890	2710
General Surgery	169	105	864	552
Haematology	0	0	0	0
O&G	39	30	0	0
Oncology	21	15	16	10
Ophthalmology	45	39	62	62
Orthopaedic Surgery	1979	906	401	341
Psychiatry	0	0	1	1
Urology	14	14	0	0
Vascular	3	3	1	1
Total	**8126**	**4387**	**8639**	**5982**

Source UHD Bank Staff Office Table 14

Emergency Medicine, General Medicine and General Surgery have remained the departments with the most shifts requested, equating to 93% of the total shifts requested in 2023 and 96% in 2022.

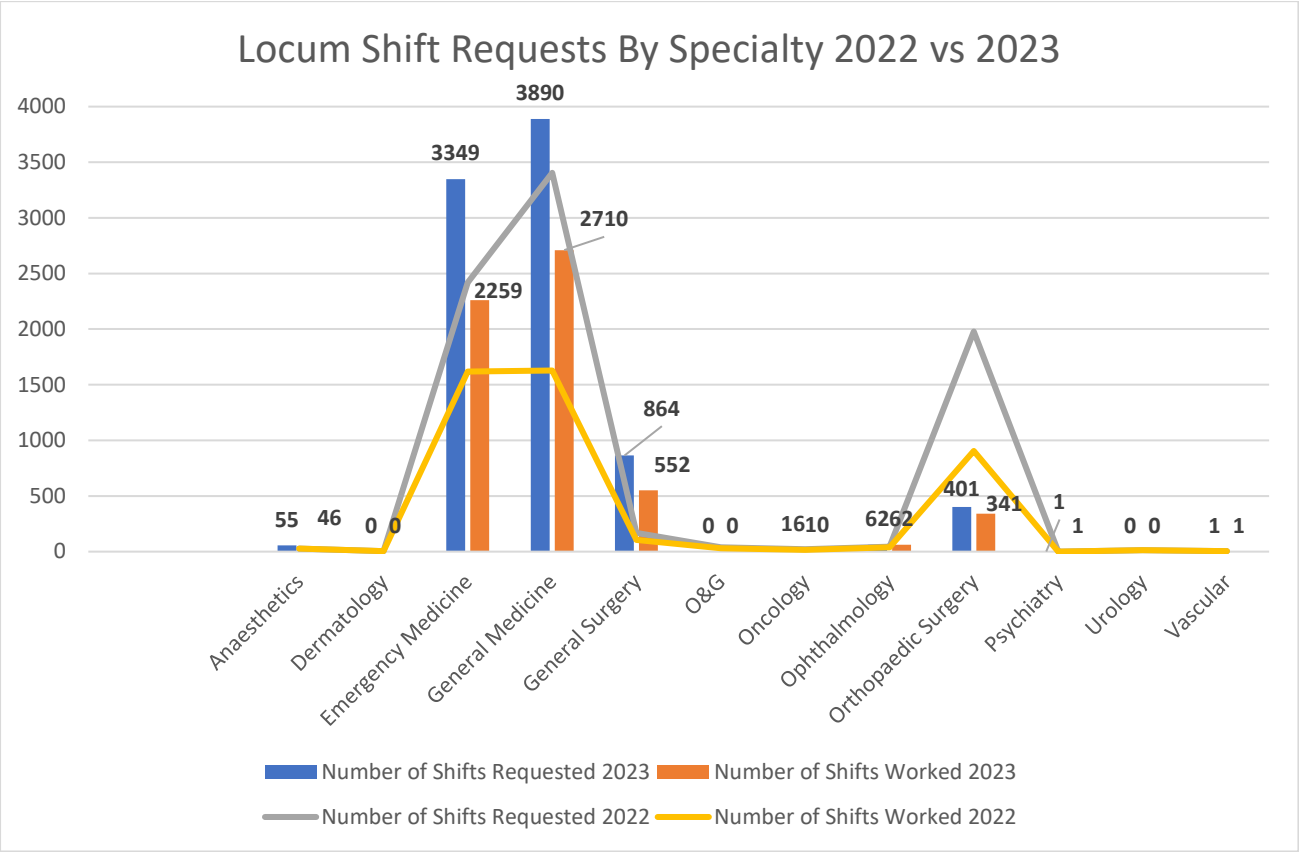


Figure 14

The figure below depicts the Locum Shift Requests by Specialty during 2023 broken down into their respective quarterly requests:

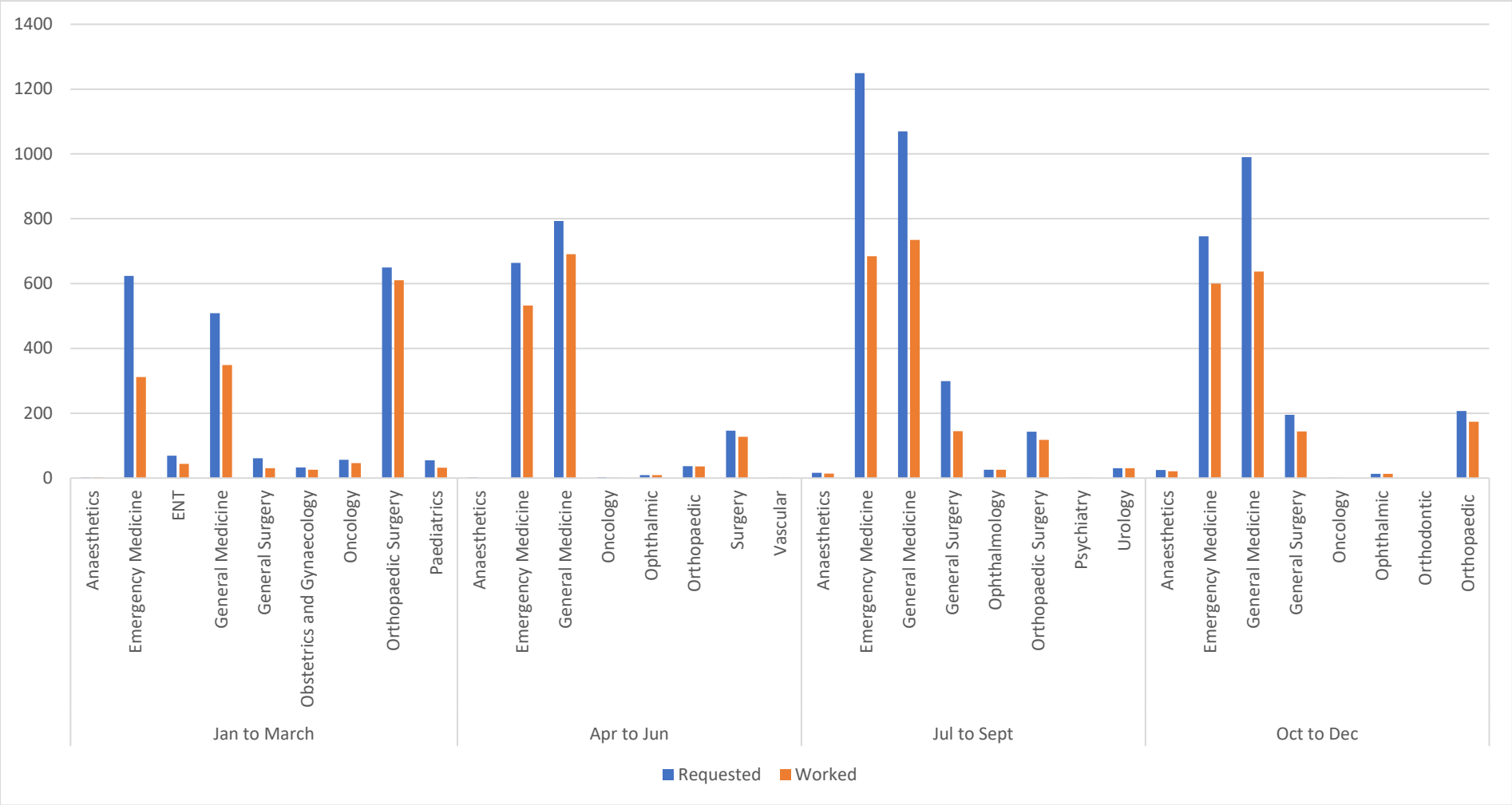


Figure 15

Summary

The year January 2023 – December 2023 has been characterised by Junior doctors' industrial action. It is very likely that this has impacted significantly on the metrics reported in this report

The total number of exception reports submitted during the year was 335. This showed a decrease of 46% from the previous year. The biggest changes were in General Medicine with a decrease of 58% and in Older person services with a decrease of 63%. It is not possible to be definitive about the causes for this drop but a lot of work has been put in place to improve staffing in these areas and this would have contributed to this drop as well as the industrial action which is likely to have caused a reluctance and despondency about exception reporting

The majority of exception reports raised relate to hours of working accounting for 80% of the total reports raised compared to 73% in 2022. Almost all these exceptions were settled by agreeing overtime payments.

There has also been a notable reduction in the number of immediate patient safety issues raised during 2023. The prevailing theme for immediate patient concerns was mostly related to the capacity to manage unwell patients when staffing levels were low. All ISC were raised to the directorates

The data below highlights an increase of 35% in the number of shifts requested from 2022 to 2023 from 6568 to 8869. Whilst in 2022, 56% of shifts requested were worked, in 2023 62% of the requested shifts were worked in comparison. Emergency Medicine, General Medicine and General Surgery have remained the departments with the most shifts requested, equating to 93% of the total shifts requested in 2023 and 96% in 2022.

This year the joint Junior Doctor Forum has been established and is now running regularly hosted alternately at Poole and Bournemouth Bi monthly

During 2024 The Guardian of safe working for each site with continue promoting Exception reporting at every induction and will continue working with Junior doctor representatives to support them in their work in the Trust. The Trust will also move exception reporting to Health Rota from August 2024.

Recommendations

1. Continue promoting a culture of exception reporting from induction, encouraging new doctors to exception report as per terms and conditions of 2016 Junior Doctor Contract.
2. Move Exception reporting to Health Rota from August 2024
3. Work with the Junior Doctor committee to support Doctors in Training and Locally employed doctors

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 01 May 2024

Agenda item: 6.5.1a

Subject:	Key Issues and Assurance Report to Board of the Finance and Performance Committee meeting held on 22 April 2024
Prepared by:	John Lelliott, Chair of the Finance and Performance Committee
Presented by:	John Lelliott, Chair of the Finance and Performance Committee

Key Issues/matters discussed by the Committee:	The Committee received the following: • Operational Performance Report including Board Assurance Framework: Risks 1 and 2; and Risks rated 12 and above • 2024/25 Financial Performance Month 12 including Board Assurance Framework Risk 7; Risks rated 12 and above • Draft annual accounts 2023/2024 • An update in relation to the Medium Term Financial Plan • Consultancy commitments • Electronic Health Record including Board Assurance Framework Risk 10 • Information Governance Report • Transformation Update including Board Assurance Framework Risk 9; Risks rated 12 and above • Annual Plan 2024/25 • Efficiency Improvement Programme Month 12 • Contract Decision Timetable • Risk Register – Heatmap. The Committee received certain recommendation reports which it approved or endorsed with a recommendation for approval by the Board.
Significant issues for escalation to Board for action:	There were no significant issues for escalation to the Board for action. However, the two assumptions in the 2024/2025 financial year to highlight to the Board were delivery of a 5% cost improvement target and the assumed level of elective activity performance. Focus upon the Electronic Health Record continued. In addition:

	• In relation to Operational Performance, the Committee noted the Trust having delivered a reduction in both referral to treatment waits greater than 78 weeks and 65 weeks in March 2024, but had not been able to recover against its trajectory to eliminate long waiters due to the in-year impacts of lost activity due to industrial action, workforce challenges and high non-elective bed occupancy. The Trust had delivered a 6% reduction in the RTT waiting list in 2023/24 and had maintained an improvement in 18 week RTT performance at 62% compared to 53.8% in March 2023. The percentage of fractured neck of femur patients operated on within 36 hours of admission improved in March 2024. • The Trust's year end financial position was reported to and noted by the Committee. • The levels of service for which the Trust was commissioned and the provision by the Trust would need further review. • During April 2024, the Trust would be considerably off plan. • A Board Development Session in relation to the Digital Strategy was recommended.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 01 May 2024

Agenda item: 6.5.1b

Subject:	Key Issues and Assurance Report to Board of the Finance and Performance Committee meeting held on 25 March 2024
Prepared by:	John Lelliott, Chair of the Finance and Performance Committee
Presented by:	John Lelliott, Chair of the Finance and Performance Committee

Key Issues/matters discussed by the Committee:	The Committee received the following: • Operational Performance Report including Board Assurance Framework: Risks 1 and 2; and Risks rated 12 and above • Theatres Deep Dive • 2024/25 Financial Performance Month 11 including Board Assurance Framework Risk 7; Risks rated 12 and above • Operational Budget Update 2024/25 • Electronic Health Record including Board Assurance Framework Risk 10 • Key IT Systems – Implementation and Programme Update • Transformation Update including Board Assurance Framework Risk 9; Risks rated 12 and above • Wessex Fields Update • Annual Plan 2024/25 • Private Patients Strategy Update • Efficiency Improvement Programme Month 12 • Contract Decision Timetable • Risk Register – Heatmap. The Committee received certain recommendation reports which it approved or endorsed with a recommendation for approval by the Board.
Significant issues for escalation to Board for action:	There were no significant issues for escalation to the Board for action. Some of the items presented to the Committee would also be considered by the Board.

University Hospitals Dorset
NHS Foundation Trust

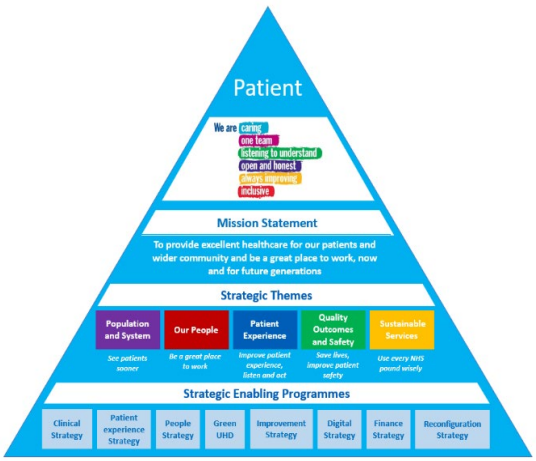
BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 01 May 2024

Agenda item: 6.5.2

Subject:	Annual Plan 2024/2025
Prepared by:	Alan Betts, Director of Integration
Presented by:	Richard Renaut, Chief Strategy & Transformation Officer

Strategic themes that this item supports/impacts:	Systems working and partnership ☒ Our people ☒ Patient experience ☒ Quality: outcomes and safety ☒ Sustainable services ☒ Patient First programme ☒ One Team: patient ready for reconfiguration ☒
BAF/Corporate Risk Register:	All BAF Risks
Purpose of paper:	To provide for approval by the Trust Board on the annual plan for 2024/25.
Executive Summary:	**National/System Update** The national planning guidance has been released but finance allocation and activity assumptions/targets at Dorset system level are still "live". Key issues include a 5% cost improvement, a 109% activity level compared to 2019/2020 and reducing of headcount. **UHD Annual Plan 2024/25** 

	The plan is aligned with our Patient First approach, and strategic objectives. The plan will inform all staff objectives based around the five priorities: On-going discussions with ICBs on finance and activity submissions will continue to refine the details.
Background:	The Annual Plan summarises the UHD plans for a range of priorities organized under our strategic themes, and within the patient first triangle.  Feedback from governors, staff and commissioners has helped develop this plan. For further information on the feedback see the information note in the reading room.
Key Recommendations:	(1) To approve the UHD annual operating plan for 2024/25. (2) To focus now on delivery and regular updating of the plan. This will be tracked via the Strategy Deployment Reviews (SDRs). (3) To note that the plan will be used to prepare for objective setting and appraisals across the organisation.
Implications associated with this item:	Council of Governors ☒ Equality, Equity, Diversity & Inclusion ☒ Financial ☒ Health Inequalities ☒ Operational Performance ☒ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☒ Regulatory ☒ Strategy/Transformation ☒ System
CQC Reference:	Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well Led ☒ Use of Resources ☒

Report History: Committees/Meetings at which the item has been considered:	Date	Outcome
Trust Management Group	19/03/2024	Recommendations agreed.
Finance & Performance Committee	25/03/2024	Reviewed
Finance & Performance Committee	22/04/2024	Approval
Council of Governors	04/04/2024	Reviewed
Board of Directors	03/04/2024	Draft agreed

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

Appendix 1 – 2024/2025 UHD Operational Plan (Master Version)

University Hospitals Dorset
NHS Foundation Trust

2024/25 Operational Plan: University Hospitals Dorset NHS Foundation Trust

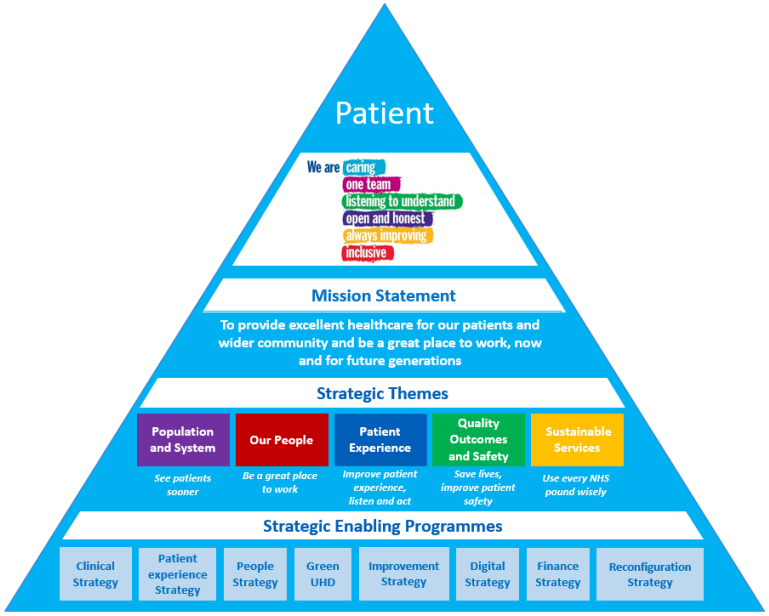
MASTER VERSION

Contents

1. Foreword – A Year of Transition Ahead

As we look forward to 2024/2025 as a team, dedicated to our patients and public, there are mixed emotions. There is hope, for the exciting future we are creating, trepidation at the scale and range of challenges, and pride at the awesome staff, partners and volunteers who deliver amazing things 24 hours a day, 7 days a week.

What this plan sets out to do is provide the framework guiding our efforts to achieve our vision. This is summarised in our triangle.

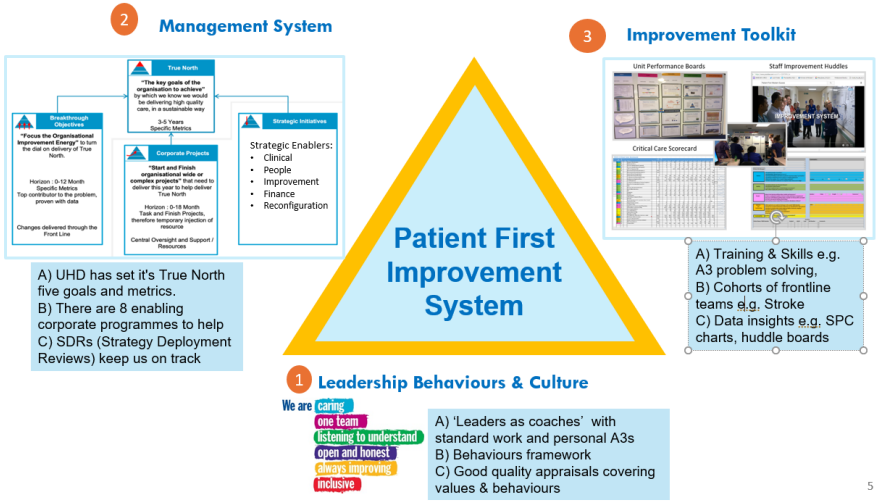


For 2024/2025 we have five objectives that every member of staff should be contributing to. These are:

It is my role as Chief Executive to ensure we create the conditions for all our staff to thrive. That way we can make real, tangible progress in all five areas. How we do that, and all the supporting plans required, are summarised in the Patient First Improvement System (PFIS) below, and in the pages that follow. As we start this year, we need a sense of curiosity. To enquire, to listen, to understand, go and see. The solutions lay with our staff and patients – where the magic happens, that makes great healthcare and a great place to work.

PFIS has three parts:

1. Living our values, and the behaviours that reinforce our Patient First approach, will be more and more about how we succeed in the future. This fits within our revamped management system.
2. Providing greater alignment and better ways of delivering major changes. Key to these are our 8 corporate projects and 10 breakthrough measures.
3. Having the tools and training for continuous improvement being deployed at scale in services.



This is a journey that will take many years, to embed our Patient First way of working. It is also accepting "better never stops". Learning from other NHS Trusts that started their similar journeys eight or nine years ago, shows we need to have perseverance and a willingness to change, along with the self-discipline and psychological safety for staff and services to thrive. With our values and twelve positive behaviours, we are set for the first full year of our exciting Patient First journey.

UHD's Values and 12 Positive Behaviors

With very best wishes
Siobhan Harrington

1.1 Background – enabling future success

University Hospitals Dorset NHS Foundation Trust (UHD) has an exciting future ahead, built upon many years of progress across a broad range of areas. These include:

- Creation of the largest planned care hospital in England by 2026.
- Creation of the major emergency care hospital, starting with the opening of the BEACH building in 2025.
- Integrated community neighbourhoods, as part of our NHS Dorset vision of Dorset becoming the healthiest place to live in the UK.
- A digital future, including an integrated electronic health record across Dorset and Somerset by 2026.
- A green and sustainable future, including 80% decarbonisation by 2030 and other targets set out in our Green UHD Strategy, including significant energy reduction investment in 2024.
- A workforce strategy, which has seen significant achievements already, including cutting our vacancies from 9% to 6%, and improvements across the board in our staff survey.
- A patient experience strategy agreed in 2024 which maps out improving our partnership with patients and listening to improve.
- Our clinical strategy, based upon the Clinical Services Review and creation of planned / emergency separation. This will be updated in 2024/2025 as part of our work to set our ambitions, by service, for the next ten years.

These form our enabling strategies to help us achieve our "True North" mission of excellent care, and a great place to work. They each have a background, based on many years of effort, and a forward looking, optimistic and ambitious approach.

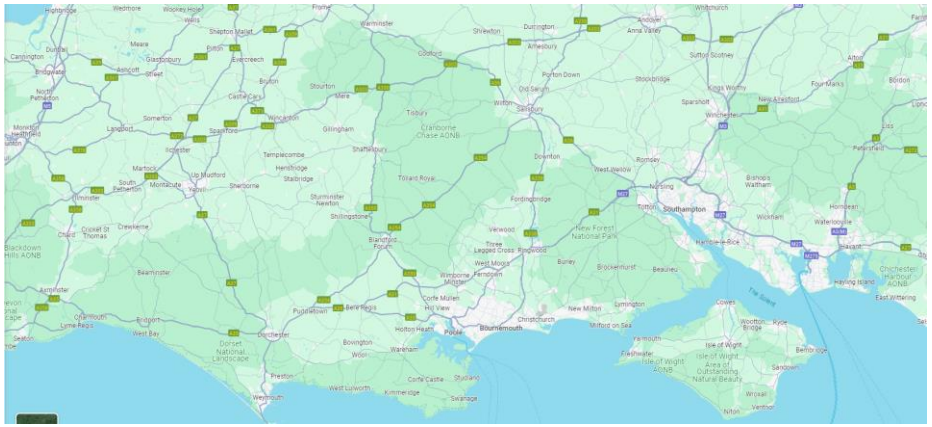
For an organisation formed by merger in October 2020, that has navigated Covid, industrial action and major construction programmes, this shows how we are both responsive to todays issues whilst also laying strong foundations for our future.

1.2 Our Trust and our communities

UHD serves Bournemouth, Poole and Christchurch, East Dorset and Purbeck, and parts of the New Forest for most hospital services. This is a population of around 750,000 with one of the most elderly populations in the UK. Significant health inequalities exist. For more information see the Director of Public Health report: (Annual report 2022-23)

Our specialist services also serve the whole of Dorset, South Wiltshire and parts of Hampshire, for a population of around 1 million. These services include Oncology, Neurology, Vascular, Cardiac and Interventional Radiology, along with specialist areas in services like Surgery.

Our three main sites are Poole, Royal Bournemouth and Christchurch hospitals. We also have services in many community setting including patient's homes. Our Outpatient Assessment Centre at the Dolphin Shopping Centre (Poole) is also popular. We then have many staff working offsite at Yeomans Way, Discovery Court and Alderney Sterile Services.



UHD employs around 10,000 staff including via our staff bank. We are blessed with hundreds of volunteers and strong partners, and have a thriving charity and allied independent charities.

All this stands us in good stead for what are significant challenges to meet the health needs of our population, which is ageing and growing, by about 1% per year. In addition the local area remains popular for 30,000+ students and over one million visitors a year.

More detail at service level is set out in the annexe.

1.3 Vision, Values and Strategic Themes

We are part of an integrated system of health and care, working towards making Dorset the healthiest place to live in England. That requires us to not just change, but transform in many ways. All our enabling strategies have this vision and a transformative ambition. Whilst this is an Annual Plan, it is a stepping stone to those positive transformations.

Our values have been developed as a result of engaging with and listening to our staff to understand 'what is important to them'? This appreciative inquiry was carried out over many months with the support of our culture champions - a representative group and cross section of staff across UHD.

Our values underpin our vision and mission. They are the standards shared by all UHD staff. They guide our day to day decisions and the way we behave. They describe what is important to us and 'the way we do things around here'.

What is striking about the values developed by staff is their duality. Each one consistently and equally speaks to the values for staff **and** for patients. This is a very distinct feature.

Patient First is the overarching strategy for University Hospitals Dorset. It's our guiding principle at the heart of everything that we do. It's also the long term approach we take to transforming health services. It sets out that our True North is the 'patient first and foremost'. This is supported by the values of compassion, teamwork, communication, respect, continuous improvement, and inclusion.

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

This is a journey that will take many years and includes delivery of our key strategic enabling programmes that will set us up for success. Taken together this is an ambitious plan, that will require our upmost ability and resilience to see through but is

the right thing for us to ensure we achieve putting our patients first.

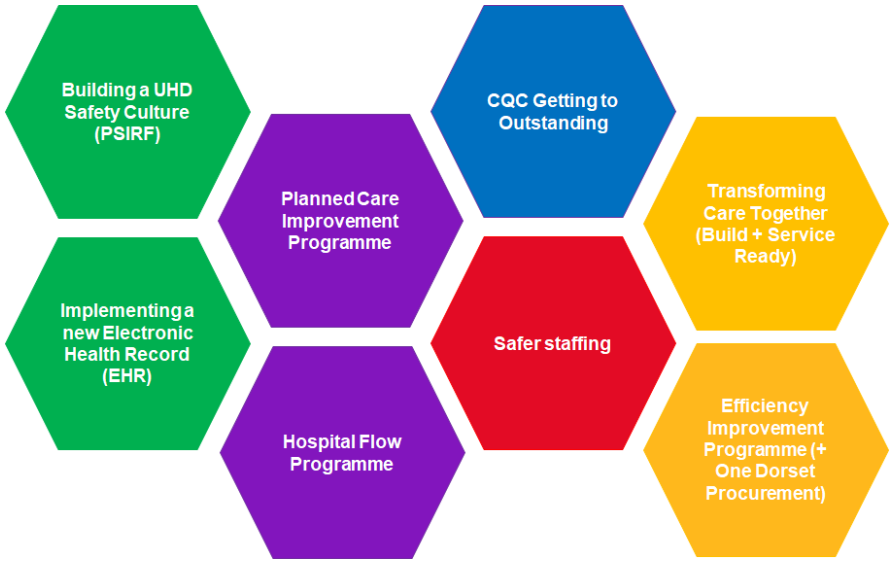
Our strategic themes will support the delivery of our vision and shape our 'breakthrough' annual objectives and enabling programmes. The five strategic themes are:

PATIENT EXPERIENCE	All patients at UHD receive quality care, which results in a positive experience for them, their families and carers. Every team is empowered to make continuous improvement by engaging with patients in a meaningful way, using their feedback to make change
QUALITY OUTCOMES AND SAFETY	To be rated the safest Trust in the country and be seen by our staff, as an outstanding organisation for effectiveness (Hospitalised Standardised Mortality Ratios - SMR) and patient safety (Patient Safety Incidents - PSIs)
SUSTAINABLE SERVICES	To maximise value for money enabling further investment in our services to improve the timeliness and quality of care for our patients, and the working lives of our staff
OUR PEOPLE	To be a great place to work attracting, developing and retaining the best talent
POPULATION AND SYSTEM	Consistently delivering timely, appropriate, accessible care as part of a wider integrated care system for our patients

Within the next 12-18 months we aim to achieve the following which are known as our breakthrough objectives:

Strategic Theme	Breakthrough Objective SHORT TERM: 12 – 18 MONTHS
POPULATION AND SYSTEM	• **Planned Care** - to have no patients waiting in excess of 52 weeks on an RTT pathway to be seen and treated •**Emergency/Urgent Care:** >77% of patients treated within 4 hours through the emergency care pathway
OUR PEOPLE	To deliver improvements in the NHS Staff Survey Results for: • "I would recommend my organisation as a great place to work" > 62% • Staff Engagement Score >7/10
PATIENT EXPERIENCE	• A 5% improvement in employees who see patient care as a top priority for UHD • To increase the Friends & Family Test (FFT) and Have Your Say (HYS) feedback rates by 30%
QUALITY OUTCOMES AND SAFETY	• HSMR <100 • Improve Staff Survey safety culture questions by 5% • Implement MaPSAF
SUSTAINABLE SERVICES	• To fully deliver the budgeted Efficiency Improvement Programme target of £30.3m (4%) with at least 80% recurrent

Progress has been made in 2023/2024 in these areas, but there is a long way to go. To help us get from here to there we have the following eight organisational wide and/or complex projects. They all need to deliver within 1 to 2 years to enable us to deliver our strategy. They are, each in their own right, a "blockbuster" programme with their own governance and projects. All are overseen by the Trust Management Group (TMG) the most senior operational group in the Trust.



These are covered in more detail in the specific sections within this document. Whilst the colour coding links to the primary strategic theme, all projects support multiple areas. They are therefore reinforcing each other and our transformation efforts.

1.4 Patient First and our Improvement Strategy

We are developing a culture of continuous improvement to support the delivery of our refreshed strategy and strategic priorities.

We believe that our staff working together in their teams are most engaged in their roles when they have a degree of authority and control over their work and environment, as well as the opportunity to stretch themselves and develop.

We also aspire to a new style of leadership, working alongside our frontline staff to better understand their practical challenges, supporting them to remove barriers and tackle daily frustrations.

Patient First will help us all by improving the way we work at UHD. It is not a 'quick fix', it will take time to embed and deliver this commitment across the whole organisation to ensure we rise to the challenges ahead and grow our UHD family.

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

Patient First is a systematic approach to improvement led delivery of quality that will help build upon UHD strong foundations and what works well within the organisation. It will refresh our culture of excellence and further developing *the way we do things around here*.

All of this will require a different way of working to unleash the passion and skills of our staff, create a sense of belonging, and promote a more inclusive service and workforce, so that all people will want to stay and positively contribute to the success of our organisation.

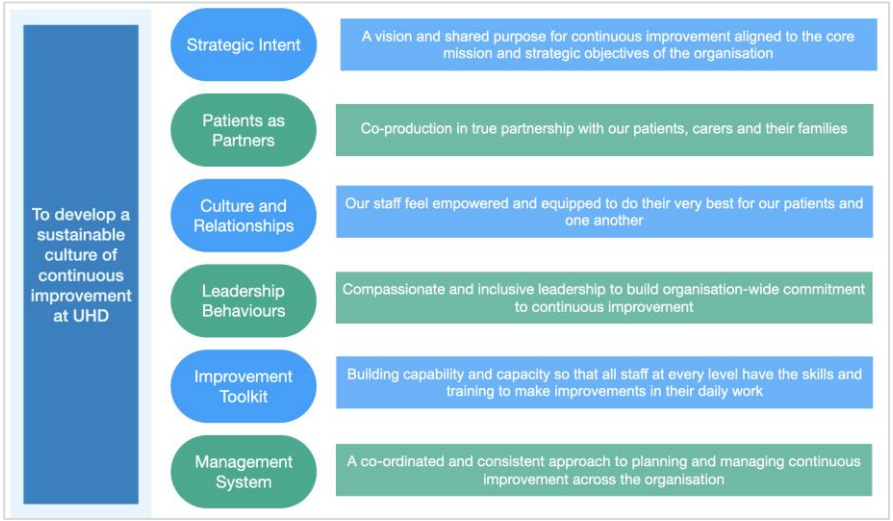
The first clinical services using this approach are Stroke, Critical Care and Christchurch Day Hospital. The next group starting in 2024 are Maternity, Paediatrics and Acute Medicine. Further cohorts of services will be selected over 2024/2025.

Patient First is the UHD Improvement Method

Patient First has a vision to develop a sustainable culture of continuous improvement at UHD. At its heart is an acknowledgement that when staff thrive our patients experience sustained improvements in the quality and experience of their care.

Our Patient First improvement strategy sets out our approach and proposed arrangements for a Patient First continuous improvement system, to be deployed organisation wide over the next three years.

To support delivery of our organisational strategy and priorities and ensure we create the right conditions for continuous improvement, we will adopt the following principles:



2. Patient Experience

True North Goal - Improve patient experience, listen and act	All patients at UHD receive quality care, which results in a positive experience for them, their families and carers. Every team is empowered to make continuous improvement by engaging with patients in a meaningful way, using their feedback to make change.
Breakthrough Objectives	A 5% improvement in employees who see patient care as a top priority for UHD To increase the Friends & Family Test (FFT) and Have Your Say (HYS) feedback rates by 30%
Corporate Projects	***CQC Getting to Outstanding*** – One plan with one purpose to coordinate delivery of improvements in order that: • Staff feel they work in an outstanding organisation committed to delivery of great care. • There is structure, capacity and resilience to excel going forward • We are confident that we will be able to demonstrate we are well led.

The UHD Patient Experience and Engagement Strategy 2023-2025 sets out how the Trust will deliver the patient first objectives and guide how we will continue to meaningfully engage with patients during the continued transformation of our services.

As part of the Patient First journey, our patient experience **CARE** Priorities further expand on the trust priority of 'improving patient experience' by acting on feedback. The **CARE** priorities for the organisation are the following;

Continuous Feedback- increasing the opportunity for patients to give their views on their care and increase accessibility by using different methods to enable patients to tell us about their experiences.

Areas for Improvement- teams use this feedback to recognise and drive changes, ensuring any improvements that are made deliver the intended improvement.

Recognising People- ensuring all patients who use our services are heard, by actively seeking out their opinion through engagement with the community.

Excellent Partnerships- working with health, social and voluntary partners to understand the views of the public and work together to solve problems.

The **CARE** Priorities link to our trust values. The strategy describes what activities and measures will be taken to achieve these Priorities. During 2024-2025 it is expected that the **CARE** priorities, set out in the strategy will be realised in full, with the outcome being outstanding care for our patients.

Clear and transparent communication with the public about the transformation of our services has been vital and will

continue into 2024-2025, where plans for moving of services across UHD will be realised. The public and patients of the hospitals have been extensively involved in decision making through the Clinical Services Review engagement, but this was several years ago. Therefore, this next phase will include being informed of the changes and provided with educational materials and workshops to understand what the transformation will mean to them. Involvement includes co-designed workshops for the transformation of services e.g. stroke services. Similar involvement of our patients is planned into future transformation, which will include larger scale workshops and smaller group work for particular changes.

2.1 Care Quality Commission (CQC)

During 2023/24 the CQC undertook short notice announced focused inspections to urgent and emergency care services (Emergency Departments at Poole Hospital and Royal Bournemouth Hospital) as well as Outpatients at Poole Hospital and the Outpatients Assessment Clinic at Dorset Health Village on 27 and 28 June 2023.

As it was a focused inspection, no ratings were produced but CQC focused on the key questions of well-led, safe and responsive for these services as well as caring for urgent and emergency services at both hospitals. University Hospitals Dorset NHS Foundation Trust is yet to receive a rating by CQC for its services or hospital locations.

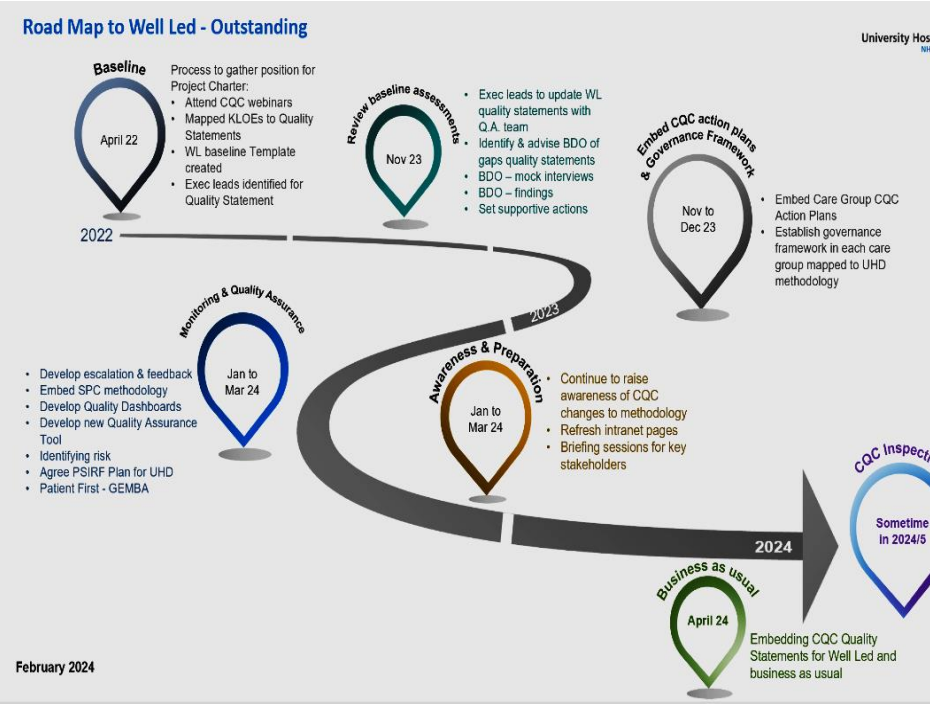
Poole Hospital remains rated 'Requires Improvement and Royal Bournemouth Hospital remains rated 'Good' overall. However, we aspire to be "Outstanding" and have established a corporate project and roadmap for success.

The project plan includes:

- Completion of a baseline assessment against the new Care Quality Commission Quality Statements for Well led
- Creation of well led action plan from the completed baseline assessments
- Provision of briefing sessions to staff to raise awareness about the new Care Quality Commission single assessment framework. Ensuring staff are aware of the new quality statements, evidence sources and assessment methodology that will be used for future inspections.
- Provision of resource materials to help teams discuss the new Care Quality Commission methodology and help teams prepare for the new style inspections.
- Utilise our Patient First work to support best practice, innovation and quality improvement
- Ensure ongoing monitoring of CQC action plans to address the issues highlighted in previous reports. The Trust Management Group and Quality Committee will ensure oversight of effectiveness of the actions identified.
- Horizon scan reports published by external bodies such as the Care Quality Commission, NHS England and

Health Services Investigations Body, to learn from others and aim for continuous improvement. External reports and reviews on our services, and the services of others, are an important part of the quality approach at UHD, and we will continue to use these to understand where further improvements to our services can be made.

- Develop and implementt peer review and ward accreditation processes to support assurance against quality statements



3. Quality Outcomes and Safety

***True North Goal* – Save lives, Improve patient safety**	To be rated the safest Trust in the country and be seen by our staff, as an outstanding organisation for effectiveness (Hospitalised Standardised Mortality Ratios – SMR) and patient safety (Patient Safety Incidents – PSIs)
Breakthrough Objectives	Reduce HSMR <100 Reduce PSI by 5%, Improve staff survey safety culture questions by 5%
Corporate Projects	***Building a UHD Safety Culture (PSIRF) –*** Developing a culture and programme plan of safety that will deliver: • PSIRF – e-learning from deaths, formal investigator and compassionate engagement training. Patient Safety syllabus • LfPSE – Learning from Patient Safety Events • Safety skills and leadership training • Business Intelligence for quality and safety ***Implementing a new electronic health record (EHR)*** - To sign a contract with an EPR vendor by 31.3.2024 that enables UHD to begin its migration off the current EPR (which is expected to take at least 2 years).

3.1 Clinical Strategy

At a high level our Clinical Strategy is to deliver the Clinical Services Review from 2019. For UHD this is the creation of the planned and emergency hospitals by 2026, supported by £500m capital investment. The programme is a once in a generation change unlocking huge benefits. Implementation is already well underway (see Transforming Care Together, section 6.3). In 2014/15 key service changes include Pathology, Haematology, Stroke and Maternity and preparations for virtually every other service affected in 2025/2026.

Looking beyond that change, the need for a clinical strategy for the next 10 years, now needs to be developed. The critical phase of work in 2024/2025 will provide the framework. Alignment with clinical strategy development across Dorset and Hampshire will be required both through and with the Dorset Provider Collaborative. This will need to start with how best to meet our populations needs and to navigate the limited resources available. Exploiting opportunities, especially in technology, research and innovation will be important.

Workforce trends and developing staff, including with education providers, will assess opportunities for Dorset, including more Allied Health Professionals and a Medical School.

The clinical strategy will need to be meaningful and owned at specialty level for it to truly shape our future. This will mean significant time, and numerous iterative stages of work before completion, expected in 2025/2026.

3.2 Building a UHD Safety Culture

The corporate projects for 2024/2025 includes ***Building a UHD Safety Culture***

- Development of a patient safety strategy for UHD which focuses on using the experiences of staff and patients to identify opportunities for learning and improvement.
- Development of an implementation and transitional plan for the new Patient Safety Incident Response Framework (PSIRF)
- Development of an integrated framework for patient safety, quality improvement, transformation and innovation that maximises resources and reduces duplication
- Development of the UHD Patient Safety Culture Assessment Tool.

The Patient Safety Incident Response Framework (PSIRF) is a fundamental cultural safety change in the way we think, report and investigate incidents. Our Patient Safety Incident Response Plan, based on the NHS framework, focuses on

learning and improvement. It is built on a culture in which people feel **safe to talk**, and we will be working **in partnership with patients** to improve.

With compassionate engagement, we want to:

- Improve the experience for patients and families whenever a patient safety incident occurs.
- Reduce harm from patient safety incidents through learning and improvement.
- Support compassionate leadership, just culture and learning for improvement.
- Work with system partners to undertake thematic reviews of patient safety across care pathways.
- Improve the safety and care we provide to our patients.
- Maximise our resources to support quality and safety.
- Train staff in improvement methodologies.

We will be looking for themes and interconnected causal factors. This way, we aim to reduce repeat patient safety risks and focus on the quality, rather than the quantity, of patient safety investigations. Investigations will be viewed as improvement projects with clear plans.

Our Patient Safety Incident Response Plan (approved in December 2023) set out our Patient safety priorities for Team UHD for the next 12-18 months. We will focus on**:**

- Patient falls
- Medication safety
- Hospital Acquired Pressure ulcers
- Diagnostics processes, specifically the follow up of radiology and laboratory investigations
- Deteriorating patient management
- Mental health (management and reducing restrictive interventions)
- Post-partum haemorrhage
- Unexpected term admission to neonatal intensive care (NICU)
- Still births

We aim to engage with patients, carers, relatives and Patient Safety Partners in our improvement and learning responses to patient safety incidents and we will provide training for our staff in investigation skills, report writing and compassionate engagement. We will also look to improve how we support staff involved in a patient safety incident and create safe spaces for open and honest reporting and learning. We will develop additional feedback mechanisms to share learning and improvement across the Trust and within the wider community.

Measuring and improving safety culture within teams and across the trust is a key component of our Patient First strategy and Patient First objectives.

We have adapted some of the language used in the original 2006 Manchester Patient Safety Framework tool to create a bespoke UHD Patient Safety Assessment Culture Toolkit. The UHD PSaF Tool links to the UHD Trust values and Patient First objectives and will support staff to look think about the strengths and weaknesses of the patient safety culture in their teams and consider what a more mature safety culture might look. Teams will then use patient first improvement methodology to look at areas for improvement and also to share good practice. We aim to roll out UHD PSaF across the Trust over the next 12 months.

3.3 Implementing a new PAS/EHR

The UHD Board of Directors supported a decision in December 2023 for Dorset to collaborate with Somerset Foundation Trust in order to address the affordability of achieving an Electronic Health Record Solution (EHR) for each ICS. The collaboration will bring some savings in terms of the overall costs, e.g. a single instance across the regions, staffing costs associated with the configuration effort and third party systems costs. Following National and Regional advice it has been agreed to develop a single Outline Business Case (OBC) covering both Somerset and Dorset.

The OBC will be prepared for submission to NHS England by May. There is a five-month process for approval. This should lead to the procurement commencing in Autumn 2024. Contract award should be April 2025 with implementation from October 2026.

The scope of the EHR is all the patient related IT Systems in the Acute Trusts excluding the scanned records, PACS system and Pathology system. The increased scope includes Mental Health and Community being in the same solution, with future aspirations for Primary care and Social Care to move onto the same single system.

The joint EHR Programme will deliver transformational change to digitise and modernise our technology landscape to support higher quality care. It will also be a sustainable solution. By creating a joined-up electronic heath record and harmonising our care pathways, this delivers many benefits:

- eliminate unwarranted variation and waste,
- unlock efficiencies and financial savings,
- retain, and attract the best workforce,
- deliver the best care across our services.

All these achieve better patient outcomes.

The current plans for UHD are to continue to ensure that the existing systems in the Trust are kept up to date and supported, until the new system is implemented. The following programmes of work therefore are required:

- An upgrade to the order communications system along with looking at an interim solution for closed loop result management to reduce the risk of Serious Incidents associated with pathology and radiology results.
- Expansion from the proof of concept to the next stage of deployment of the Strategic Integrated Image Solution (SIIS) as part of the south-east three diagnostics network
- A systematic rolling stock replacement of all layers of our technical infrastructure and end-user devices
- Work to achieve a fully compliant Data Security and Protection Toolkit submission will also be continued.

4. Our People

True North Goal - Be a great place to work	To be a great place to work, attracting and retaining the best talent
Breakthrough Objectives	To deliver improvements in the NHS Staff Survey Results for: • "I would recommend my organisation as a great place to work" > 62% • Staff Engagement Score >7/10
Corporate Projects	***Safer Staffing*** – **There is a need to establish baseline workforce data in order to improve confidence in workforce deployment, utilisation and planning** Agreed staff establishment is aligned financially and professionally Agreed process for identifying and changing future workforce and staff in post maintains currency and accuracy Systems use, Rostering process and quality assurance processes in place ensuring optimum use - including staff satisfaction Provision of management analytics to inform workforce deployment decisions and Board assurance

4.1 People Strategy

National guidance sets out the requirement to accelerate plans to grow the substantive workforce and work differently as we keep our focus on the health, wellbeing, and safety of our staff. It sets out the need to invest in our workforce, with more people tackling substantive gaps in acute care. It emphasises new ways of working and strengthening the compassionate and inclusive culture needed to deliver outstanding care. Our people have remained under increasing pressure and have also been impacted by the cost-of-living crisis, workforce capacity issues and a need to focus on the large-scale integration and transformation plans that UHD have in place.

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

Our overarching ambition and True North goal is to be within the top 20% of acute Trusts for the National staff engagement score along with increasing the number of staff who would recommend the organisation as a place to work. This will support us to improve our people's experience and ensure the Trust is a great place to work, attracting, developing and retaining the best talent.

We know there remains a shortfall of trained people to meet the rising demands for healthcare. We will need to be more flexible, creative and innovative in how we attract, retain and develop our people. This then enables us to fulfil our core purpose and achieve our vision. A key focus on workforce planning. Our work continues to be underpinned by the principles of the NHS Long Term Plan, the CQC Well Led domain and the NHS People Plan.

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

Key Actions for 2024/25:

Compassionate and Inclusive Leadership

We will continue to place health and wellbeing at the heart of our line manager's duties, encouraging them to have meaningful conversations, giving feedback and communicate clearly and consistently about expectations and objectives. Ensuring the strong voice of staff is essential to ensure their involvement and innovation. We recognise colleagues that most need help are the most unlikely to speak up. We will also continue to face the inequalities agenda head-on, with a particular focus in 2024/25 on improving key Workforce Race

Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) indicators.

Key actions:

- Continue focussed work on the Trust's cultural development programme to embed organisational values and ensure the voice of our staff continues to be heard.
- Launch our new online *Thank You* tool, and a new annual staff award event to show staff how proud we are of everything they do for UHD.
- Continue focus on supporting our managers to have valued based appraisal conversations with a focus on individual development and aligning objectives to the Trust's True North.
- Further integrate our leadership and lifelong learning offers for staff including apprenticeship and accreditation opportunities in partnership with Bournemouth University and further developing a modular programme to support basic people management skills and competencies.
- Develop a Talent Management strategy aligned to *Patient First* and the needs of our workforce – a co-ordinated approach to attracting, developing and retaining our staff and harnessing their potential
- Review the 2023 staff survey results at team, directorate and care group level and design improvement interventions, including:
    - increase in % BAME composition target to improve leadership diversity by 2025
    - improvements in our Black, Asian and minority ethnic disparity ratio
    - continue to implement priorities within our *Leading for Equality, Diversity and Inclusion* plan and health inequalities within our staff groups.
- Continue to enhance staff network engagement and intersectionality to strengthen contribution to organisational decision-making process.

Systemic Wellbeing Offer

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

Key actions:

- Further develop our Mental Health First Aid (MHFA) and Wellbeing Ambassador programmes.
- Embed a range of targeted resources, education and support for line-managers.

- Increase proactive health and wellbeing initiatives enabling staff to remain well at work.
- Review “hotspots” of MSK injury-reviewing processes and working patterns and continue to work closely with the ICS MSK team.
- Embed a speaking up culture and remove any barriers staff may face, through the support of our Freedom to Speak Up Guardians and ambassadors. To help support our leaders build working environments that are psychologically safe and based on respect and civility.

4.2 Workforce Planning and Data

Workforce Planning, Recruitment and Retention

During 2024/25 we will continue to focus on Workforce Planning by generating information, analysing it to inform future requirements of staff and skills and translating that into a set of actions that will develop and build on the existing workforce to meet UHD’s future resource requirements. Planning will also reflect patient pathways and care of the future.

Corporate Project – Workforce Baseline Data

We will ensure:-

- Agreed staff establishment is aligned financially and professionally
- Agreed processes for identifying and changing future workforce maintains currency and accuracy
- There is a provision of management analytics to inform workforce deployment decisions and Board assurance

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

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

5. Population and Systems

True North Goal - See patients sooner	Consistently delivering timely appropriate, accessible care as part of a wider integrated care system for our patients.
Breakthrough Objectives	**Planned Care** - To achieve a minimum of 109% weighted value elective activity against a 2019/20 baseline, including specialist advice and guidance. **Emergency/Urgent Care:** >78% of patients treated within 4 hours through the emergency care pathway. Stretch target: • To have no patients waiting in excess of 52 weeks on an RTT pathway to be seen or treated by March 2025.
Corporate Projects	***Planned Care Improvement Programme*** To coordinate delivery of improvements in planned care in order that we meet patients' expectations and national constitutional standards for planned care and reduce inequalities in outcomes and access for patients whilst improving productivity and value. ***Hospital Flow Programme*** Single plan to coordinate delivery of improvements in Urgent and Emergency Care that will meet the constitutional standards for Urgent and Emergency Care and reduce inequalities in outcomes and access for patients whilst improving productivity and value.

Overarching aim:

Our True North goal for our Systems and Partnerships is to consistently deliver timely appropriate, accessible care as part of a wider integrated care system for our patients. For planned care our 2024/25 breakthrough is to achieve a 109% weighted value elective activity against a 2019/20 baseline, including specialist advice and guidance, and for emergency care that 78% of patients are consistently treated within 4 hours in Emergency Care Services.

How to achieve this:

We will plan to increase the amount of elective activity we undertake compared to 2019/20. Our Planned Care Improvement Corporate Project is helping us focus our efforts to achieve this.

In the challenging context of recovering services following the COVID-19 pandemic and continuing high demand for hospital services, we are working to achieve these targets by first ensuring that no patients wait in excess of 65 weeks on an open RTT pathway by September 2024 and in excess of 52 weeks by March 2025. Our breakthrough objective for Emergency/Urgent Care relates to reducing the number of patients waiting in our emergency departments in excess of 4 hours to be treated and either admitted or discharged. Our Hospital Flow Programme supports the work needed to achieve this.

Our population and system goals are also supported by our Transforming Care Together programme. This is a £501million capital investment programme that includes the establishment of the Bournemouth Emergency Hospital and Poole Planned Care Hospital in December 2025.

5.1 Planned Care

Our Planned Care Improvement Programme focuses on knowing what our population needs and delivering the best care and support to our population within the facilities, budget and workforce available. This covers patients requiring cancer treatment, outpatient care, patients needing surgery, diagnostic and therapy services. To see or treat people in a timely way we need to fully understand the demand for services through a fully validated waiting list and referral data, and what productive capacity we will need to meet this demand.

The planned care programme is closely aligned to the Hospital Flow programme ambitions to reduce the average length of stay, bed occupancy and the number of patients in hospital with no criteria to reside. It is also aligned to the ICP three strategic priorities: prevention and early help, thriving communities and working better together.

Planned care - Activity

Guidance issued by NHS England in 2023/24 asked the Trust to seek to increase activity levels to above those we delivered in 2019-20 levels, to increase the amount of day case activity, improve our use of theatre capacity, and to free up slots for outpatient treatment by reducing unnecessary follow-up treatment. This remains the ask in 2024/25.This table summarises how the Trust performed against this ask and the level of activity we are committed to delivering in 2024-25.

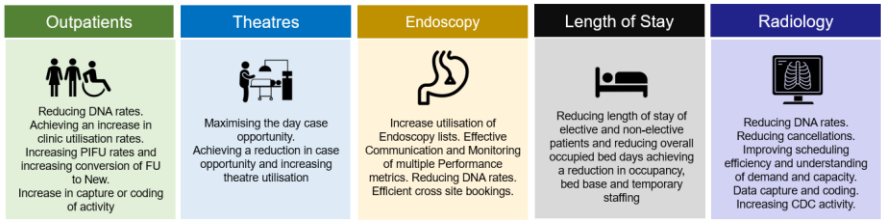
Activity Type	2019-20 Baseline	2023-24 Forecast outturn	2023-24 % Increase	Planned % Increase 2024/25
Ordinary spells	12,837	13,202	13,587	105.8%
Day cases	84,630	77,771	90,382	106.8%
Outpatient procedures	71,743	71,753	73,853	102.9%
Outpatient first attendances without a procedure	198,425	209,940	212,685	107.2%
Outpatient follow up attendances without a procedure	295,290	281,511	305,714	103.5%

How we will achieve it:

The Trust plans to increase its planned care activity by:

- Increasing productivity of services to operate within existing capacity. The Trust has identified five areas of

focus: outpatients, theatres, endoscopy, reducing length of stay in hospital and radiology.



- Increasing the provision of High Volume Low Complexity (HVLC) outpatient clinics and theatre sessions. This will include HVLC pathways for upper limb surgery in trauma and orthopaedics and expansion of HVLC pathways in ENT, Oral Maxillofacial Services and Ophthalmology.
- Continuing to reduce unwarranted variation in clinical standards and outcomes through the adoption of best practice outlined in the Getting It Right First Time (GIRFT) programme. This includes implementing a day case arthroplasty pathway and reducing length of stay for hip and knee replacements. The Trust will also seek to rapidly adopt best practice outlined through the Further Faster programme speciality handbooks where it has not done so already.
- Full implementation of National evidence-based intervention guidance to improve the quality of care being offered to patients by reducing unnecessary interventions and freeing up resources that can be put to use elsewhere.
- Increasing the use of one-stop ambulatory pathways supported by diagnostic teams.
- Enhancing use of the Outpatient Assessment Centre, in Poole and efficient use of theatre capacity including transfer of activity and capacity from Wimborne to UHD Theatres. We will also improve efficiency and utilisation in the Cardiac Cath Labs via scheduling improvements.
- We will continue the work started in 2023-24 to ensure we meet national standards on data quality and that all inpatient, outpatient and day case activity is suitably recorded and reported against.

With the support of the Clinical Acute Networks Dorset (CANDo) programme, we will work with Dorset County Hospital and other relevant partners to improve the resilience and sustainability of services by:

- Implementing a single service across Dorset for Orthodontics and Rheumatology.
- Increase the frequency of HVLC cataract lists and increased Glaucoma follow ups.
- Establish Networks across nine specialities, including Gastroenterology, Ear, Nose and Throat Services, Gynaecology, General Surgery, Urology, Trauma & Orthopaedics, Dermatology, Ophthalmology and Respiratory

- Establish a single Orthopaedic hand service across Dorset.
- Designing and implementing a community-oriented model for Dermatology.
- Optimising treatment in acute care for Respiratory.

Planned Care – Referral to Treatment Times

National planning guidance sets out that patients waiting more than 65 weeks should be seen by September 2024 and one of the stretch ambitions within the Trust is to eliminate waits over 52 weeks by March 2025.

How we will achieve it:

In 2023-24 the Trust improved its referral to treatment times and has significantly reduced the numbers of patients waiting more than 65 weeks for planned care. The number of patients who potentially would wait over 65 weeks if not seen in the year reduced from just over 40,000 to below 330 between April 2023 and March 2024.

The Trust plans to achieve zero patients waiting more than 65 weeks for treatment or outcome by September 2024. Our modelling of our capacity to reduce 52 week waits, including the impact of increased productivity and increasing planned care activity, indicates that the Trust will not reduce these to zero by March 2025 without delivering more activity. The Trust would need to exceed the national activity targets to be able to deliver this, such that Trust plans to deliver 109% of the baseline (2019/20) activity in 2024/25 to bring about a reduction in waits exceeding 52 weeks.

We will achieve this reduction by implementing efficiency and productivity improvements. This will include, ensuring only the patients who need our services are referred, effective management of referrals, outpatient and diagnostic clinic capacity, follow up (including increasing patient initiated follow up pathways) and discharge. We will also work to reduce lost capacity through missed appointments.

In theatres, we aim to reduce our dependency on agency staff and insourcing/outsourcing by encouraging workers back into substantive and bank roles. The Trust aims to deliver an improvement in the time our surgeons spend operating by increasing theatre utilisation rates to be in line with national best practice at 80% by March 2025, moving to 85% in some specialities. The number of theatre sessions run will also increase returning to 93% against the template operating in 2019/20.

We forecast that there will be areas where increased productivity alone will not deliver the reduction planned in the waiting list or the length of time patients wait. In these areas, we will consider ways of investing that delivers the best value for patients.

We will ensure waiting lists are validated achieving 90% validation of pathways greater than 12 weeks, supported by the

expansion of digital first validation. The Trust developed an RTT waiting list management training programme for staff in 2023-24 and will continue to roll this out in 2024-25 to promote evidence based best practice.

Diagnostics and Community Diagnostic Centres

The national planning guidance requires trusts to maximise the roll out of community diagnostic capacity with new community diagnostic centres (CDCs). Trusts are also asked to increase the percentage of patients that receive a diagnostic test within six weeks compared to 2023/24; to 95%.

The Dorset CDC Programme is responsible for rolling out additional diagnostic across Dorset in line with the 2020 Richards' Review and Dorset's strategy for delivery. Over the last 12 months the Trust has made progress in the following areas:

- Ultrasound, Dexa scanning and phlebotomy services have commenced at the Outpatient Assessment Centre, Poole.
- We have increased colposcopy services, delivered additional endoscopy (including Cytosponge and TNE) and increased CT capacity in Poole hospital.
- Mobile MRI services in AECC, Boscombe are in place until end of March 2024.

In 2024/25 the Trust will continue its roll out programme to increase diagnostics capacity by:

- Completion of AECC, Boscombe CT and ultrasound room build in order to deliver an increase in capacity.
- Provision of additional Echocardiograms, MRI and familial health breast surveillance capacity at Poole.
- Provision of additional fibroscan capacity at the Outpatient Assessment Unit, Poole.
- Completion of an endoscopy modular build at Poole by 2025.
- Roll out of tele-dermatology pre and post referral pathways across all CDC sites.

The increased capacity will provide additional diagnostics in a range of locations across Dorset enabling a reduction in wait times for tests and development of one stop clinics.

Two of the CDC sites in Dorset are in known areas of deprivation, thus providing tests closer to home and supporting a reduction in health inequalities.

Transforming Outpatient Care

The planning guidance sets out continuing to further improve outpatient services. Trusts are also asked to increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff. For UHD this target is 49% across 2024/25

How we will achieve it:

The overarching aim is to work towards operating models, capacity and scheduling that deliver clinically effective and efficient outpatient care and reduces waiting times across our sites, optimising opportunities for transformation that includes digital models of care and better space utilisation. The Trust will achieve this by:

- Continuing to deliver safe, high quality patient care for our outpatients and scaling up on actions to reduce health inequalities in patient access and experience of outpatients.
- Providing a sustainable nursing, administrative and Phlebotomy workforce now and into the future.
- Digitally transforming services that will enable improved patient access and experience, and responsive and effective ways of working, increasing productivity and workforce retention. This includes moving to paper free booking methods, expanding the use of DrDoctor patient facing digital capabilities including the coverage of text reminders, video consultations and implementing two-way bookings. The Trust will roll out e-outcomes for capturing the outcomes of clinics and e-assessment pathways.
- Optimising clinic templates and clinic room utilisation, supporting elective recovery plans.
- We will continue to support a reduction in the number of patients waiting a follow up appointment through validation and increased clinic utilisation.
- Providing a more personalised approach to outpatients by expanding the use of patient-initiated follow-up (PIFU) to all major outpatient specialties, moving or discharging 5% of outpatient attendances to PIFU pathways by March 2025.
- Using an approach to understanding where efficiencies in our outpatient processes can be made through deploying process mining and intelligent workflow analysis.
- Increasing the reach of Specialist Advice and Guidance (Vascular, UGI) and reducing response times to ensure General Practitioners receive advice when they need it and to reduce referrals into secondary care.

Timely Access to Cancer Care

The Trust continues to work as an integral part of the Dorset ICS Cancer Programme alongside the Wessex Care Alliance (WCA) to ensure key priorities are met in the national planning guidance.

The national planning guidance specifies for Trusts to recover the 62 Day Standard to 70% by March 25 and for the 28 Day Faster Diagnosis Standard to achieve 77% by March 2025.

We will also maintain the number of people waiting no longer than 62 days (including 104 backstops) below 220 patients (nationally agreed target in 23/24).

How we will achieve it:

In 23/24, UHD signed up to the Cancer Recovery and Improvement Programme that was led by the Dorset ICS Cancer Programme to recover cancer performance to meet the national targets, whilst implementing new and best practice pathways to support rapid diagnosis and treatment.

For 24/25, the programme is moving away from 'recovery' internally at UHD, to a programme of sustainability and improvement across the entire remit of Cancer Services.

The priorities for 24/25 consist of sustaining the performance priorities whilst working to meet the requirements in the planning guidance. The following pillars make up the wider Cancer Improvement Programme at UHD to aspire towards becoming a Centre of Excellence for Cancer:

- Developing a Clinical Strategy for Cancer as the 12th large treating hospital in the UK.
- Articulating and supporting our cancer workforce to be fit for the future.
- Transforming MDT meetings and processes to maximise digital opportunities and to use our clinical resources efficiently.
- Quality, Safety and Patient Experience – driven through the development of the Personalised Care programme.
- Work collaboratively with the ICS to confirm commissioning and financing arrangements for the future.
- Establish the Cancer Improvement Programme at UHD
- Appoint a Clinical Director for Cancer Services
- Implement the Best Practice Timed Pathways, including maintaining priority pathway changes for prostate cancer.
- Fully implement Tele-dermatology
- Develop and embed process to identify and support patients on an open cancer pathway who are impacted by health inequalities.
- Grow links with the VCS to enhance experiences for patients and to support clinical teams.
- Ensure the counting and coding opportunities are maximised for new work such as Personalised Stratified Follow Up (PSFU) pathways.
- Roll out Rhabdomyosarcoma (RMS) treatments to Lung, Thyroid, Renal and Skin if there is agreement for sustainable commissioning of this service.

5.2 Hospital Flow Programme

Key Challenges

Long waiting times in Emergency Departments have a potential to cause harm and a negative impact on patients and staff experience. This increases risk across the organisation of a longer length of stay in hospital, less access to care by our community and Ambulance waits at our front door. Our patients have an expectation and constitutional right to receive Urgent and Emergency care in line with National Standards, and our Trust along with every other hospital, is challenged to deliver these standards consistently. These standards are

agreed by clinical experts who evidenced receiving care in a timely manner improved quality of care and mortality rates and will increase staff morale and experience.

The creation of the emergency hospital in 2025/2026 is a major step towards meeting these challenges. Planning for transition to the new configuration of services is where this programme and Transforming Care Together are joined up.

At any time, more than 20% of UHD beds in 23/24 continued to be occupied by patients that have No Criteria to Reside (NCtR) in hospital but who have an ongoing health or social care need that requires support. UHD has remained one of the most challenged Trusts for the numbers of patients wating to leave that no longer require a hospital bed. This may delay physical rehabilitation or support to undertake daily activities at home. The lack of availability of resources to care for people out of hospital often delays patients' discharge, sometimes for a considerable period. This pressure is felt throughout the Urgent and Emergency Care Pathway, and manifests as increased bed occupancy and increased escalation beds being opened (planned and unplanned surge beds). At its worst it results in crowded Emergency Departments and delayed Ambulances in the departments.

In 2023 UHD returned to reporting the 4-hour standard as the key Emergency Department metric. Previously UHD had been part of a national pilot for a different set of metrics set by NHS England. This change of metrics has embedded through 2023 in to 2024. Achievement of 76% of patients being seen and discharged from the Emergency department within 4 hours is proving challenging to achieve. Work will continue through 24/25 towards achieving and increasing performance against the 4-hour standard.

The challenges faced by UHD are not unique and sites with Emergency Care Pathways throughout England are facing similar issues. The most recent National UEC Delivery Plan for Recovering Urgent and Emergency Care Services was published at the end of January 2023 and links with plans for the NHS with those of the Department of Health and Social Care. Many of the actions in the National UEC Delivery Plan for Recovering Urgent and Emergency Care Services focus on challenges and factors outside of the Acute Hospital. While the Dorset ambition to reduce NCtR by 50% was not achieved in 23/24 UHD remains committed to working as part of the Integrated Care System and with our partners from Local Authorities and other sectors to achieve the benefits for our patients as laid out in the plan.

For the in-hospital actions the previous UHD Hospital Flow Improvement Group became the Urgent and Emergency Care (UEC) programme board in October 2023 and refreshed its Terms of Reference to meet fortnightly to oversee plans to deliver productivity and transformational change to support the

delivery of the 4-hour standard and UEC pathway improvements. The UEC programme board reports to our Executive led Trust Management Group. There are four Key Lines of Enquiry:

- 4-hour Safety Standard,
- efficient hospital pathways,
- discharge, and
- operational flow.

These report to a single steering group. Each workstream is led by a senior team that are accountable for delivering transformational change required to achieve the National UEC Delivery Plan for Recovering Urgent and Emergency Care Services.

Risks and Issues

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

Assumptions

- Dorset system plans to achieve 50% reduction in NCtR is achieved.
- UTCs are funded and are developed to fully integrate into the core Urgent and Emergency Care front door in 2024/25
- Transformation initiatives and funding support for schemes will facilitate deliverables, safe care and progress against key standards.

Patient Flow & Bed Capacity

In 2022/23, investment was made in key areas to improve flow and increase inpatient capacity. Funding for 23/24 was minimal and provided a small element of escalation bed funding. In 2023/24 the teams enhanced and developed services with SDEC services across both sites, introducing highly successful Departure Lounges, and recruitment of Discharge Facilitators. In 2024/25 our teams will continue to develop schemes to improve productivity and efficiency in patient pathways, for both elective and emergency patients. This also puts us on the trajectory for the reconfigured planned / emergency hospitals.

Underpinning the Trust's surge and capacity planning is our bed modelling. The UHD bed modelling tool is being adopted

by the Dorset system in 24/25 to underpin the overall capacity requirements for Dorset and adopt system wide assumptions. UHD used high levels of 'escalation' beds, above core for initial months post winter pressures, at considerable cost. A key assumption in our modelling, as well as our bed gap mitigation plans, is the role of the system-wide community capacity and the Discharge to Assess (D2A) programme. In addition to supporting our system-wide work, internally, our focus is on planning for discharge from admission and Pathway 0 discharges, which form 88% of all discharges daily.

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

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

Discharge to Assess (D2A)

The Dorset system implemented a simplified discharge pathway in 23/24 which continues to embed. This is supported by a Discharge to Assess (D2A) model for those patients who are unable to be discharged to their usual place of residence due to new care needs. The model aims to optimise patient rehabilitation and recovery and complete assessments for their longer term needs outside of the acute hospital. 23/24 has seen challenges as patients have not moved through the D2A pathway as efficiently as planned or required for a successful impact to be felt at UHD. Delivery of this model remains a priority for the Dorset system for 24/25.

Key Benefits once achieved

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

Further system-wide improvement work includes:

- Ensuring flow through the D2A capacity and that it does not become blocked.
- Continuing to expand community capacity.
- Review of pathways and commissioning for complex and specialist patient needs.
- 'Front door' pathways for unnecessary admission avoidance.
- 7-day discharge planning and discharges – UHD now have a 7-day service but this is not in all providers.
- Transport services that support discharge, a new transport provider will be announced in 24/25 for routine transport.
- Planning for the high level and increasing number of frail older patients in Dorset, including over 85s.

Discharge Planning – Planning to leave from point of admission

Our internal work on early planning and reduced discharge delays is being driven by our Urgent and Emergency Care (UEC) programme board. The workstream's next phase of work is focused on:

- Estimated Date of Readiness (EDR) - rollout of our Best Practice Toolkit for early and effective discharge planning and processes, supported by developments to our Health of the Ward bed management system. This aims to optimise the time our patients spend in our hospitals, reduce long lengths of stay, increase P0 discharges and provide early information to our system partners to support discharges and capacity planning.
- Developing pathways and processes on our wards that support the Discharge to Assess (D2A) model.
- 7-day discharges/discharge planning so patients are discharged when they are medically optimised.
- Streamlining assessment and referral pathways including the development of digital solutions that release time to therapy.
- Develop our Health of the Ward bed management system as central conduit for digitally sharing timely information and to support our data driven intelligence and reporting internally, across the system and nationally.

Risks and Issues

- Demand (non-elective and/or elective) exceeds bed modelling scenario assumptions.
- 'Staycations and visitors to Dorset result in surge demand at peak periods.
- Increase in the number of patients ready to leave requiring step down to community services.

- Discharge to Assess capacity and pathways are unable to deliver further reductions in Length of Stay to offset the acute bed capacity gap.
- Workforce gaps, particularly in therapy and care capacity, impacting on service and system delivery.
- Inability of system partners to meet demands on services – health and social care out of hospital.

5.3 Health Inequalities

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

In 2023/24 we sought to strengthen our use of population health management to narrow the gap in health inequalities and improve health outcomes. We built on work to proactively identify the health inequalities of our population to inform service design and policy development. Our Population Health and System Committee of the Trust Board was established to support the Trust in achieving its strategic objective, to transform and improve our services in line with the Dorset ICS Long Term Plan.

In 2024/25 the Committee will continue to do this through:

• Providing oversight of the implementation by the Trust of its responsibilities pursuant to the system Making Dorset the healthiest place to live - Joint Forward Plan: 2023-2028.

• Assisting the Trust's Board of Directors in its oversight of achievement of breakthrough objectives and strategic initiatives relating to population health and health inequalities.

• Receiving and reviewing information and data relating to population health and health inequalities and reporting to the Board.

We will frame our vision for addressing health inequalities around: patients and families, our workforce and our leaders. This will include:

- A focus on reducing variation in access to elective health care and reducing Hospitalised Standardised Mortality Ratios (HSMR). We will take a particular focus on Children and Young People in reducing DNA rates in our ENT services.
- Ensuring accessible information related to care and treatment. Including ensuring our Transforming Care Together programme considers accessibility and signage.
- Building on our patient experience and community networks in co-designing improvements; including capturing the views of our staff living in Dorset.
- Embedding health inequalities in our Patient First methodology for improvement.
- Reviewing our Equality Impact Assessment to ensure it comprehensively considers the impact on health inequalities.
- Expanding opportunities for staff to access training on health inequalities and building an informed workforce that understands their role in reducing health inequalities. We will also work with the ICS to develop a

communications plan to support staff to deliver public health messages.

- Increasing our staff's access and use of data to better understand unwarranted variation.

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

- Against the 24 Domains introduced in NHS England's statement on information on health inequalities published in November 2023, we will make available in our Annual Report an assessment of variation and identify the areas requiring strengthening.
- Working in partnership with the system and its health inequalities delivery programme, we have identified data as a priority, including further rapid development of indicator definitions for the collection above and development of dashboards in relation to the Core20Plus5 national framework for adults and children.
- We will use this data to identify the needs of our communities' experiencing inequalities in access, experience and outcomes in relation to their health, so that we can respond with tailored strategies for addressing inequalities and track the impact of these strategies.

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

Building on the work undertaken in 2023/24 to evaluate the impact of elective recovery plans on addressing pre-pandemic and pandemic-related disparities in waiting lists we will continue to spread the learning to date to other prioritised cohorts. Including a focus on reducing DNA rates and increasing health literacy.

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

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

6. Sustainable Services

True North Goal - Use every NHS pound wisely	To maximise value for money enabling further investment in our services to improve the timeliness and quality of care for our patients, and the working lives of our staff.
Breakthrough Objectives	To develop and fully deliver recurrent financial efficiencies of 5% in the 2024/25 budgeted Cost Improvement Programme target.
Corporate Projects	***Efficiency Improvement Programme (including One Dorset Procurement***) – Full delivery of planned CIP targets, with at least 80% achieved recurrently ***Transforming Care Together Programme (Build Ready and Service Ready Programmes) -*** **Build ready:** • Completion of BEACH building • Completion of NHP funded Wards and Theatres • Completion of associated enabling works • Completion of Poole's new Endoscopy Unit **Service Ready:** • Teams Integrated, new clinical models in place. • Move plans implemented and services safely moved. **Staff Ready:** • Engagement • Workforce planning

6.1 Financial Strategy

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

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

Revenue

Considerable financial planning and detailed financial modelling has been undertaken within the Trust. This reflects the national planning guidance together with the agreements reached within the Integrated Care System in relation to the distribution of funding across partner NHS organisations.

Whilst the plan reflects a financial break-even position, a number of financial risks remain which could, if unmitigated, drive an in-year deficit.

These include:

- CIP plans currently are still in development for the full £42m (5%), representing a risk.
- Recovering elective services to the 109% threshold may cost more than the funding available, or funding may be clawed back for failing to achieve this threshold.
- Pay costs have been budgeted based on the substantive cost, with only a small amount budgeted for the premium cost of agency cover. If the current agency expenditure run rate continues there is an additional risk of up to £4 million.
- Inflation costs reflect the national planning assumptions, representing a risk of circa £7 million against local forecasts.

These risks, together with the wider financial governance procedures will be managed through the Trust Management Group (supported by the Financial Planning Group) and

assured by the Finance and Performance Committee and ultimately the Board.

Capital

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

This very significant and ambitious programme totals almost £0.5 billion with budgeted spend of £199 million during 2024/25 (assuming final approval of the New Hospitals Programme business case) comprising three key elements:

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

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

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

Cash

The trust continues to hold a significant cash balance which has been strategically built up over many years and is fully committed, supporting the medium-term capital programme.

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

2024/25 Financial Priorities

The Trust's absolute priority during 2024/25 is to recover the projected revenue deficit thereby mitigating the strategic implications of depleting its cash reserves.

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

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

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

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

6.2 Transforming Care Together Programme

The existing healthcare facilities in east Dorset are insufficient to cater to the rising healthcare demands of our ageing community. To ensure access to timely, high-quality healthcare services for our residents, we need to transform services and separate planned and emergency care per the Clinical Services Review.

This requires the planning and construction of the £201m BEACH (Births, Emergency care, And, Critical care and child Health) building and £262m NHP funded wards and buildings on the Bournemouth Hospital Site to create the Emergency Hospital. On the Poole Hospital site, new theatres, wards and a new Endoscopy building will create the Planned Care Hospital. This modern, fit for purpose estate will have advanced construction, adequate bed capacity, and the capability to offer comprehensive healthcare services.

These changes will help to meet the needs of our population and deliver the overarching benefits of improved outcomes due to centralised emergency and specialised services, shorter waiting times, reduced cancellations and clinical/financial sustainability.

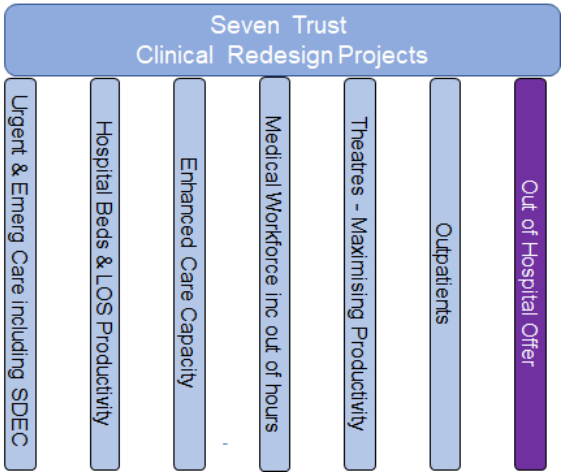
Our Transforming Care Together Programme will be delivered by our Service Ready and Build Ready projects.

Service Ready

Establishing the Planned and Emergency Hospitals means changes to the majority of our clinical services. Our scope is made up of:

- 7 clinical redesign projects
- 23 specialties going from two teams to one
- 31 specialties moving site
- 3 teams going from single site working to split site planned / emergency

Our clinical redesign projects are outlined below:



This will necessitate the development of new clinical and operational models and the integration of teams where the same service is currently supplied over different sites.

Our headline dates for the movement of services are outlined below:

- Phase 1 - Q4 2023/4 & Q1 2024-5: TIU, Haem, Surgical moves, Pathology hub opens
- Phase 2 – Q1 2025/6 – BEACH opens, Maternity, RBH-CC and RBH-ED move
- Phase 3 – Q3-Q4 2025/6 – Planned and Emergency separation
- Phase 4 – Q3-Q4 2026/7 – Final moves and completion

The Transforming Care Together programme will deliver:

1) Clinical excellence delivered from fit for purpose estate
2) Improved patient safety and infection control
3) Shorter waiting times and reduced cancellations
4) Clinically and financially sustainable services

This is a huge programme of change for all our staff and patients and as such there are several risks to manage:

a) Build ready delays (funding and/or construction) – successful management of the construction critical path will help to mitigate these risks

b) Service ready delays (Integration of teams, clinical/operational models, possible workforce shortages) – successful critical path management, staff engagement, workforce and OD support will help to mitigate these risks.

The completion of the Transforming Care Together Programme will deliver:

- Clinical, Financial and Societal benefits as determined in the STP and NHP business cases.
- STP (BEACH) - £21.6m cost savings, 5 specialties with quantified benefits, 6 speciality benefits for up to 150,000 patients per year from planned and emergency separation, societal benefits of £11.4m
- NHP funded Schemes - £6.1m of cash releasing benefits, £8.0m of non-cash releasing benefits and £12.2m societal benefits

Together these benefits will deliver the vision and ensure clinically and financially sustainable services for the UHD service users.

Build Ready

As in previous years, the creation of the planned care hospital at Poole and the emergency hospital on the Royal Bournemouth site remains the centre piece of the Clinical Services Review (CSR) agreed by the Secretary of State for

Health in 2019, following three years of public, staff and partner engagement.

The benefits and reconfiguration changes are set out in our Future Hospitals Website: Investing in our hospitals (uhd.nhs.uk). The links on the website layout the changes across all the UHD sites, with funding coming from a range of sources including the New Hospitals Programme, Sustainability & Transformation Programme as well as other capital investment schemes.

The Estates masterplan provides visuals and the timeline for the major changes that complete in 2026/27:

- The first clinical changes commenced in 2023/24 covering Stoke, Cardiology and the opening of the Pathology Hub.
- The next significant changes are planned for the start of 2024/25 when the new catering block will come online.
- The BEACH building will be handed over to the Trust for commissioning in Oct 2024.
- The initial clinical opening of the BEACH building will be in April 2025 providing Births (Maternity), Emergency Care (Bournemouth ED will move into the new facility; however Poole ED will remain the designated Trauma unit), Antenatal, Bournemouth Critical Care will also move into the new facility.
- All other changes will move as part of the Major Reconfiguration in Q3 2025/26.

There are other extensive changes across both Poole & Bournemouth including the work related to the New Hospitals Programme, the Wessex Fields Access Road and the commencement of the Clinical Diagnostic Hub (CDC) for Endoscopy in Poole.

In 2024/25, there are six strategic changes:

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

2. **BEACH Building completes** in November 2024, with Trust commissioning finishing by the end of March 2025. The first services will move into the BEACH in April 2025

3. **Wessex Fields Access Road completes** in September 2024, at which UHD staff will be able to enter and exit the site directly from the South Bound Wessex Way carriageway

4. **CDC in Poole commences** in Spring 2024 with plans to complete in early 25/26

5. **New Hospitals Programme (New Ward Block and Catering commences)** is due to complete in November 2025 with commissioning running into December 2025.

6. **Catering.** The Central Production Kitchen (CPK) will be fully open, allowing a totally new, improved catering offer. This will offer more choice, be more sustainable, provide greater resilience and provide future opportunities for revenue growth by providing catering to partners.

These six significant service changes will happen in 2024/25 but across all our sites, small and medium sized building works in preparation for major reconfiguration in 2025/26 will continue and step up. The enabling works for the New Hospital Programme will continue, and the Full Business Case for the New Hospitals Programme is expected to be approved in the summer of 2024. Other capital projects will also be progressed, including back log estates works across the Trust.

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

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

6.3 Environmental Sustainability

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

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

The Sustainability Strategy, or Green UHD Plan, sets out our:

- **Vision** - to provide excellent healthcare to our patients and wider community and be a great place to work, now *and for future generations*
- **Green objectives** – to deliver healthy lives, a healthy community and a healthy environment.
- **Cornerstone targets** –
  - To reduce UHD’s core carbon footprint to 80% by 2030 (against 1990 baseline) and to net zero by 2040.
  - Carbon footprint plus to be net zero by 2045.
  - To become an excellent rated clean air hospital by 2026, reduce single use plastics, generate zero waste to landfill and consume 100% renewable energy.
  - The trust also uses a sustainable development assessment toolkit with circa 500 criteria and aims to score 100% by 2030.

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

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

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

- Carbon

- Social value / anchor institution

Our Green Plan aligns the Trust with NHS net zero targets. Given the unprecedented nature of the challenges being addressed, the measures taken to achieve the Green Plan and the Green Plan itself will require regular review and revision along this journey.

In 2024/25, we will build on work through 23/24 and continue to give particular focus to three areas:

- **Decarbonisation of the energy consumed by our estate.** This includes major investment to increase the electrical supply capacity, increase renewable generation on site and detailed planning for heat decarbonisation.

- **Green travel.** The delivery of a detailed sustainable travel plan in 2023/24 was a significant milestone. 2024/25 will see the implementation of several projects needed to deliver against this plan. This includes the introduction of Mobilityways which will provide staff with personalised travel plans and provide the trust with a powerful modelling tool to better assess staff travel needs and support them with sustainable travel solutions. Our aim to ensure staff travel is both easier and more enjoyable (as well as cheaper, healthier and greener).

- **Sustainable quality improvement.** During 2023/24, UHD started on our transformational journey to embrace the “Patient First” quality improvement approach, with the first cohort of staff including 200 managers beginning their training. Through 2024/25 we will ensure environmental sustainability is integrated with Patient First and reconciled with our target to mainstream sustainable quality improvement throughout the trust. Progress is already starting with our Green Theatres work.

The Green Plan is aligned with our work across Dorset ICS, the SW region and fits with our ambitious, bet essential, vision for future generations to benefit from our work today.

7. Corporate Governance

7.1 System partnerships

Integrated Care System (ICS)

The ambition for Dorset to be the healthiest place to live in the UK fits UHD's ambition for our population, and our place as a team player within our ICS. NHS Dorset Integrated Care Board as the key organisation, is leading this work, and their plans on behalf of the system align within ours. In turn these fit within wider national strategies.

For more detail on the Dorset ICS strategy see website (link). UHD's contributions are summarised with the driver diagram overleaf.

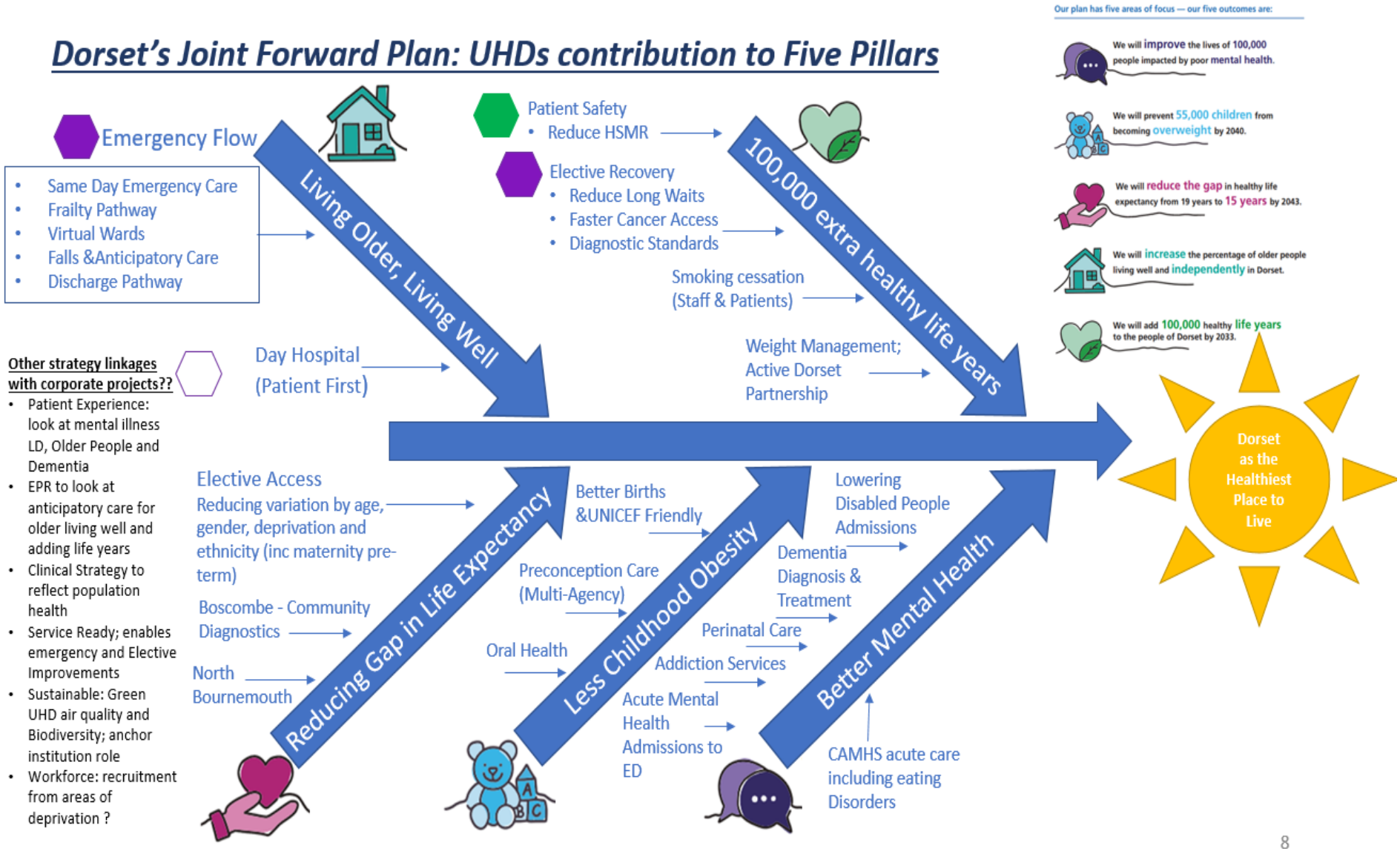
Wider determinants of health

This plan is set within the context that a predominately hospital based healthcare provider is only a small part of an individuals', and populations health and happiness. Therefore our work as an "anchor institution", as an employer, landowner, purchaser of goods and services, and focal point for a community are also important. The progress against what good looks like as an anchor institution, is tracked via our Green UHD plan. In addition we are active members of numerous networks, and partnerships both as a Trust and through the ICS, including for example with the voluntary sector.

University Partnership

A key formal partnership is with Bournemouth University, a highly ranked institution. Over the last three years our partnership has supported education, research, joint appointments and a range of projects, including in leadership development. The strategy will be updated in 2024. One area to explore will be development of a medical school for Dorset, alongside expanding existing programmes including physicians' assistants.

Dorset's Joint Forward Plan: UHDs contribution to Five Pillars



7.2 Membership and Governors

Member Engagement

The Trust currently has over 14,000 public members, with staff and volunteer members being in the region of 10,000. All individuals in our staff constituency automatically become members unless they choose to opt out. In 2024/25, Governors will further develop upon successful events, communication and outreach, supporting their role of representing the interests of members and the public.

The vision set out in the Trust's Membership Engagement Strategy is to build on the engagement with Trust members to create an active and vibrant membership community, representative of the diverse population the Trust serves and of the staff who work here, that has a real voice in shaping the future of the Trust and the services it provides. To achieve this, the Membership Engagement Strategy sets out three overarching aims:

1. To build representative membership that reflects our whole population of Dorset and West Hampshire;
2. To improve the quality of mutual engagement and communication so that our members are well informed, motivated and engaged;
3. To ensure our staff members have opportunities to be become more actively engaged as members.

Council of Governors (CoG)

In the absence of vacancies, the Council of Governors currently comprises the following:

- 6 Public Governors from the Bournemouth Constituency;
- 6 Public Governors from the Poole & Rest of Dorset Constituency;
- 5 Public Governors from the Christchurch, East Dorset & Rest of England Constituency;
- 5 Staff Governors, each representing a staff class:
    - Medical and Dental;
    - Nursing, Midwifery & Healthcare Assistants;
    - Allied Health Professions, Scientific & Technical;
    - Administrative, Clerical and Management;
    - Estates and Ancillary Services
- 4 Appointed Governors, each representing a partnership organisation:
    - Bournemouth, Christchurch & Poole Council;
    - Dorset Council;
    - Bournemouth University;
    - University Hospitals Dorset Volunteers

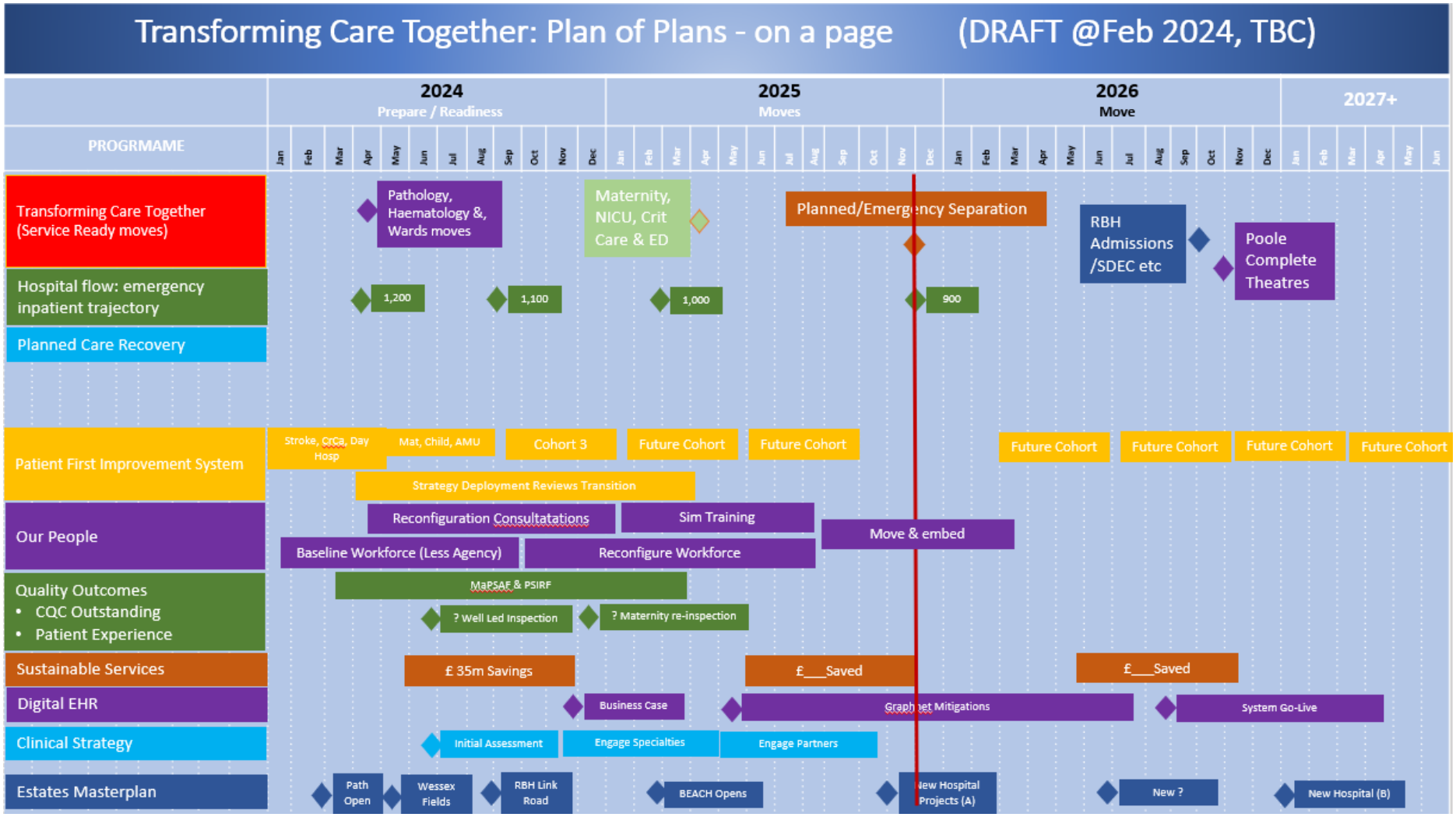
More information about our Council of Governors can be found here

Informal Groups

The Council of Governors has established four informal groups:

- **Membership & Engagement Group** – a forum for discussion on membership, engagement, development and recruitment of members;
- **Effectiveness Group –** a forum for discussion on the effectiveness of the Council of Governors and to informally oversee the development and implementation of plans to enhance this;
- **Quality Group –** a forum for discussion on matters relating to quality and the Quality Account;
- **Constitution Review Group:** a forum for discussion on matters relating to the review and updating of the Trust's constitution triennially. The process for the constitution review is underway and will conclude in 2024/25.

Appendix A – Overarching Transformation Plan



Appendix B – Speciality Level Plans

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 01 May 2024

Agenda item: 6.6

Subject:	Key Issues and Assurance Report to Board of the Population Health & System Committee meeting held on 25 March 2024
Prepared by:	Helena McKeown, Chair of the Population Health & System Committee
Presented by:	Helena McKeown, Chair of the Population Health & System Committee

Key Issues/matters discussed by the Committee:	The Committee received the following: • Update on the alignment of Patient First and Population Health • Trust Activity • NHSE Statement on Information on Health Inequalities Data.
Significant issues for escalation to Board for action:	There were no significant issues for escalation to the Board for action. Work was in progress to align the Trust's objectives to the wider system, with a driver diagram depicting this presented to the Committee. Within each of the Trust's Patient First Corporate Projects, an aspect of population health and health inequalities was to be weaved in. The Committee received a paper in relation to the data available for Dorset (or where applicable, the Trust) against the 24 metrics outlined within the NHS England Statement on Information on Health Inequalities and noted the progress made. It also received an update on Trust activity to address health inequalities in the period since its last meeting, including covering: a) analysis of the referral to treatment waits by deprivation, age and ethnicity; and b) emergency attendances by deprivation group as reported within the Trust's integrated performance report; and c) an update on the 100-day challenge did not attend (DNA) project in ear, nose and throat services.
Progress of Board Assurance Key Risks Assigned to Committee:	N/A

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 01 May 2024

Agenda item: 6.7.1

Subject:	Key Issues and Assurance Report to Board of the Audit Committee meeting held on 09 April 2024
Prepared by:	Judy Gillow, Chair of the Audit Committee
Presented by:	Judy Gillow, Chair of the Audit Committee

Key Issues/matters discussed by the Committee:	The Committee received the following:
	• Internal Audit:
	  ○ Progress Report – ED IT Application Controls and Theatre Utilisation Data Quality
	  ○ Follow-Up Report
	  ○ Audit Plan
	• External Audit
	  ○ Progress Report
	  ○ Audit Plan
	• Counter Fraud:
	  ○ Progress Report
	• Risk Register (including update on action plan)
	• Trust Policies Update
	• Terms of Licence – Draft Compliance Report
	• Annual Certificates – Continuity of Services 7 and Training of Governors
	• Code of Governance – Draft Compliance Report
	• Draft Annual Governance Statement
	• Going Concern
	• Commercial Compliance Report
	• Audit Committee Governance Cycle

Significant issues for escalation to Board for action:	• Discussed data quality – agreed to auditing annually. • Audit Plan – approved subject to reviewing whether IT infrastructure should be part of the plan. Service ready and capital funding also recommended to be included and to start with initial focus on maternity move in 2025. • Reviewed the Terms of Licence draft Compliance Report, the Code of Governance – Draft Compliance Report, Draft Annual Governance Statement and Going Concern, all were endorsed by the Committee to the Board.

Progress of Board Assurance Key Risks Assigned to Committee:	N/A for this meeting of the Committee.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS – PART 1 MEETING

Meeting Date: 1 May 2024

Agenda item: 6.7.2

Subject:	Annual Certificates – Continuity of Services 7 and Training of Governors
Prepared by:	Ewan Gauvin, Acting Deputy Company Secretary Pete Papworth, Chief Finance Officer
Presented by:	Rob Whiteman, Trust Chair Pete Papworth, Chief Finance Officer

Strategic themes that this item supports/impacts:	Systems working and partnership ☒ Our people ☒ Patient experience ☒ Quality: outcomes and safety ☒ Sustainable services ☒ Patient First programme ☒ One Team: patient ready for reconfiguration ☒
BAF/Corporate Risk Register:	N/A
Purpose of paper:	Decision/Approval
Executive Summary:	Under its provider licence the Trust is required to, not later than two months from the end of each financial year, submit to NHS England a certificate as to the availability of the required resources. It must also declare that it is satisfied that during the financial year most recently ended it has provided the necessary training to its Governors as required by the Health & Social Care Act 2012. To note that the previously required declarations relating to conditions G6 and FT4 are no longer required under the new provider licence (March 2023).
Background:	Rationale for condition CoS7 is contained within the certificate. Training provided to Governors during 2023/24 included: • A comprehensive induction programme for new Governors in December 2023, which was also attended by many existing Governors. This included an additional session for new Governors on regulation and governance; • Development sessions, including sessions jointly with the Board of Directors, covering topics such as

	transformation, population health, the Membership & Engagement Strategy, Trust priorities and public engagement. • Informal briefings providing updates from private Board meetings and further development on topics such as the Code of Governance, Staff Survey and health and wellbeing. There were also presentations for Non-Executive Director Committee Chairs on their respective Committees. • Opportunities to attend training sessions and conferences organised by NHS Providers. The majority of responses in the Council of Governors' Assessment of Collective Performance in relation to development plans were positive. The Council has established an Effectiveness Group to further enhance opportunities for training and development.
Key Recommendations:	The Board is asked to consider and if thought fit approve the draft certificates.
Implications associated with this item:	Council of Governors ☐ Equality, Equity, Diversity & Inclusion ☐ Financial ☐ Health Inequalities ☐ Operational Performance ☐ People (inc Staff, Patients) ☐ Public Consultation ☐ Quality ☐ Regulatory ☒ Strategy/Transformation ☐ System ☐
CQC Reference:	Safe ☐ Effective ☐ Caring ☐ Responsive ☐ Well Led ☒ Use of Resources ☒

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Audit Committee	09/04/2024	Endorsed with a recommendation to the Board to approve.

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

Worksheet "CoS7"

Financial Year to which self-certification relates 2024/25 Please complete the explanatory information in cell

Declaration required by Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

1a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. — Please Respond

OR

1b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services. — **Confirmed** — Please fill details in cell E22

OR

1c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate. — Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

Locally, the Dorset Integrated Care System continues to operate under significant pressure, with high demand for urgent and emergency care services and a significant number of patients in acute hospitals who no longer meet the criteria to reside.

The Dorset ICS will submit a final operational plan which includes a financial deficit of £21m, within which the Trust has a planned break-even financial plan. There remains considerable risk within this plan reflecting the significant operational pressues together with the recurrent impact of not being able to achieve recurrent efficiencies due to numerous periods of Industrial Action during the current year.

The risks to the availability of required resources consistent with operating within this context have been highlighted in the Trust's annual plan. These risks have been recorded in the Trust's risk register and are regularly monitored and reviewed together with the associated plans to mitigate these risks.

In approving its annual plan the Board of Directors has taken into account the reserves of the Trust, which would enable it to allocate additional resources as required, and the fact that it has provisional contract values agreed with commissioners.

It is recognised that this remains a draft plan and further work is being undertaken to mitigate financial risk and identify further opportunities to reduce the deficit further.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Rob Whiteman	**Name**	Siobhan Harrington
Capacity	Chair	**Capacity**	Chief Executive
Date		**Date**	

Worksheet "Training of governors"

Financial Year to which self-certification relates 2023/24 Please Respond

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Rob Whiteman	**Name**	Siobhan Harrington
Capacity	Chair	**Capacity**	Chief Executive
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under+A1

A

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 01 May 2024

Agenda item: 7.1

Subject:	Staff Survey and Action Plan
Prepared by:	Bridie Moore, Head of Organisational Development Deborah Matthews, Director of Organisational Development
Presented by:	Tina Ricketts, Chief People Officer

Strategic themes that this item supports/impacts:	Systems working and partnership ☐ Our people ☒ Patient experience ☐ Quality: outcomes and safety ☒ Sustainable services ☐ Patient First programme ☒ One Team: patient ready for reconfiguration ☐
BAF/Corporate Risk Register: (if applicable)	None
Purpose of paper:	Assurance
Executive Summary:	This paper gives a summary of the results from the 2023 Staff Survey which was published on 7 March 2024. The response rate increased from 45.4% to 59% in 2023. Our scores show improvement in most of the questions and all themes. Recommending the organisation as a place to work or be treated is considered one of the best indicators of employee engagement. Patient satisfaction is significantly higher in trusts with higher levels of employee engagement. In 2023 63.42% of our staff would recommend UHD as a place to work (2022: 56.18%) and 67.33% would recommend UHD a as place to be treated (2022: 64.21%). Results are now available at Trust, Care Group and team level. The national benchmark report is provided in the reading room, and all participating trusts can be viewed on the website. The IQVIA Management report is also provided. This provides an excellent review of our results against our 2022 scores by the independent survey provider.

Background:	The survey was independently administered by IQVIA and ran for 11 weeks from 12 September 2023. All staff were invited to complete the survey electronically only for the first time. There was significant preparation during 2023 to improve the completion rates including a communication campaign, a drive to update email addresses on ESR, and to group teams in a representative manner. There was also charity funding to offer a Costa voucher to all respondents.
Key Recommendations:	Our Staff Survey results will allow UHD to assess progress against the strategic objectives. Care Group leadership teams, Directors and team leaders are encouraged to use the valuable information they have received and demonstrate how they are taking effective action.
Implications associated with this item:	Council of Governors ☐ Equality, Equity, Diversity & Inclusion ☒ Financial ☐ Health Inequalities ☐ Operational Performance ☐ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☐ Regulatory ☐ Strategy/Transformation ☐ System ☐
CQC Reference:	Safe ☐ Effective ☐ Caring ☐ Responsive ☐ Well Led ☒ Use of Resources ☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
People and Culture Committee	10/04/2024	For information

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

UNIVERSITY HOSPITALS DORSET NHS TRUST

REPORT TO BOARD OF DIRECTORS – PART 1

NHS Staff Survey 2023 Results

1. INTRODUCTION

1.1 This report provides an overview of the NHS National Staff Survey 2023 for University Hospitals Dorset NHS Trust (UHD), outlining how our survey was conducted, response rates, results and associated actions.

1.2 The NHS Staff Survey is undertaken annually the 2023 NHS Staff Survey followed the same methodology and timings as in previous years. The questionnaire comprised of a set of core (compulsory) questions, asked in all organisations, with the themes aligned to the People Promise headings. This year bank staff were also surveyed for the second year with a separate survey.

1.3 Full survey reports for the NHS, including UHD, are available from the national Coordination Centre website.

2. NHS STAFF SURVEY 2023

2.1 The survey was independently administered by IQVIA and ran for 11 weeks between 12 September and 24 November 2023. We were pleased to go live 3 weeks earlier than in 2022.

2.2 For the first time in 2023, we invited all staff at UHD to participate in the survey only using the electronic survey.

2.3 In addition, from 2023 all bank staff must also be offered the opportunity to participate via the survey.

2.4 The Organisational Development team led a small task group including Communications and BI, to support the administration and running of the survey and develop a communication campaign throughout. Since the 2022 survey managers have been encouraged to complete the online Staff Survey training and have conversations with their teams to create and own local level action plans. During the summer, we contacted senior leaders to improve the grouping of team on ESR in order to maximise the number of teams that could be eligible for a team report (10+ respondents). We also worked with IT to cleanse email addresses and encourage individuals to update their email addresses on ESR. For 2023 we also secured charity funding to offer a Costa voucher to all respondents.

3. SURVEY RESULTS

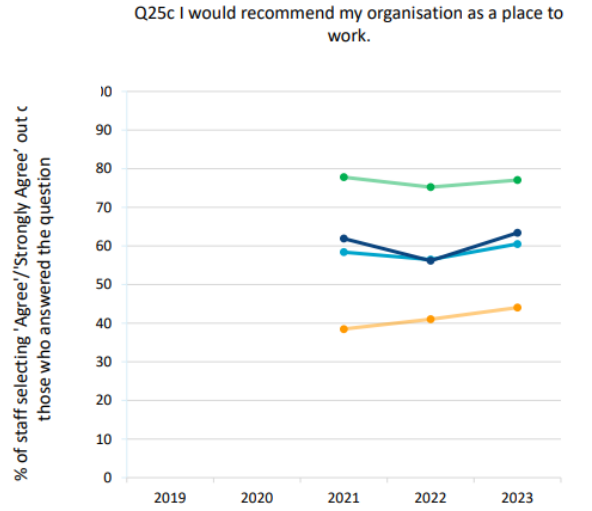
3.1 UHD results are benchmarked against other Acute and Acute & Community Trusts (122 organisations).

4.0 RESPONSE RATE

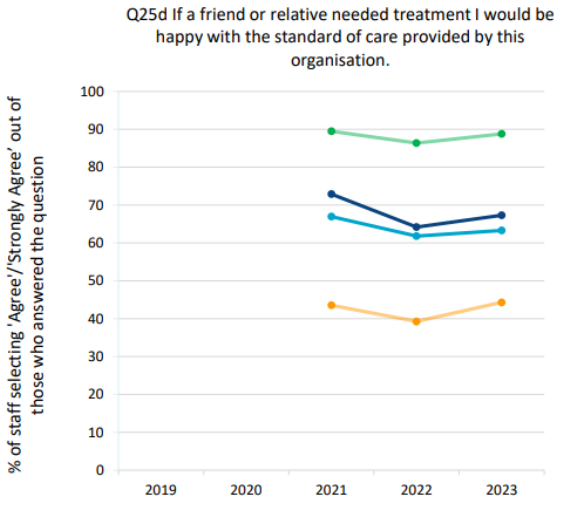
4.1 5619 staff completed the survey which is a response rate of 59% of eligible staff (2022: 45.5%) against the benchmarking group median of 45%. 424 bank staff completed the survey from a usable sample of 1,3348 which is a response rate of 31.5%.

4.2 Recommender Questions

Evidence from the Kings Fund shows a clear link between patient experience and employee engagement. Recommending the organisation as a place to work or be treated is considered one of the best indicators of employee engagement. Patient satisfaction is significantly higher in trusts with higher levels of employee engagement. In 2023 **63.42%** of our staff would recommend UHD as a place to work (2022: 56.18%) and 67.33% would recommend UHD a as place to be treated (2022: 64.21%). Both scores have increased which is great news in terms of attracting colleagues and a good foundation to build on. As this is one of the key Patient First measures of the strategic theme of Our People it demonstrates a significant step forward in our aspiration to make UHD a “great place to work”.



	2019	2020	2021	2022	2023
Your org	-	-	61.93%	56.18%	63.42%
Best result	-	-	77.82%	75.24%	77.09%
Average result	-	-	58.40%	56.48%	60.52%
Worst result	-	-	38.47%	41.03%	44.05%
Responses	-	-	3351	4121	5591



	2019	2020	2021	2022	2023
Your org	-	-	72.93%	64.21%	67.33%
Best result	-	-	89.51%	86.38%	88.82%
Average result	-	-	66.99%	61.82%	63.32%
Worst result	-	-	43.54%	39.27%	44.31%
Responses	-	-	3350	4111	5592

5.0 Workforce Race Equality Standard (WRES)/Workforce Disability Equality Standard (WDES)

5.1 In terms of our WRES and WDES indicators there are key improvements to be celebrated and built on with other areas requiring a continued focus for improvement. The questions responded to in the survey will inform the national WRES and WDES ratings later in the year.

5.2 WRES

5.2.1 The percentage of our BAME colleagues who said they experience harassment, bullying and abuse from the public, patients, families has reduced to 30.25% (2022: 34.06%) and from other staff to 24.97% (2022: 31.70%) However this remains below the average scores in our comparator group.

Workforce Race Equality Standard (WRES)

Survey Coordination Centre NHS

	2019	2020	2021	2022	2023
White staff: Your org	-	-	26.28%	27.89%	25.62%
All other ethnic groups*: Your org	-	-	30.02%	34.06%	30.25%
White staff: Average	-	-	26.47%	26.91%	24.72%
All other ethnic groups*: Average	-	-	28.84%	30.82%	28.11%
White staff: Responses	-	-	2888	3463	4505
All other ethnic groups*: Responses	-	-	413	593	995

*Staff from all other ethnic groups combined

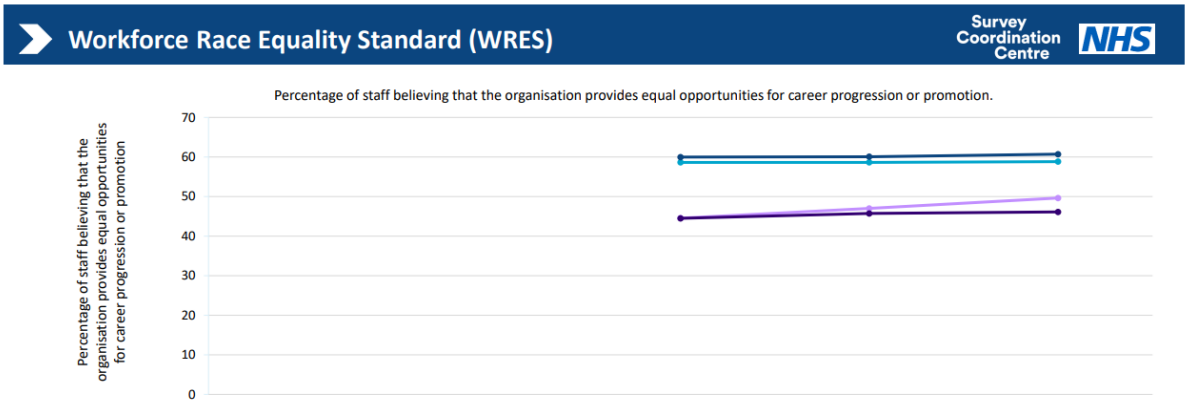
Workforce Race Equality Standard (WRES)

Survey Coordination Centre NHS

	2019	2020	2021	2022	2023
White staff: Your org	-	-	23.94%	22.47%	18.26%
All other ethnic groups*: Your org	-	-	31.05%	31.70%	24.97%
White staff: Average	-	-	23.65%	23.25%	22.37%
All other ethnic groups*: Average	-	-	28.53%	28.81%	26.20%
White staff: Responses	-	-	2895	3462	4513
All other ethnic groups*: Responses	-	-	409	593	993

*Staff from all other ethnic groups combined

5.3 More staff from BAME backgrounds reported that the organisation provides equal opportunities for career progression or promotion compared to 2022 (+ 0.39 %). There has been progression in this area since 2021. However UHD is still below the average of our comparator group.

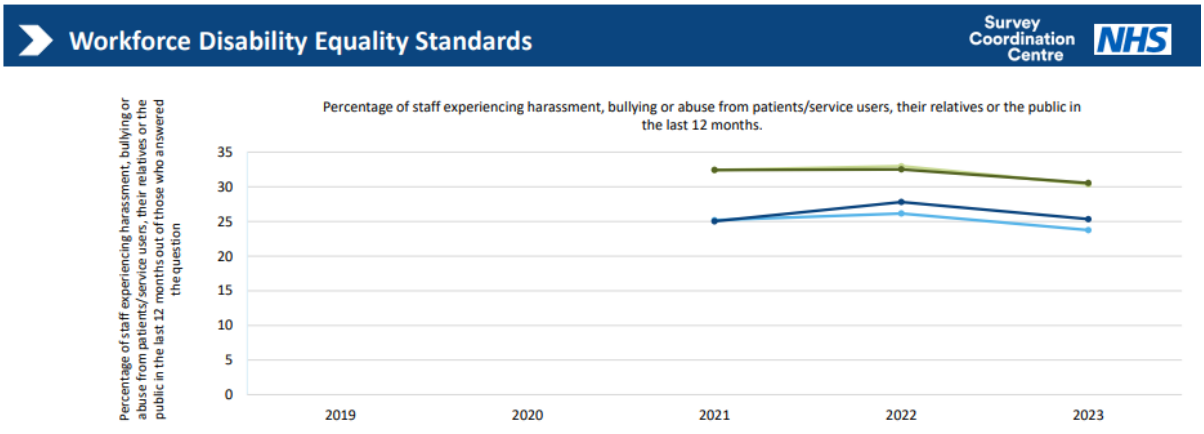


	2019	2020	2021	2022	2023
White staff: Your org	-	-	59.97%	60.07%	60.72%
All other ethnic groups*: Your org	-	-	44.50%	45.73%	46.12%
White staff: Average	-	-	58.64%	58.65%	58.84%
All other ethnic groups*: Average	-	-	44.56%	47.00%	49.64%
White staff: Responses	-	-	2873	3441	4486
All other ethnic groups*: Responses	-	-	409	586	993

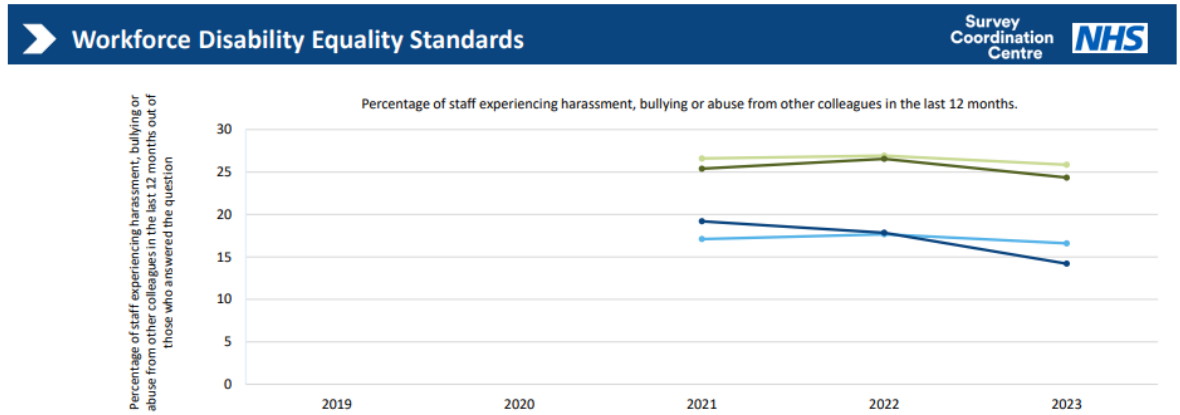
*Staff from all other ethnic groups combined

5.4 WDES

5.4.1 Slightly less of our staff with a long-term condition or illness are reporting harassment, bullying and abuse from the public, patients, families (-1.97%) fellow staff (-2.21%) and managers (-2.21%), however we need to see improvements continue in relation to this area.



	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	-	-	32.43%	32.53%	30.56%
Staff without a LTC or illness: Your org	-	-	25.03%	27.81%	25.34%
Staff with a LTC or illness: Average	-	-	32.43%	32.98%	30.35%
Staff without a LTC or illness: Average	-	-	25.19%	26.16%	23.76%
Staff with a LTC or illness: Responses	-	-	703	870	1188
Staff without a LTC or illness: Responses	-	-	2605	3197	4298



	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	-	-	25.40%	26.56%	24.35%
Staff without a LTC or illness: Your org	-	-	19.20%	17.85%	14.21%
Staff with a LTC or illness: Average	-	-	26.60%	26.93%	25.86%
Staff without a LTC or illness: Average	-	-	17.11%	17.67%	16.60%
Staff with a LTC or illness: Responses	-	-	693	866	1187
Staff without a LTC or illness: Responses	-	-	2578	3171	4287

	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	-	-	15.33%	15.26%	13.05%
Staff without a LTC or illness: Your org	-	-	9.08%	8.57%	5.83%
Staff with a LTC or illness: Average	-	-	18.00%	17.09%	15.87%
Staff without a LTC or illness: Average	-	-	9.77%	9.88%	8.74%
Staff with a LTC or illness: Responses	-	-	698	865	1188
Staff without a LTC or illness: Responses	-	-	2589	3184	4289

6.0 BANK STAFF

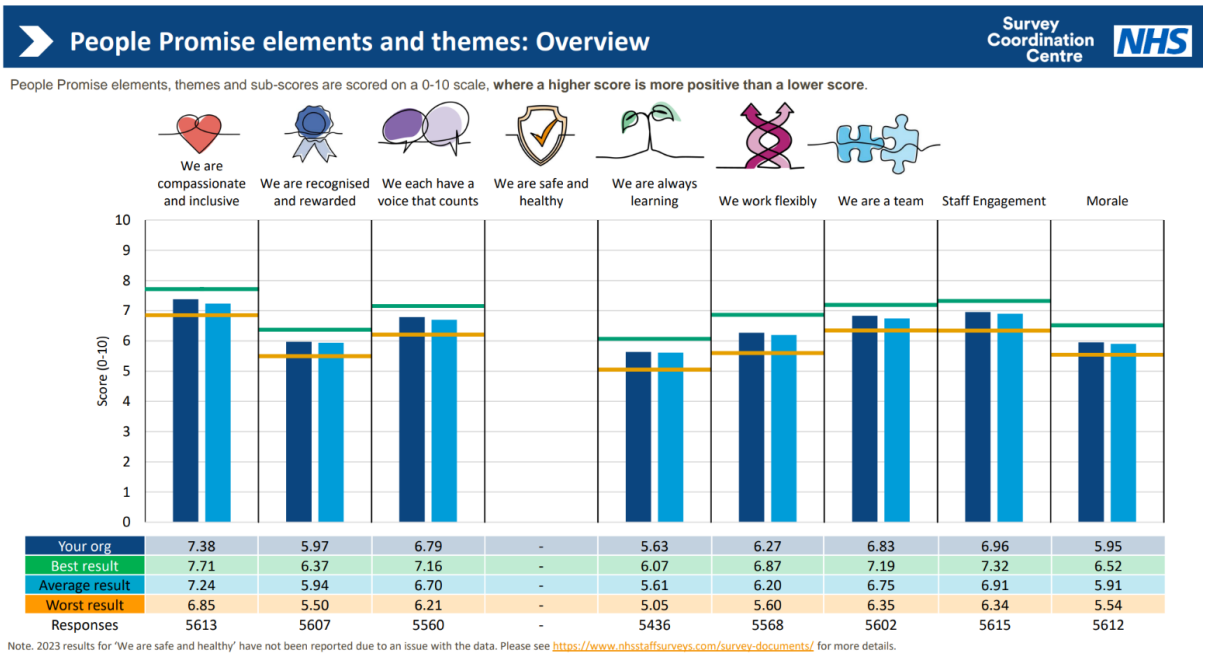
6.1 Bank staff responses are not included in our overall results for the 2023 survey and are reported separately. Our completion rate for 2023 showed a significant improvement, demonstrating all the work engaging our temporary workers. The results show that bank staff were significantly more positive than in 2022 in all the themes. In 2023 compared to substantive staff, the Bank survey shows more positive responses in ‘We are safe and healthy’, ‘We are always learning’, and ‘We work flexibly’. The Bank Survey was introduced in 2022. As we continue to survey bank staff on their experience of working for the Trust, we will build up a better picture in terms of trends and analysis.

Summary of Scores

People Promise/Theme/Question	2022 Score	Significance	2023 Score	Significance	Sub. Score
Theme - Staff engagement	6.68	Not Significant	6.80	Not Significant	7.00
Theme - Morale	5.48	Not Significant	5.86	Not Significant	5.99
People Promise 1 - We are compassionate and inclusive	7.01	Not Significant	7.36	Not Significant	7.43
People Promise 2 - We are recognised and rewarded	5.72	Not Significant	6.12	Not Significant	6.01
People Promise 3 - We each have a voice that counts	6.34	Not Significant	6.50	Not Significant	6.83
People Promise 4 - We are safe and healthy	6.17	Not Significant	6.59	Significantly Better	6.12
People Promise 5 - We are always learning	5.93	Not Significant	6.03	Not Significant	5.67
People Promise 6 - We work flexibly	6.17	Not Significant	6.47	Not Significant	6.30
People Promise 7 - We are a team	6.29	Not Significant	6.74	Not Significant	6.87

7.0 THEMES

7.1 The NHS Staff survey is aligned to the People Promise, increasing inclusivity, and uses a standard methodology to ensure it is the most accurate measure of employee experience in the NHS.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.38	5.97	6.79	-	5.63	6.27	6.83	6.96	5.95
Best result	7.71	6.37	7.16	-	6.07	6.87	7.19	7.32	6.52
Average result	7.24	5.94	6.70	-	5.61	6.20	6.75	6.91	5.91
Worst result	6.85	5.50	6.21	-	5.05	5.60	6.35	6.34	5.54
Responses	5613	5607	5560	-	5436	5568	5602	5615	5612

Note. 2023 results for 'We are safe and healthy' have not been reported due to an issue with the data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

7.2 Our performance is better than the average in our comparator group in all of the reported themes. For the theme 'We each have a voice that counts' the improvement is not significant. For all other People Promise elements and the Staff Engagement and Morale themes, our 2023 results are significantly higher.

7.3 61 questions scored significantly better than in 2022. 2 questions scored significantly worse. 44 questions were not significantly changed.

8.0 Results by Theme

8.1 Theme 1 – We are Compassionate and Inclusive

8.1.1 This theme remains a key focus theme for the Trust. Questions include one of our Patient First measures for the strategic theme, Patient Experience. (Q25a Care of patients/service users is my organisation's top priority). It also includes a key advocacy measure for our strategic theme, Our People (Q25c I would recommend my organisation as a place to work).

8.1.2 Every question in this theme is better our comparator group. Every question also is better than our UHD score for 2022 except for:

- Q15 (Does your organisation act fairly with regard to career progression/ promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?) which has reduced from 57.97% to **57.48%**
- Q7i (I feel a strong personal attachment to my team) which has reduced from 67.70% to **67.16%**

8.2 Theme 2 - We are Recognised and Rewarded

8.2.1 Overall, this theme improved on the 2022 results and is slightly above the comparator group score. Part of this theme includes questions relating to pay which is influenced by the current national position.

8.2.2 Every question in this theme is better our comparator group except:

- Q4b (How satisfied are you with the extent to which my organisation values my work) which is **0.16% lower** than the average of 44.28%
- Q4c (How satisfied are you with the level of your pay) which is **3.42% lower** than the average of 30.61%

8.2.3 Every question is better than our UHD score for 2022.

8.3 Theme 3 – We each have a voice that counts

8.3.1 Overall, this theme slightly improved on the 2022 results and the comparator group score.

8.3.2 Every question in this theme is better our comparator group except:

- Q3f(I am able to make improvement happen in my area of work) which is **0.48% lower** than the average of 56.35%

8.3.3 Seven questions are better than our UHD score for 2022. The following:

- Q3d (I am able to make suggestions to improve the work of my team/department) has reduced from 74.72% to 73.95%
- Q3e (I am involved in deciding on changes introduced that impact my work area/team/department) has reduced from 52.31% to 51.65%
- Q3f (I am able to make improvements happen in my area of work) has reduced from 56.01% to 55.87%)

- Q20a (I would feel secure raising concerns about unsafe clinical practice.) had reduced from 73.57% to 72.65%

8.4 Theme 4 – We are safe and healthy (Not currently being reported on by NSS due to a national error during the fieldwork period connected to completing the survey on an iPhone.)

8.5 Theme 5 – We are always learning

8.5.1 Overall this theme improved on the 2022 results and was slightly better than the comparator group score.

8.5.2 Every question in this theme is better or the same as our comparator group except:

- Q23a (In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?) which is less than 0.1% less than the comparator score of 83.12%.
- Q23b (My appraisal helped me to improve how I do my job) which is 1.07% less than the comparator score of 25.44%.
- Q23c (My appraisal helped me agree clear objectives for my work) which is 0.3% less than the comparator score of 36.02%.

8.5.3 Every question is better than our UHD score for 2022 except:

- *Q24a (This organisation offers me challenging work) which has reduced from 73.32% to 70.85%.*

8.6 Theme 6 – We work flexibly

8.6.1 Overall this theme improved on the 2022 results and was slightly better than the comparator group score.

8.6.2 Every question is better than our score for 2022.

8.6.3 Every question is better than the comparator score.

8.7 **Theme 7 – We are a team**

8.7.1 This theme has improved from 6.68 in 2022 to 6.83 in 2023. It is also slightly better than the comparator group by less than 0.1 (6.75)

8.7.2 Every question is better than our scores for 2022 except Q7e (I enjoy working with the colleagues in my team) which is only 0.02% lower than 2022.

8.7.3 Every question is slightly better than our comparator group except:

- Q7b (The team I work in often meets to discuss the team's effectiveness) which is 0.91% lower than 61.43%.
- Q9b (My immediate manager gives me clear feedback on my work) is 64.80%. The comparator group score is 64.96%

8.8 Morale

8.8.1 This is an important measure for UHD during our Patient First journey. It has improved from 5.61 in 2022 to 5.95 in 2023. It is also very slightly better than the comparator group by less than 0.1% (6.75)

8.8.2 Every question is better than our scores for 2022 except Q3e (I am involved in deciding on changes introduced that affect my work area / team / department) which is 0.66% lower than 2022.

8.8.3 Every question is slightly better than our comparator group except:

- Q3g (I am able to meet all the conflicting demands on my time at work.) which is 45.10%. The comparator score is 46.63%

- Q3i (There are enough staff at this organisation for me to do my job properly) which is 29.57%. The comparator score is 31.75%

- 5a (I have unrealistic time pressures) which is 24.74% and the comparator score is 25.08%.

9.0 Next Steps

9.1 Following the publication of the national results in March 2024 the breakdown reports for the Care Groups have been share to celebrate successes and identify areas of improvement at team level. These results have also been triangulated with the UHD scorecard data for review at the individual Strategy Deployment Review (SDR) meetings.

9.2 During April 2024, we will produce simple info graphics to support cascade of information and encourage learning from the results and sharing of staff engagement ideas across UHD.

9.3 More than 200 team level reports will be shared with the Care Group and Directorate leadership teams for cascading who will encourage local action planning in line with the monthly SDR process.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 01 May 2024

Agenda item: 7.2

Subject:	Gender Pay Gap Report 2023/243
Prepared by:	Jon Harding, Head of Organisational Development Deborah Matthews, Director of Organisational Development
Presented by:	Tina Ricketts, Chief People Officer

Strategic themes that this item supports/impacts:	Systems working and partnership ☐ Our people ☒ Patient experience ☐ Quality: outcomes and safety ☐ Sustainable services ☐ Patient First programme ☐ One Team: patient ready for reconfiguration ☐
BAF/Corporate Risk Register: (if applicable)	BAF3 & BAF4
Purpose of paper:	Assurance
Executive Summary:	The UHD data presented in this report was taken from the Electronic Staff Record for the period ending 31 March 2023. The data has been presented along with recommended actions to provide the People and Culture Committee assurance that UHD will continue to work towards a situation without a gender pay gap. This data demonstrates that there could be greater female representation in senior clinical roles. Similarly, the Trust acknowledges that there could be greater male representation in less senior clinical and non-clinical roles. Our headcount has increased by 148 to 9439 since last year with 33 more female and 115 more males across UHD (31 March 2022 compared to 31 March 2023). There is an increase in representation at senior Manager level (8a, 8b, 8c and 9) of female staff. This is a positive move towards equitable representation with our workforce demographics.

	A reduction in the number of females in Agenda for Change [AfC] Band 2 positions and an increase in females in AfC Band 3 and 7 specifically. An increase in female representation at AfC Band 8a, 8c and consultant roles which will have supported the reduction in the median Gender Pay Gap from 5.33% to 3.5% over the previous year. Comparing the median hourly pay gap women earn approximately 96p for every £1 that men earn. Due to local intervention the median bonus pay awarded has removed the gender pay gap, however when comparing the mean (average) bonus pay, women's mean bonus pay is 35.96% lower than men's.
Background:	Reporting Gender Pay disparity is a statutory requirement as part of the Public Sector Duty within the Equality Act 2010. The Gender Pay Gap reporting is a mandatory requirement for all organisations with +250 employees. UHD is required to publish six calculations showing their: • Average gender pay gap as a mean [average] • Average gender pay gap as a median [average] • Average bonus gender pay gap as a mean average] • Average bonus gender pay gap as a median [average] • Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment • Proportion of males and females when divided into four groups ordered from lowest to highest pay. The data has been uploaded to the Gender Pay Gap service to meet the compliance standard [30 March 2024.] The attached report has been provisionally published on the UHD external internet and internal intranet pending Board approval.
Key Recommendations:	The Board are requested to approve this report. The following actions will further support reducing the gender pay gap during 2024: • Review internal leadership development opportunities and encouraging our managers to have values-based appraisal and personal development discussions. This will impact the amount of UHD women who are ready for promotion to senior roles. • Review recruitment guidance and training to include a more inclusive approach. Notably

	through positive action and diverse recruitment panels for senior vacancies. • We will further develop and raise the profile of the UHD Women's network. • Disseminate the infographic at Appendix A The Chief People Officer and Director of OD will continue to work with the Executive team to support the identified actions. Delivery of these will be supported by the Trust's Equality, Diversity and Inclusion Group (EDIG) and assured through the People and Culture Committee.
Implications associated with this item:	Council of Governors ☐ Equality, Equity, Diversity & Inclusion ☒ Financial ☐ Health Inequalities ☐ Operational Performance ☐ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☐ Regulatory ☐ Strategy/Transformation ☐ System ☐
CQC Reference:	Safe ☐ Effective ☐ Caring ☐ Responsive ☐ Well Led ☒ Use of Resources ☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
People & Culture Committee Equality, Diversity & Inclusion Group	10/04/2024 04/04/2024	Data has been uploaded to the Gender Pay Gap Service and the attached report has been provisionally published externally.

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

University Hospitals Dorset
NHS Foundation Trust

Gender Pay Gap Annual Report 2023/24

University Hospitals Dorset NHS Foundation Trust

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

1. Background

1.1 It became mandatory from 31 March 2017 for public sector organisations with over 250 employees to report annually on their gender pay gap. The results must be published on a government website, as well as the employer's own website (and remain there for 3 years).

1.2 Gender pay reporting presents data on the difference between men and women's average pay within an organisation. It is important to highlight the distinction between this and equal pay reporting, which is instead concerned with men and women earning equal pay for the same (or equivalent) work. Across the country, average pay of women is lower than that of men and this tends to be because there are fewer women in senior high earning positions in organisations than men. Whilst a workforce may be predominantly female, if the most senior positions are taken up by men, the average pay of women in that organisation could well be lower. The Regulations have been brought in to highlight this imbalance, the aim being to enable employers to consider the reasons for any inequality within their organisation and to take steps to address it. (link NHS Employer Guide to *Gender Pay Gap Reporting retrieved* 2024-02)

1.3 University Hospitals Dorset NHS Trust has consecutively published annual reports since merger, our first report was March 2021. This data was taken from a snapshot date of 31 March 2023 for our March 2024 report.

1.4 The NHS terms and conditions of service handbook contain the national agreements on pay and conditions of service for NHS staff other than very senior managers and medical staff. Job evaluation (JE) enables jobs to be matched to national job profiles or allows Trusts to evaluate jobs locally, to determine in which Agenda for Change pay band a post should sit.

2. The Gender Pay Gap Six Indicators

2.1 An employer must publish six calculations showing their:

- Average gender pay gap as a mean [average]
- Average gender pay gap as a median [average]
- Average bonus gender pay gap as a mean [average]
- Average bonus gender pay gap as a median [average]
- Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment
- Proportion of males and females when divided into four groups ordered from lowest to highest pay.

Under national guidance, medical staff clinical excellence awards are included within bonus pay.

3. Methodology

3.1 The statutory calculations have been undertaken at the snapshot date of 31 March 2023, using the national Electronic Staff Record (ESR) Business Intelligence standard

report. In line with NHS Employers guidance Clinical Excellence Awards and the approach taken to award them at UHD have been categorised as bonuses.

3.2 Pay includes: basic pay, full paid leave including annual, sick, maternity, paternity, adoption or parental leave, bonus pay, area and other allowances and shift premium pay. (**Note: bonus pay is included, but only as a separate metric as one of the 6 key indicators we need to produce. The gender pay gap figure is calculated from hourly pay – which can only be ordinary pay, bonus pay is not hourly).**

3.3 Pay does not include: overtime pay, expenses (payments made to reimburse expenditure wholly and necessarily incurred in the course of employment, e.g. mileage for use of vehicle), remuneration in lieu of leave, the value of salary sacrifice schemes, benefits in kind (e.g. childcare vouchers), redundancy pay and tax credits.

4. UHD Workforce Context

4.1 The gender split within the overall workforce is 74.70% female and 25.30% male. The breakdown of the proportion of females and males in each banding is as set out below:

	2022-23				
	Female		Male		Total
Pay Band	Headcount	%	Headcount	%	
Band 1	15	39.5%	23	60.5%	**38**
Band 2	1181	71.8%	464	28.2%	**1645**
Band 3	1021	83.3%	205	16.7%	**1226**
Band 4	598	83.1%	122	16.9%	**720**
Band 5	1348	80.4%	328	19.6%	**1676**
Band 6	1237	83.8%	239	16.2%	**1476**
Band 7	782	81.5%	178	18.5%	**960**
Band 8a	170	68.0%	80	32.0%	**250**
Band 8b	81	65.9%	42	34.1%	**123**
Band 8c	25	62.5%	15	37.5%	**40**
Band 8d	11	55.0%	9	45.0%	**20**
Band 9	8	57.1%	6	42.9%	**14**
VSM	4	50.0%	4	50.0%	**8**
Executive Director	0	0.0%	2	100.0%	**2**
Non-Executive Director	1	20.0%	4	80.0%	**5**
Chair	0	0.0%	1	100.0%	**1**
Other	10	71.4%	4	28.6%	**14**
Consultant	191	39.2%	296	60.8%	**487**
Non-Consultant Career Grade	63	42.3%	86	57.7%	**149**
Trainee Grades	305	52.1%	280	47.9%	**585**
Total	**7051**	**74.7%**	**2388**	**25.3%**	**9439**

5. Results for UHD - 31 March 2023 snapshot

5.1 Gender Pay Gap Results

- Our headcount has increased by 148 to 9439 since last year with 33 more female and 115 more males across UHD (31st March 2022 vs. 31st March 2023).

- This year our Gender Pay Gap is 3.53%.

- This is an improvement on last year's reported figure of 5.33% and continues the positive trend following the organisational merger in 2020.

- There is an increase in representation at senior Manager level (8a, 8b, 8c and 9) of female staff. This is a positive move towards equitable representation with our workforce demographics.

Mean and Median Pay Gap

- The gender pay gap for the Trust overall, is 3.53%. This has decrease from 5.33% reported last year.
- The **mean gender pay gap** for the Trust overall is 19.63%. This has decreased by 1.32% from 20.95% reported last time.
- If the Medical and Dental workforce are excluded from the calculation, the Trust's mean gender hourly pay gap would be 1.27%, compared to 19.63%. The Trust's median gender pay gap would be 9.78% in favour of female staff.

a) Average gender pay gap as a <u>mean</u> average

Overall

	Male	Female	% difference
Mean hourly rate	£22.88	£18.39	19.63%

Agenda for Change

	Male (AFC)	Female (AFC)	% difference
Mean hourly rate	£16.82	£17.04	1.27%

Medical

	Male (medical)	Female (medical)	% difference
Mean hourly rate	£39.47	£35.15	10.95%

b) Average gender pay gap as a <u>median</u> average

Overall

	Male	Female	% difference
Median hourly rate	£17.46	£16.84	3.53%

(Note small variation from published overall GPG figure, due to recalculating with the staff group breakdown)

Agenda for Change

	Male (AFC)	Female (AFC)	% difference
Median hourly rate	£14.58	£16.16	9.78%

Medical

	Male (medical)	Female (medical)	% difference
Median hourly rate	£39.61	£29.80	24.75%

5.2 **Clinical Excellence Awards Bonus Payments**

5.2.1 Local Clinical Excellence Award's (LCEA) recognise and reward NHS consultants in England, who perform over and above the standard expected of their role. Awards are given for quality and excellence, acknowledging exceptional personal contributions.

5.2.2 Overall, there remains a large differential between the amount of CEA bonus pay in 2022-23 with 11.0% of male staff receiving bonus pay in comparison to 2.3% of staff. The average annual CEA pay being just over £8,249.50 for male medics compared to £5,283.04 for female medics representing a decrease for both male and female medics.

The payment of existing Local Clinical Excellence Awards (LCEA) pre-2018 awards is pro-rata. In the 2022-23 round of Local Clinical Excellence Awards which we implemented in November 2023 salaries, an agreement was reached with the Joint Local Negotiating Committee that there would be an equal distribution of awards. The amount paid (£3,503.66) is not pro-rata and all eligible consultants received an equal share.

c) Average Clinical Excellence Awards bonus gender pay gap as a mean average (medical)

	Male (Medical)	Female (Medical)	% difference
Mean bonus pay	£8,249.50	£5,283.04	35.96%

d) Average Clinical Excellence Awards bonus gender pay gap as a median average (medical)

	Male (Medical)	Female (Medical)	% difference
Median bonus pay	£3,173.31	£3,173.31	0.0%

e) Proportion of male medics receiving a bonus payment and proportion of female medics receiving a bonus payment

Male proportion receiving bonus	Male medical staff overall	%	Female proportion receiving bonus	Female medical staff overall	%
263	649	39.7%	163	551	29.2%

5.3 **Proportion of Males and Females in each Quartile Pay Band**

5.3.1 At the time the snapshot was taken the percentage of female staff was 75.29% female and 24.71% male.

f) Proportion of males and females in all staff groups when divided into four groups ordered from lowest to highest pay

	Male %	Female %
1. Lower	22.88%	77.12%
2. Lower Middle	23.52%	76.48%
3. Upper Middle	18.10%	81.90%
4. Top	34.32%	65.68%

g) Proportion of Agenda for Change males and females when divided into four groups ordered from lowest to highest pay

	Male %	Female %
1. Lower	22.88%	77.12%
2. Lower Middle	23.04%	76.96%
3. Upper Middle	15.70%	84.30%
4. Top	20.58%	79.42%

h) Proportion of Medical staff males and females when divided into four groups ordered from lowest to highest pay

	Male %	Female %
1. Lower	0.0%	0.0%
2. Lower Middle	41.54%	58.46%
3. Upper Middle	50.29%	49.71%
4. Top	55.60%	44.40%

For Medical and Dental staff, there are a higher proportion of males in the highest paid quartile.

a) Average (Mean) Gender Pay Gap - Ordinary Pay

	2022-23		
	Female	Male	*% difference*
All Staff	£18.39	£22.88	**19.63%**
Non-Medical Staff Groups	£17.04	£16.82	**1.27%**
Medical Staff Group	£35.15	£39.47	**10.95%**

j) Median Gender Pay Gap – Ordinary Pay

	2022-23		
	Female	Male	% difference
All Staff	£16.84	£17.46	**3.53%**
Non-Medical Staff Groups	£16.16	£14.58	**9.78%**
Medical Staff Group	£29.80	£39.61	**24.75%**

6. Conclusion

6.1 The Trust is required to report on snapshot data from 31 March 2022. This data demonstrates that there could be greater female representation in its senior clinical roles.

The position is consistent with previous snapshot data taken from 31 March 2022 data. Similarly, the Trust acknowledges that there could be greater male representation in less senior clinical and non-clinical roles.

6.2 It should be noted that the 2020 data was first published in March 2021, and this latest data snapshot took place on 31 March 2023, as per the regulations. Therefore, it will take some time for the impact of any actions to reduce the gender pay gap.

6.3 Separating the data for Agenda for Change and the Medical/Dental workforce gives a better understanding of where the greatest difference in pay and gender representation.

6.4 Comparing the median hourly pay gap, women earn 96.5p for every £1 that men earn. Their median hourly pay is 3.53% lower than men's.

6.5 There is no median bonus pay gap for 2023. When comparing mean (average) bonus pay, women's mean bonus pay is 35.96% lower than men.

7. Update on Action Plan from 2021 and 2022

7.1 The following actions continue to support closing the gender pay gap:

	Action Plan	**Progress**
1.	Share Gender Pay Gap information across the Trust, see Appendix A	Published on intranet and internet.

		Shared with Care Groups
2.	Review and transfer any outstanding actions into the revision of the UHD Equality, Diversity, and Inclusion Priority Action Plan in Quarter 1 of 2024/25	The UHD EDI Priority Action Plan is monitored through the EDI Group; work steams will be aligned to Patient First methodology
5.	Continue the Trust's commitment to an equitable workforce	Demonstrated in our Trust objectives and values and the wider EDI action plan
6.	Continue equitable access to trust leadership training and development	On-going leadership programmes and additional capacity through the Dorset Integrated Care System for underrepresented groups
7.	Support all staff in protected groups through living our Trust values and implementing our people strategy	The EDS Assessment identified areas where protected characteristics should be recorded including Occupational Health and Education Continuous Professional Development
8.	Flexible working – Raising the profile of the benefits of Flexible Working across UHD through a range of methods, including communication briefings, inclusive leadership conversations	A new UHD Flexible Working Policy was created in January 2022 and is also being promoted via the Space Allocation Group to support the Reconfiguration strategy.
9	Career Progression - Accessible bite sized and online training will continue, to ensure development can be accessed by those working part time and flexible work patterns. Bias awareness is included in new leadership and development modules.	Increased access to online leadership training modules. These rotate so they are on different days and times to increase accessibility. More modules that can be worked on independently in own time. Managers' induction launched introducing compassionate, inclusive leadership and bias awareness.
10	A Women's network was introduced with interest from staff across the organisation in 2022.	The network is now established and working to expand reach and influence

11	CEA awards – Once national guidance is received on the reform of LCEA's a new award process will be developed for UHD. This will be more inclusive, transparent, and fair and will reward excellence and improvement, underpinning the delivery of local priorities.	In the 2022-23 round of Local Clinical Excellence Awards which we implemented in November 2023 salaries, an agreement was reached with the Joint Local Negotiating Committee that there would be an equal distribution of awards.

8. Next Steps

8.1 The following actions will further support reducing the gender pay gap during 2024:

8.1.1 Review internal leadership development opportunities and encouraging our managers to have values-based appraisal and personal development discussions. This will impact the amount of UHD women who are ready for promotion to senior roles. We are recording and reporting on protected characteristics of delegates in all UHD programmes.

8.1.2 Review recruitment guidance and training to include a more inclusive approach, notably through positive action and diverse recruitment panels for senior vacancies.

8.1.3 We will further develop and raise the profile of the UHD Women's network.

8.1.4 Publish the infographic at Appendix A

8.2 The Chief People Officer and Director of OD will continue to work with the Executive team to support the identified actions. Delivery of these will be supported by the Trust's Equality, Diversity, and Inclusion Group (EDIG) and assured through the People and Culture Committee.

Jon Harding
Head of Organisational Development
March 2024

Useful Abbreviations:

- BAME - Black, Asian, and Minority Ethnic
- BME - Black Minority Ethnic
- EDI - Equality Diversity and inclusion
- EDIG - Equality Diversity and Inclusion Group
- WRES - Work Race Equality Standards
- WDES - Work Disability Equality Standards
- ICS – Integrated Care System

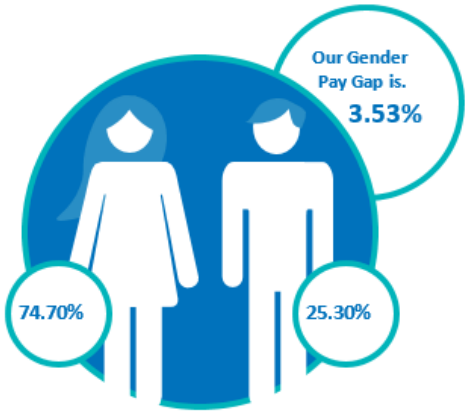
Appendix A, Gender Pay Gap Infographic 2024

NHS
University Hospitals Dorset
NHS Foundation Trust

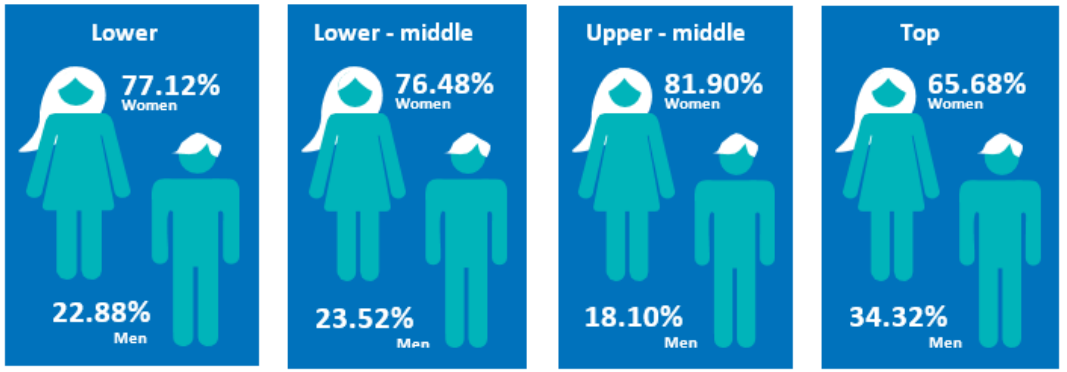
Story of our Gender Pay Gap

Data taken from 31 March 2023

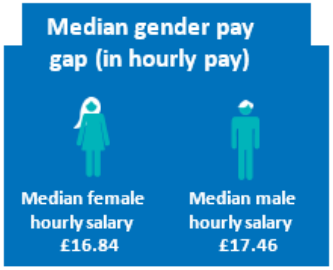
- The Gender Pay Gap at University Hospitals Dorset has fallen from 5.3% reported in March 2023 to 3.53% reported in March 2024.
- We fully support the equality of opportunity and recognise that further work is needed to achieve this.
- Female staff are represented in many senior positions, and we acknowledge there are still significant gaps with variances evident in senior clinical roles which drive the greatest variations in our results.



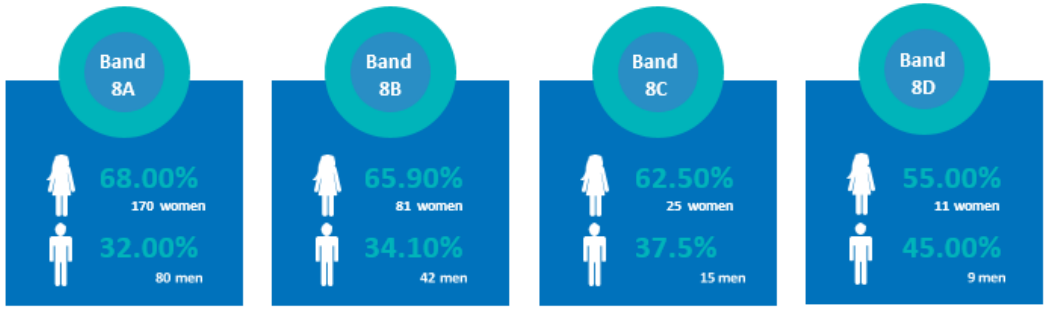
Proportion of males and females in each pay quartile



Our Workforce has an employee basethat is predominantly female.



Senior agenda for change grades



University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 01 May 2024

Agenda item: 7.3.1

Subject:	Freedom to Speak up Annual Report (2023/4)
Prepared by:	Helen Martin, Freedom to Speak Up Guardian (FTSUG)
Presented by:	Helen Martin, FTSUG

Strategic themes that this item supports/impacts:	Systems working and partnership ☐ Our people ☒ Patient experience ☐ Quality: outcomes and safety ☒ Sustainable services ☐ Patient First programme ☒ One Team: patient ready for reconfiguration ☐
BAF/Corporate Risk Register: (if applicable)	BAF not applicable
Purpose of paper:	Assurance
Executive Summary:	The purpose of exception report is to: • Review our speaking up culture over 2023/4 and • Understand why our staff are raising concerns and what we have learnt.
Background:	Every Trust is mandated to have a named FTSUG in post and an expectation as part of the well led domain, to see FTSUG reports submitted at least 6 monthly to enable the Board to maintain a good oversight of FTSU matters and issues. Reports are to be presented by the FTSUG in person. Reports must include both quantitative and qualitative information and case studies or other information that will enable the senior team to understand the issues being identified, areas for improvement, and take informed decisions about action.
Key Recommendations:	• Speaking up benefits everyone; it creates learning and improvement, leads to safer care and improved patient experience. • Case headlines; 412 FTSU referrals 2023/4, an increase of 48% on previous 12month. 185 cases from Poole site and 227 cases from RBCH (45:55% respectively).

	• Staff approach the FTSU team for a number of reasons. The greatest theme had an element of behaviours (188 staff; 46%). This is followed by process and procedures (131 staff; 32%) and then worker safety and wellbeing (76 staff; 18%). Worker safety continues to grow as a theme year on year.
	• Staff use the FTSU channel more for workplace and relational issues than patient safety.
	• 47% of staff who use the FTSU route is because either their line manager is the issue or not addressing the issue. 14% felt insecure.
	• 22% of staff (89 staff) from our global majorities ethnic minority raised FTSU concern. 57% of cases (51 staff) had elements of attitudes and behaviours.
	• Thirty-seven staff reported cases anonymously (9% , similar to National 9.3%).
	• Other points to note:
	  ○ FTSU month (Oct) - #breakingboundaries increase in referrals 75% from previous month.
	  ○ Poor uptake of Speak Up, Listen Up, Follow Up', e-learning modules. Total 2023/4 – 263staff. Just over 600 staff since 2021.
	• Learning;
	  ○ The importance of a respectful and civil culture/programme of work
	  ○ We leave roles because of the people we work with.
	  ○ Merger stresses and differences across sites continue.
	  ○ Our global majorities speak up more about poor behaviours and not belonging.
	  ○ Cost of living struggles.
	  ○ Decision makers involving those who will be impacted by decisions.
	  ○ Busy line managers, not visible. Teams feeling unable to escalate issues. Line managers frustrated as unable to be present and be with teams. Issues often escalate.
	  ○ The importance of leaders creating psychologically safe workspaces and part of this is to encourage speaking up
	  ○ Listening takes time and is at the core of good leadership.
	  ○ Speaking up is everyone's business

Implications associated with this item:	Council of Governors ☒ Equality, Equity, Diversity and Inclusion ☒ Financial ☐ Health Inequalities ☐ Operational Performance ☐ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☒ Regulatory ☐ Strategy/Transformation ☐ System ☐

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

Report History: Committees/Meetings at which the item has been considered:	Date	Outcome
People and Culture Committee Trust Management Group	10/04/2024 23/04/2024	TMG for assurance and discussion. PCC for approval.

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

Freedom to Speak Up (FTSU)

Annual Report 2023/24

1.0 Introduction

Reflecting back on 2023/4 I am reminded of a quote from Megan Reitz, who spoke at last year's Freedom to Speak Up Guardian Conference:

"The silence of missing voices costs careers, relationships and lives".

Megan Reitz, 2023

Indeed, we saw this very sharply following the trial and verdict of Lucy Letby last Summer. It is tragic consequences of not listening and taking appropriate timely action like this which must lead us all to redouble our efforts to make speaking up, listening up and following up, business as usual.

Staff tell us that the main barriers to speaking up are fear and futility. Fear of what might happen if you speak up; or a belief that nothing will be done if you do. As leaders we must demonstrate that we welcome and encourage speaking up, through actions, not just words. That means listening to understand and challenging our own biases; remaining impartial and investigating the matter raised, not the person raising it.

At UHD, we have many routes that our people can use to speak up including our line managers, occupational health, staff governors, using our LERN forms, chaplains, education team and our HR team. Freedom to Speak Up (FTSU) is another alternative route which is both well used and evaluated by staff who use it.

Speaking up is entrenched within our objectives, strategy and improvement programme and we are seeing some early signs of green buds. This year, over 5600 staff shared their voice through the staff survey: 59% of UHD. This rich data tells us that over 50.63% staff feel our speaking up culture has improved from 2021 when only 46.31% felt the same. This is nearly a 10% increase from the previous 12months and will contribute to our safety culture breakthrough objective for quality outcomes and safety. Clearly there is more to do as 49.4% of staff this year do not feel the same.

This work is however more than the FTSU team. The role of the FTSU team is to highlight the challenges and act as an early warning system of where failings might occur. Our leaders, need to play a significant role in setting the tone for fostering a healthy speak up, listen up and follow up culture at UHD. Indeed, it is the experience of how our managers listen and act to concerns that we are often judged. Consequently, we need to be curious as to why staff choose not to go to their line manager. Over the last 12months, 47% of staff who come to the FTSU team say that they cannot go to their line manager because either they are the issue or that they are not addressing it. We need to better at this for us to be an embedded speaking up organisation.

Twenty-twenty-three has also been a year to celebrate. The FTSU team has expanded, with an additional FTSU guardian in post, Tara Vachell. The investment in this role has seen improvements in capacity, access and being able to deliver proactive projects such as hearing more from those seldom heard voices. A recent survey of those staff who have used the FTSU service also told us that the FTSU service reduced their absence but also resulted in them staying in the Trust; contributing to our people breakthrough objective for attracting and retaining the best talent (see section 2.1).

We also had another FTSU month in October and was a month to be proud. The team celebrated #breakingboundaries and visited departments, clinical areas, flying flags, a supportive communications plan, launched a communications development training programme for our IEN workforce and led a Schwartz round on "a time when I spoke up". Over 60 staff that month (an increase of 75% on the previous month) decided to speak up because of this work (see section 3.3).

The purpose of this paper is to review our speaking up culture for 2023/4 and understand why our staff are raising concerns and what we have learnt.

ACTION: Note approved amendments to FTSU Strategy which now reflects our Patient First Improvement Programme (section 3.8).

2.0 Vision of Speaking up and Commitment from the FTSU team

Supporting you to raise concerns
Freedom to speak up

To develop a culture of safety so that we become a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely.

The Freedom To Speak Up commitment

S You're safe and secure to talk to us; we'll support you every step of the way to raise concerns.

P We are all about our people. When we look after each other we give the best to our patients. FTSU are here for you and hearing your voice is our priority.

E We treat all staff equally, empower you to make concerns and enable the trust to make change.

A We will listen and act with integrity to ensure your concerns are heard. We are approachable and here for you.

K We treat you kindly; we know what steps need to be taken when you raise a FTSU concern, we have the knowledge to help make a difference.

Freedom to speak up

2.1 Speaking up at UHD – Our FTSU team

Our deputy FTSUG commenced in post end of August. This decision was made in line with guidance set out by the National Guardian Office (NGO) on developing FTSU internal networks. This development will allow the service at UHD be both sustainable and resilient, meeting the demands of our staff using the FTSU route, but also allow us to contribute to the organisation overcoming the barriers that result in workers feeling that they must come to a guardian in the first place. This is an exciting opportunity which will build on our FTSU network of Ambassadors set up since 2018. Our FTSU network raises awareness and promotes the value of speaking up, listening up and following up and helps address challenges posed by organisation size, geography and the nature of their work as well as support workers, especially those who may face barriers to speaking up. All members of the FTSU team have been key to our success.

We are now looking to sustain our new model and so have reviewed a number of data to evaluate it.

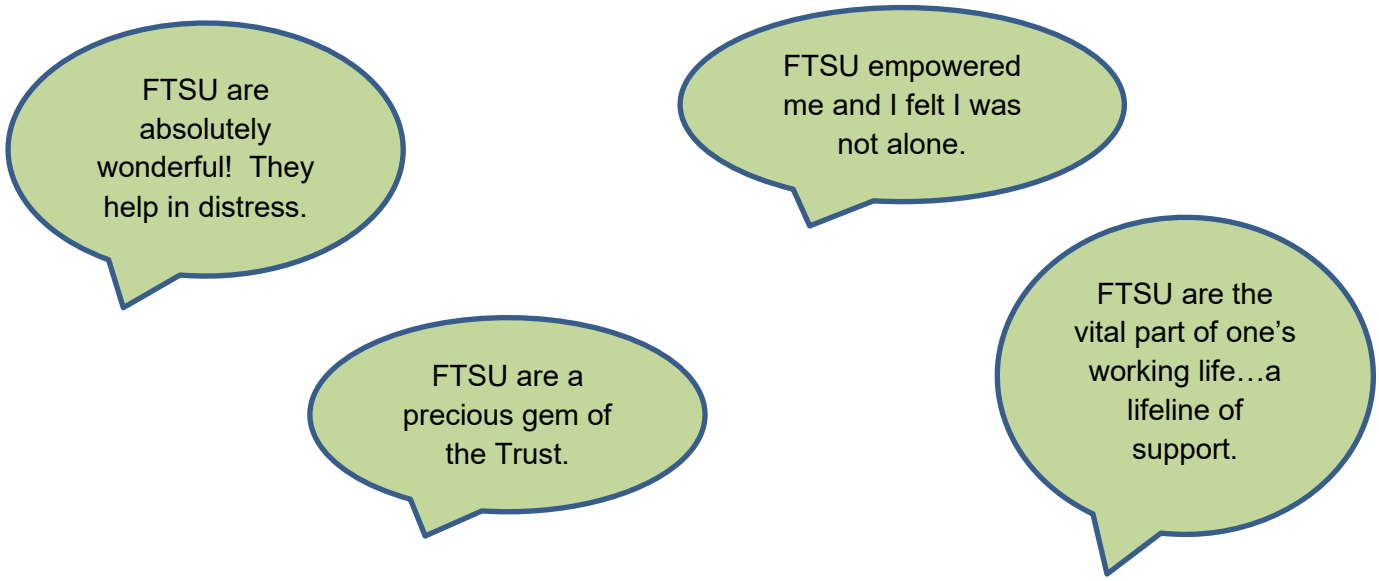
- **Increased Capacity:** The investment of this post has allowed us to meet the year-on-year increase of demand to FTSU service. In quarter 3, 2023, the number of conversations increased by 53% as compared to Q3, 2022 (142 vs 93 referrals, respectively).
- **Improved Access Times to FTSU team:** The investment of this post has allowed us to make contact following a referral within 48hrs working days in 100% of cases and of those, 99.3% within 24hrs.
- **Overcoming barriers and being more proactive:** The NGO warn leaders against FTSUG spending all their time acting as an additional channel rather than undertaking proactive work to overcome the barriers that result in workers feeling that they must come to a guardian in the first place. The investment of this post has allowed the FTSU team to proactively speak to over 400 staff (Qtr 3, 2023) as compared to less than 50 staff (Qtr 3, 2022) through presentations/team meetings/inductions. The team are now accessing groups never previously reached such as international workforce, medical, healthcare support workers and preceptees.
- **Hearing more seldom heard voices:** The function of the FTSU team is well established and continues to increase its reach to those voices seldom heard. In 2022/3 19% of referrals were from our global majority staff which has increased in 2023/4 to 21% of total referrals. Particular focus has been with our international workforce, not only at induction but also now within their development programme by leading a communication and speaking up workshop.
- **Increased team resilience:** The investment of this post has allowed 365day access to the FTSU team thereby improving team resilience but moreover removing a service with a single point of failure.

Another source of data was taken from a survey to staff who have used the FTSU service in quarter 3. Key observations were made:

- **Improved Added Value:** A service user survey was sent to all staff whom used the service in Qtr 3; 2023 to assess the value of staff using the service and supporting the breakthrough objectives for UHD (n=30):

    - **Service Value:** 44% felt stressed and worried before raising their concern
      "the situation felt like it was snowballing out of control and no one was listening", "the incident that I escalated to FTSU made me physically sick and I was off > 1 week."
    - **Support Health and Wellbeing**: 64% of staff felt speaking with the FTSU team supported their Health and Wellbeing
      "gave me the opportunity to start to learn to trust some NHS staff as I feel I have been let down in the past" and "felt listened to and the FTSU team helped me put in a plan to help deal with the situation"
    - **Reduction in Staff sickness:** 7 members of staff (25%) reported that they remained in work as a direct consequence of speaking with the FTSU team
      "The FTSU team helped me return to work more quickly" and "if it was not for the FTSU team, I would have become more physical unwell".
    - **Staff Retention:** 3 members of staff stated that the FTSU team stopped them looking for alternative employment outside of UHD
      "The FTSU team helped me remain in my department and work through the issues" and "I would have handed in my notice if it were not for the FTSU team"
    - **Staff satisfaction:** Given the experience of the FTSU team, 90% of staff service say they will speak up again (October-Dec 2023).

Finally, we asked to describe the FTSU service in one sentence. The responses included:



3.0 Key Progress over 2023/4

3.1 Speaking up at UHD – Our Senior Leaders

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

3.2 UHD staff awards – 2023 "Open and Honest"

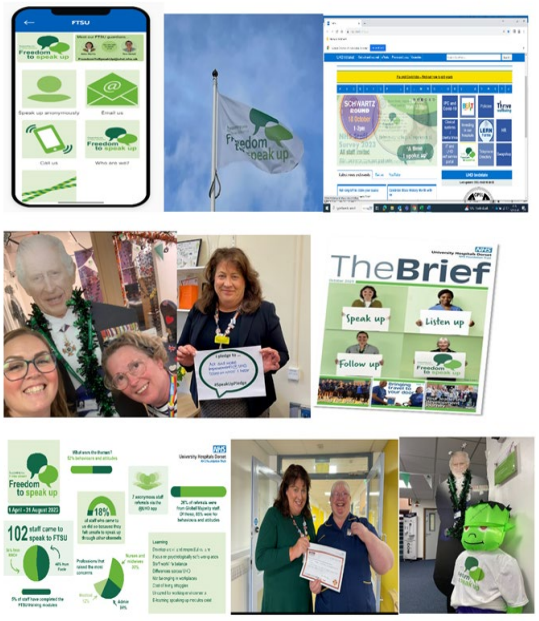
The UHD Awards is an important way to recognise each-other. In 2023, over 800 nominations were received.

One of the awards was the "Open and Honest" category, recognising an individual or team that works hard to promote an open and safe culture.

This year's worthy recipient was Catherine Bishop, one of our FTSU Ambassadors. The award celebrated the work that Catherine does to help others speak up, support their wellbeing and at times speaking truth to power. She is relentless in this work and a credit to our FTSU team.

3.3. Speaking up Month – October 2023 Breaking Barriers

Speak Up Month is the highlight of our calendar and is a chance to raise awareness of speaking up and the work which is going on to make speaking up business as usual. This year we celebrated the sixth Speak Up Month "Breaking Barriers". This topic recognised that there are many barriers which can silence people and that there are some groups which can face more barriers than others. Throughout the month we promoted the importance of speaking up through different ways. Wear Green Wednesdays also returned and visibly support this work by wearing green every Wednesday of October.



We had 63 referrals in October, an increase by 75% from the previous months. Issues raised continued to predominantly be relating to attitudes and behaviours.

3.4 FTSU Networks – "Looking in and out"

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

3.4.1 UHD FTSU Network: Our FTSU network at UHD meets monthly and discusses our observations and recent guidance. It allows us to quality assure the work and critically appraise what we do. We also completed some team and personal development in September.

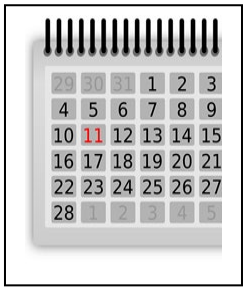
3.4.2 South-west regional Network: UHD stepped down as co-chair for the south west region in June after 3 $^{1}/_{2}$years. The National Guardian, Jayne Chidgey-Clark was present at the step-down meeting to show her appreciation of the work by the co-chairs. UHD will continue to maintain strong links and share good practice.

3.4.3 Dorset and Somerset FTSU Network: UHD set up this network in 2018 and chairs it. The vision of this group was agreed to share best practice and act as mentors for difficult cases. The membership has expanded over time, and now has representation across healthcare system.

3.5 National Guardian Office (NGO)

The NGO was created in response to recommendations made from Sir Robert Francis review in 2015 and leads, trains and supports a network of FTSUG in England. There are now over 1000 FTSUG in NHS, independent and third sector organisations and national bodies (June 2023). The office provides challenge and learning to the healthcare system as a whole, and conducts speaking up reviews to identify learning and support improvement.

A number of key documents have been published over 2023/4; all papers are critically evaluated and appraised with the board and FTSU team.



Mth	Published document	Discussed at UHD
April		
May		
June	Integrated Care Boards and FTSU guidance NGO – fear and futility; what does the staff survey tell us?	Bi-annual report
July	NGO Annual Report NGO FTSUG Survey 2023	Bi-annual report
Aug		
Sept	NHSE response to Lucy Letby case	Bi-annual report
Oct	NGO FTSU month	Annual report
Nov	NGO FTSU Champion and Ambassador Guidance NGO Annual Report laid down in Parliament	Annual report Bi-annual report
Dec		
Jan	NHSE/NGO; guide for leaders submission Publication of Good Medical Practice – including Speak Up	Annual/bi-annual
Feb		
Mar		

3.6 NGO data

UHD continues to be an active contributor to the work from the NGO. Part of this work is to submit and support requirements from the NGO. These include quarterly submissions, census information and other surveys.

Quarterly information about speaking up cases are submitted to the NGO, outlining the themes, and reporting the feedback received from those cases closed. Whilst number of referrals does not fully reflect the speaking up culture it does illustrate whether the FTSU is an established route for staff to use. Table 1 below shows how staff at UHD use this service as compared to surrounding healthcare.

Table 1: Quarterly NGO data submissions 2023/24 (x = no data submitted to NGO)

2023/4	Size	Qtr1	Qtr2	Qtr3	Qtr 4	TOTAL (qtr 1-3)
Dorset County	Small	x	56	85		**141**
Dorset Healthcare	Medium	43	29	33		**105**
Salisbury	Small	48	33	37		**118**
Solent	Medium	29	24	43		**96**
University Hospitals Dorset	Medium	57	81	142	132	**412**
University Hospitals Southampton	Large	18	X	X		**18**

Table 1 does create some questions. Why do our staff use the FTSU route when raising concerns more than neighbouring trusts? An initial hypothesis was a result of the significant staff changes in merger and re-organisational processes, resulting in staff being unaware of whom to escalate issues to. This hypothesis continues not to be the case and instead our data over 2023/4 shows us;

- 47% of staff reported that they come to the FTSU team because their line manager is the issue or that they are not addressing it.
- Fourteen per-cent staff reported that the reason they came to the FTSU team was because they felt insecure in raising concerns with line managers. This data is lower than that during 2022/23 (18%).
- A continuing increasing trend is staff are using the FTSU route for advice prior to escalating themselves via the correct route. Thirty-four percent of staff knew what they needed to do but wanted a confidential, impartial viewpoint to draft their thoughts.

These points all suggest that we need to continue to train our line managers to create working environments which are psychologically safe to speak up, and when staff do, that we listen and act.

3.7 NGO: Freedom to Speak Up training programme.

'Speak Up, Listen Up, Follow Up', is an e-learning package, aimed at anyone who works in healthcare. Divided into three modules, it explains in a clear and consistent way what speaking up is and its importance in creating an environment in which people are supported to deliver their best.

Over the last 12 months, 263 people have accessed the training, approximately 2% of the Trust. Since April 2021 when the programme was integrated into the BEAT platform, just over 600 staff have been through one of the modules (6% of UHD).

Focused communications campaigns over the year have happened alongside being implemented into core induction programmes such as Trust induction, preceptorship, medical and international educated programmes and conversations. It is also within our leadership training programmes. Other Trusts have mandated this training and more recently it has been recommended to be mandatory in NGO Freedom to Speak up Guardian Survey 2023. We also need to be mindful that following recent NGO Speak Up review with the Ambulance Trusts these packages were mandated for all staff.

3.8 Freedom to Speak Up Strategy at UHD

In January 2023, our board approved our robust and ambitious FTSU improvement strategy. It is brought again to you today to note amendments in the strategy which now reference our improvement programme Patient First work and new Trust vision, strategic goals and breakthrough objectives. The strategy has been built on national and local drivers, based on a diagnosis of speaking up issues within UHD and known areas for improvement. A detailed workplan sits beneath this strategy and its progress continues to be updated.

ACTION: Note approved amendments to FTSU Strategy which now reflects our Patient First Improvement Programme.

3.9 NHS Staff Survey

The NHS Staff Survey is aligned to the People Promise which sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements:

1. We are Compassionate and inclusive
2. We are recognised and rewarded
3. **We each have a voice that counts**
4. We are safe and healthy
5. We are always learning
6. We work flexibly
7. We are a team

The results of the NHS Staff Survey are now therefore measured against these seven People Promise elements and sub-scores, which feed into the People Promise elements. Over 5600 staff at UHD took part in 2023 NHS staff survey, giving us a response rate of 59%. Whilst this response is a significant improvement to previous years, there remains a silence at UHD. We need challenge ourselves on how we will listen to this silence and how we respond?

Speaking up is measured within the People Promise Element “We each have a voice that counts”. There are 2 sub-scores within this element of which raising concerns is one of these. All of the scores are on a 0-10 scale, where a higher score is more positive than a lower score. With this in mind, Graph 1 and Table 2 show us that more staff at UHD feel that they have a voice that counts as compared to 2022 but not yet back to that in 2021. Our bank staff also feel like they have a greater voice than they did in 2022 but overall, they feel they have less of a voice than our substantive staff.

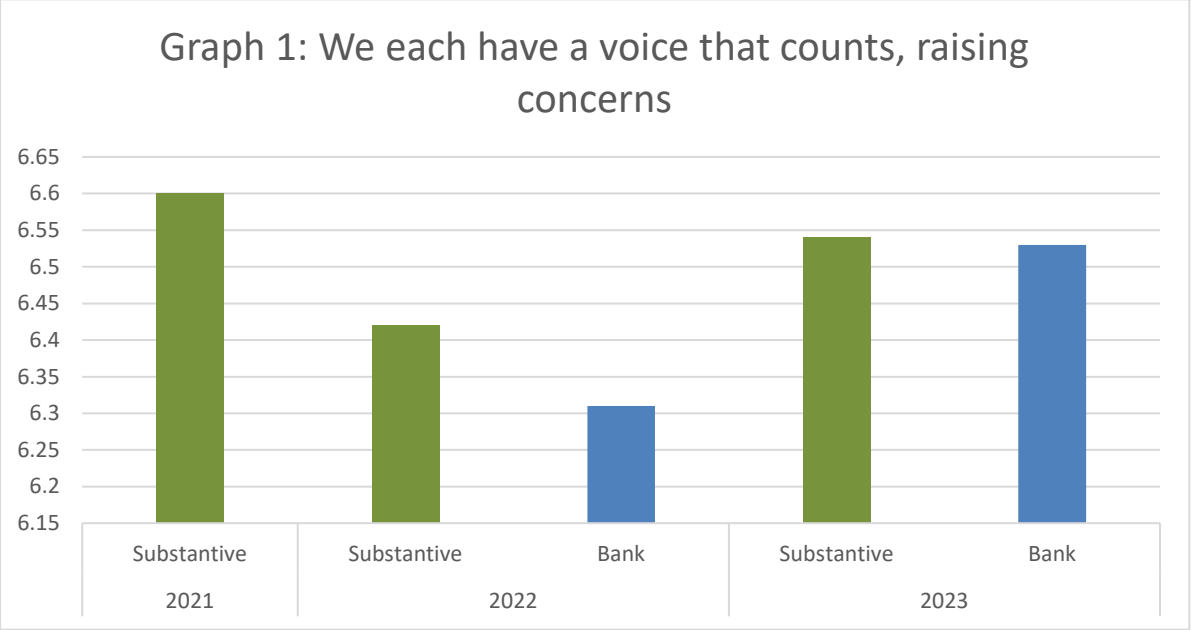
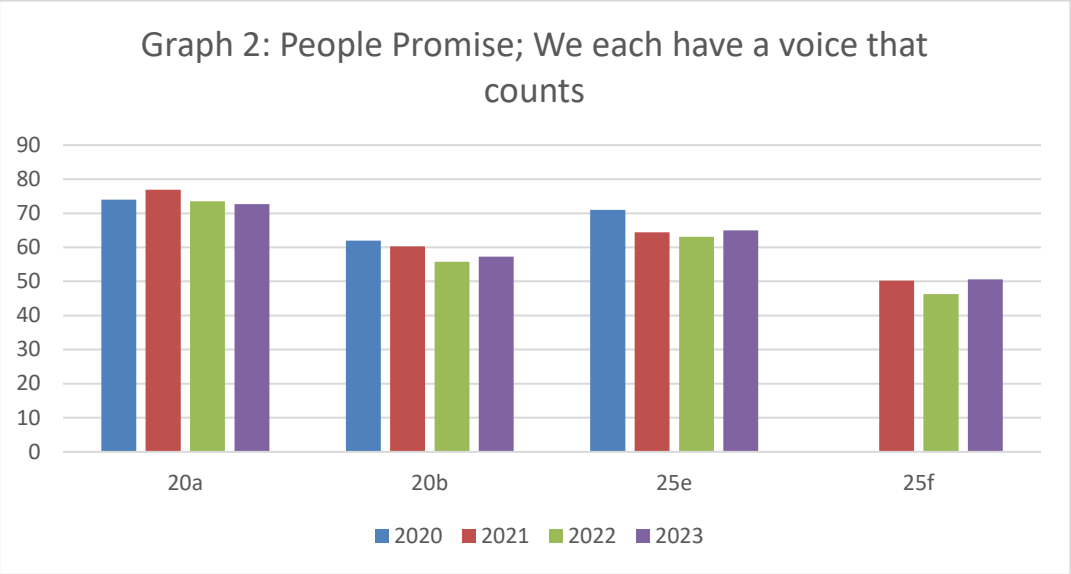


Table 2:					
SUBSTANTIVE n = 5619 (59%) Bank n = 424 (31.5%)	2021	2022		2023	
We each have a voice that counts; Raising concerns	Substantive	Substantive	Bank	Substantive	Bank
	6.60	6.42	6.31	6.54	6.53

To understand exactly which factors are driving the raising concerns sub-score, a number of questions feed into it and are represented in Graph 2. You will notice that in 3 of the 4 questions there is an improvement from 2022 (Q20a is the same as that in 2022). Moreover, for those questions relating to speaking up; raising concerns (25e and 25f) results are the same as that in 2021.

Question 25f, which is highly regarded to reflect a speaking up culture, shows that 50.63% of staff who completed the staff survey felt UHD nurtured a speaking up culture as compared to 46.31% in 2021. This is nearly a 10% increase from the previous 12months and will contribute to our safety culture breakthrough objective for quality outcomes and safety.



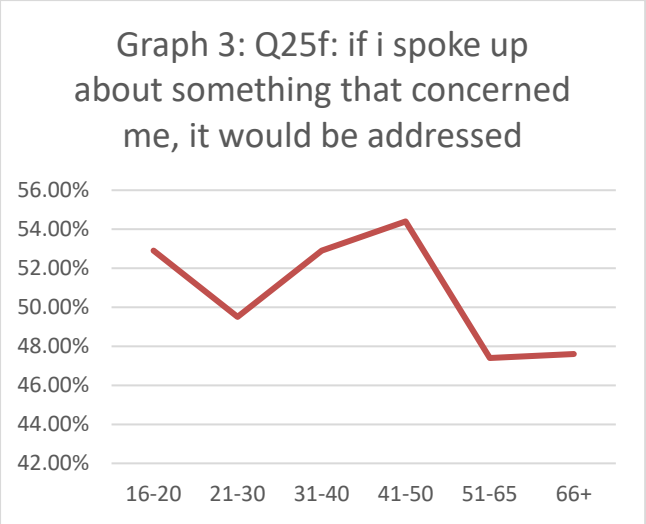
Q	Speaking up - clinical safety
20a	I would feel secure raising concerns about clinical practice
20b	I am confident that my organisation would address my concern
	Speaking up -raising concerns
25e	I feel safe to speak up about anything that concerns me in this organisation
25f	If I spoke up about something that concerned me, I am confident my organisation would address my Concern

This data can also be broken down into Care Group showing us how staff feel about our speaking up culture in different parts of the organisation. Table 3 shows us that there are differences with medical and speciality care groups reporting a better speaking up culture.

TABLE 3: If I spoke up about something that concerned me, I am confident my organisation would address my concern		UHD	Corporate	Medical	Operations	Specialities	Surgical	Non directorate
	25f	50.63	48.3	51.8	46.6	53.3	48.4	45.6

Whilst this high level of data is helpful, there will be some differences within it them and table 4 shows how staff describe the speaking up culture at a directorate level and you will also notice how this has changed from the year before in 2022. You will notice that only 3 areas show a deterioration from 2022; trauma and orthopaedics, Acute and Ambulatory and facilities.

TABLE 4: Question 25f : If I spoke up about something that concerned me, I am confident my organisation would address my concern.					
UHD 50.63%					
Green	Change from 2022/3	**Amber**	Change from 2022/3	**Red**	Change from 2022/3
Cancer Care (57%)	↑	Women's Health (53.7%)	↑	Trauma & Orthopaedics (46.9%)	↓
Child Health (60.7%)	↑	Anaesthetics (48.8%)	↑	Urgent & ED (45.8%)	↑
Radiology & Pharmacy (53.9%)	↑	Head & Neck (51.7%)	↑	Acute & Ambulatory (45.7%)	↓
Finance (58.7%)	↑	Medical Specialities (53.2%)	↑	Facilities (39.6%)	↓
Cardiology (57.4%)	↑	OPM (53.1%)	↑	Pathology (44.1%)	↑
Surgery (58.1%)	↑	People Directorate (53.2%)	↑		
		Clinical Support (50.5%)	↔		



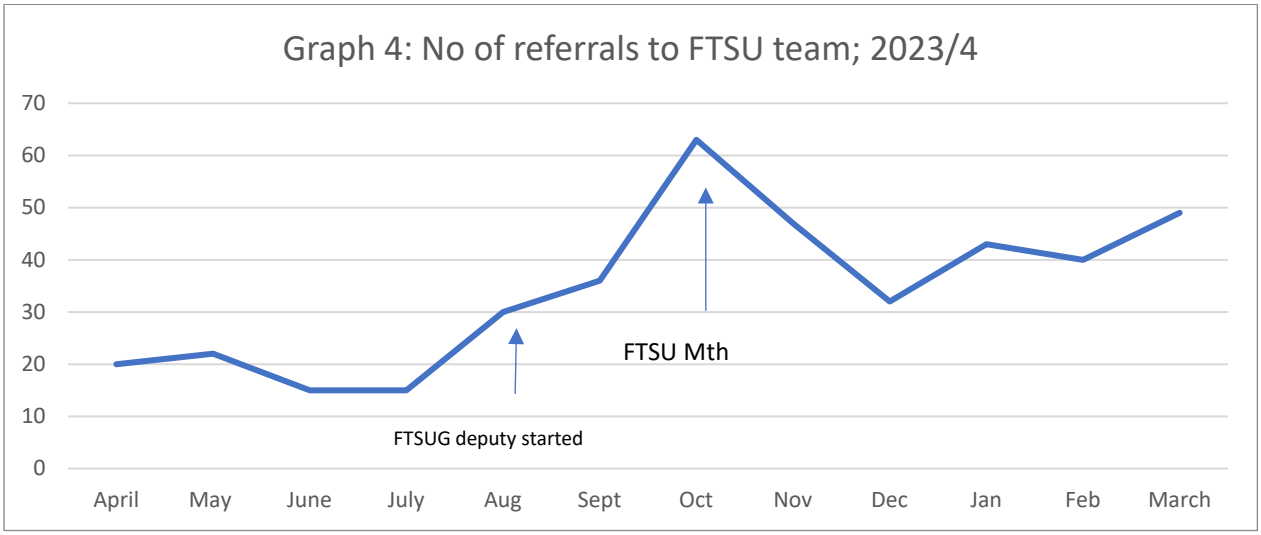
Another interesting observation can be illustrated in graph 3; the older you are in age the less confident you are those concerns addressed thereby reflecting a poorer speaking up culture.

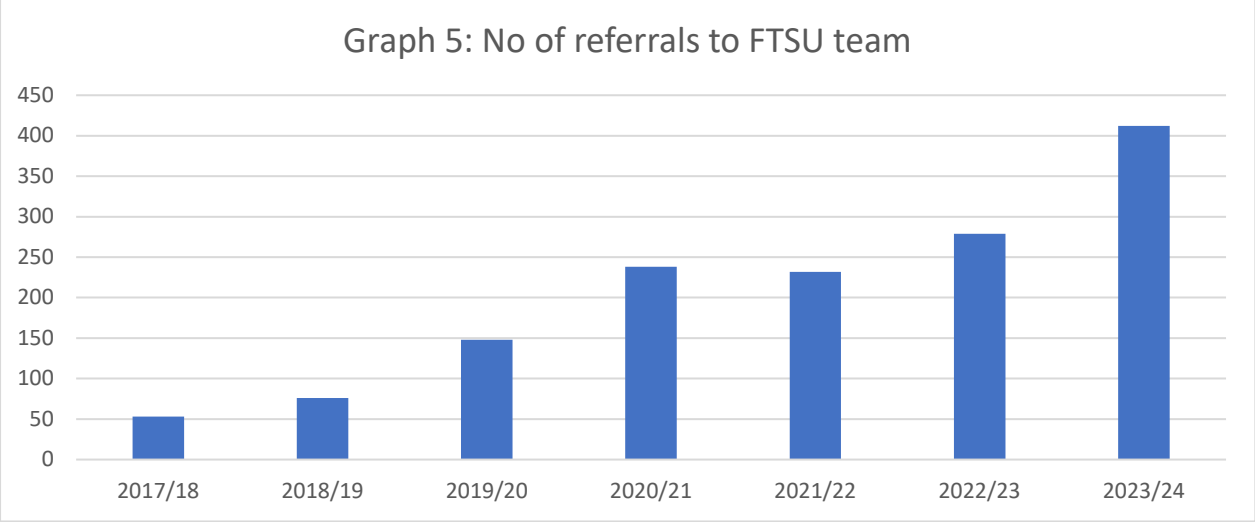
Our staff survey is one tool to understand how our staff are feeling. We are clearly seeing some emerging buds but like gardens, if we do not tend to our culture continuously, be curious and understand our silences more, they will soon become overgrown and harder to cultivate.

4.0 Case Referrals – the Headlines

A range of data is collected by the FTSUG. This report will review the data including the key themes of concerns raised, where concerns have been raised and by whom. Referrals come from a number of routes including trust communications, website, signposting from other departments such as OH and HR, word of mouth, LERNs, the UHD app and personal recommendation.

Graph 4 highlights the number of referrals received on a monthly basis to the FTSU team over 2023/4. Four hundred and twelve (412) cases were received by the FTSU team of which 185 referrals came from Poole site and 227 from Bournemouth and Christchurch (45:55% respectively). This is an increase of 48% on the previous 12 months (Graph 5).

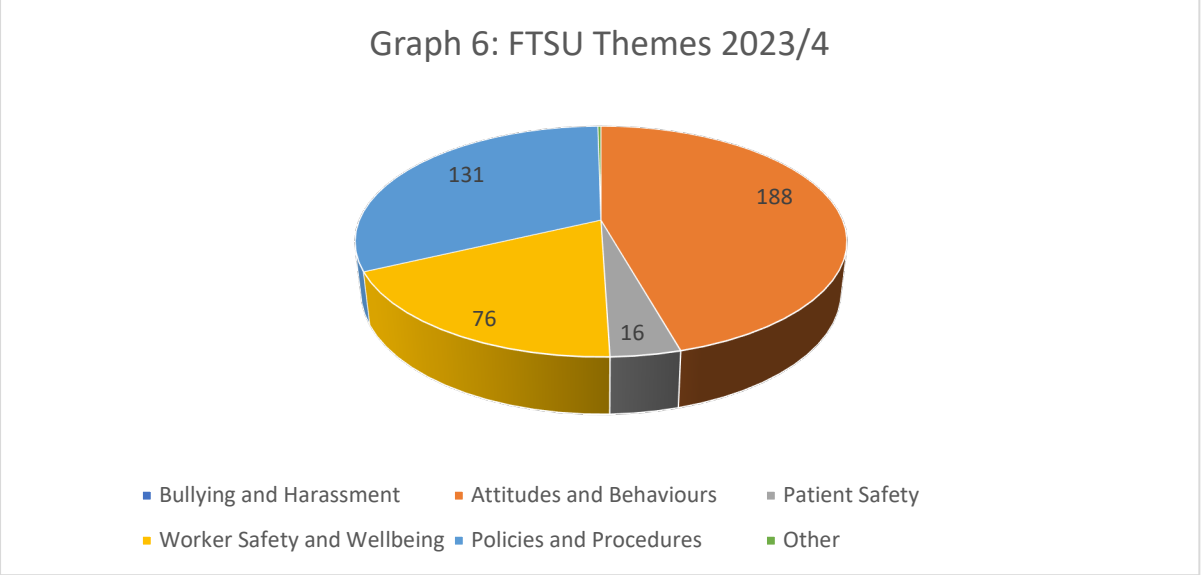




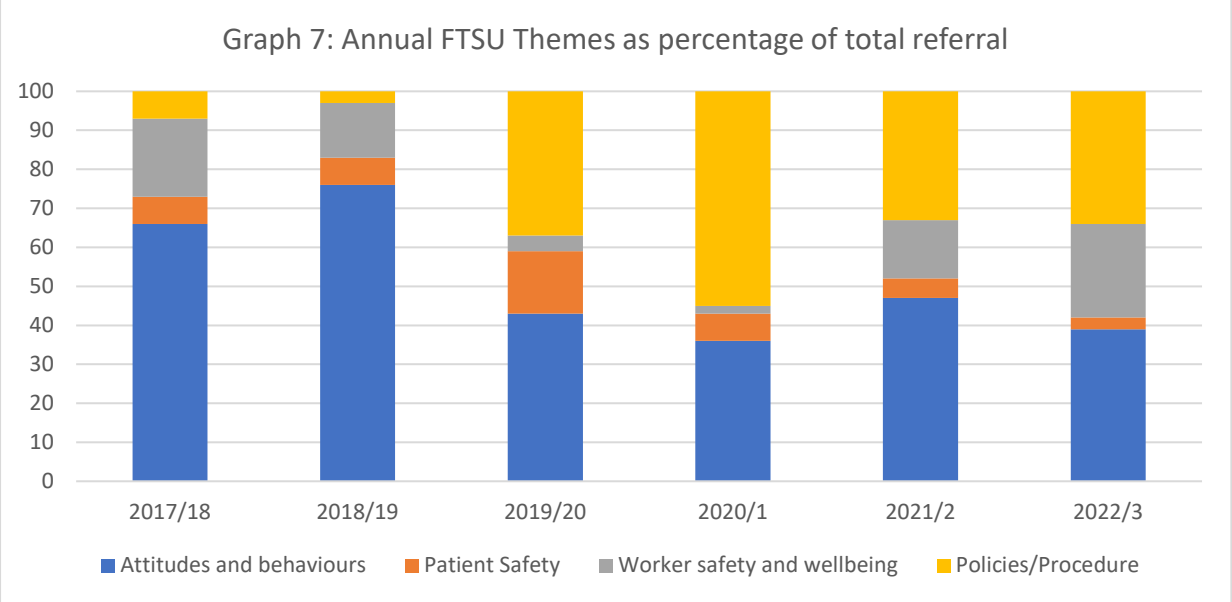
4.1 Key Themes of concerns

Staff approach the FTSU team for a number of reasons. Graph 6 illustrates the greatest theme had an element of behaviours (188 staff; 46%). This is followed by process and procedures (131 staff; 32%) and then worker safety and wellbeing (76 staff; 18%). Speaking up via the FTSU team

continues to be used predominantly for concerns relating to our working environment or relationships rather than patient safety issues and may be a product of our strong LERN culture in capturing our patient safety issues. This needs monitoring and assurance that issues or concerns are not being lost or not reported.



The themes have varied since setting up the FTSU service. Graph 7 looks at the percentage of each theme as compared to the total number of referrals. What is interesting is growth of referrals to the FTSU service relating to worker safety and wellbeing such as burnout over the last 2 years which mirrors the national picture (see section 4.1.3). The number of referrals relating to attitudes has decreased from 2017 when the service was set up, however remains the greatest theme year on year.

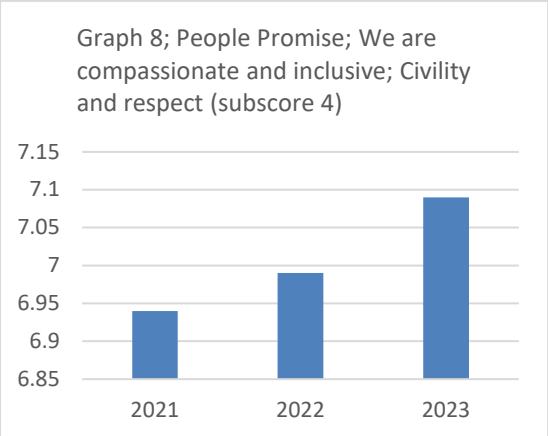


4.1.1 Behaviours and Attitudes (incivility)

"I have not stopped crying following an incident with my line manager. I was shouted at in front of the whole team leaving me mortified but also without a voice to explain. I feel I have no option but to leave UHD"

Attitudes and behaviours are a recurring theme that the FTSU team hear. Behaviours such as disrespectful attitudes, lack of compassion, gossiping, micro-aggressions, micromanagement, aggressive communication styles, rudeness and unprofessional behaviour are frequently cited. Sometimes this behaviour is well known within a team, and in other cases, it is a one off, out of character incident. Whilst both clearly need to be addressed and evidence suggests in different ways, staff feel our interventions are often inconsistent, slow, and unsatisfactory for the recipient but also to those doing the behaviour. The end result is deep, long-lasting, and far reaching causing many staff to choose to leave their role or go absent.

Work is underway with the development of behavioural frameworks, leadership behaviours, information/ tools on our intranet and our patient first improvement programme but until we have a clearer and consistent infrastructure and programme it will remain unsatisfactory for many staff. The FTSU team feel this is the most important piece of work for UHD. The way an organisation handles issues like these says a lot about the culture. We were reminded of the work from Dr Chris Turner, who spoke at our team month in November, about the impact civility and how incivility and being rude directly impacts on the safety of our patients.



With all of this said, it is always important to triangulate the FTSU work to other data. Results from our staff survey are re-assuringly showing some signs of green shoots. Graph 8 shows us improvements in the questions relating to civility and respect as compared to 2021.

People Promise; We are compassionate and inclusive; Civility and (sub-score 4)	
8b	% of staff reported that the people they work with are understanding and kind to one another (q8b)
8c	% of staff reported that the people they work with are polite and treat each other with respect (q8c)

The FTSU team call for focussed work in addressing poor behaviours so by creating psychologically safe workplaces and contributing to our breakthrough objectives to being a great place to work, attracting and retaining best talent.

4.1.2 Process and policy – compassionate and inclusive leadership

It is well documented that at times of significant change such as merger, operational re-structuring, healthcare structural changes or building work will increase workloads for FTSU teams. Part of this is due to issues relating to process or procedure. (NHSE, 2022).

Thirty-two per cent of referrals at UHD had an element of process and procedure. These issues range from requests for agile working, support of staff going through organisational change, assurances that recruitment is both fair with equal access, support through probation and access to study leave.

Since October 2022, these issues have been broken down further into sub themes and represented in Table 5. Sixty-nine per cent of referrals with an element of policy and procedure, are relating to HR issues and how to navigate employment issues. All concerns are signposted to our experts such as HR and our union colleagues. Nationally, this is also seen, and it has been postulated whether a clarity of HR policies and processes may help to reduce the volume of HR issues being raised with Freedom to Speak Up team.

Table 5	Poole	RBCH	UHD TOTAL
Organisation Change	5	1	**6**
Guideline/pathway (clinical)	1	1	**2**
HR related issues (regrading, re-deployment, HR policy	35	55	**90**
Recruitment and selection	4	1	**5**
Parking	3	0	**3**
Education/training	1	1	**2**
Non-clinical guideline/pathway	10	11	**21**
Health and Safety	0	1	**1**
Pension	0	1	**1**
TOTAL	**59**	**79**	**131**

Other issues relating to process and procedure often arises from a conversation or miscommunication often with a line manager/supervisor. When asking staff as to why they are choosing to raise concerns to the FTSU team rather than their line manager, 47% stated that their line manager was the issue of the concern or knew about the issue but not addressing it. A further 14% said it was that they felt insecure in raising this issue. The gift of change lies predominantly

with our line managers and clearly in most cases a resolution needs to happen with them. Is it therefore that our relationship with our line manager is challenged due to lack of visibility, time limitations or manager skill? In many cases, if the relationship/understanding and communication was improved between line manager and team, the need to escalate to the FTSU team would be less.

It is well documented about the importance of delivering compassionate and inclusive leadership. It is encouraged that our leaders, listen to our teams (with fascination), acknowledge and understand each-other's challenges, empathise and appreciate the frustrations and then support each other so to drive action and change (Michael West). Delivering compassionate leadership and care requires investment in time, in skill and an appreciation of the benefits for our people and ultimately the care we give to our patients. Compassion needs to meet people's needs for belonging and develop and sustain trust for psychological safety.

4.1.3 Worker safety and wellbeing

In response to concerns being raised during the pandemic, the NGO introduced worker safety and wellbeing as a new reporting category. This theme relates to cases with a risk on worker safety or wellbeing and can include issues such as lone working arrangements, insufficient access to equipment and stress at work.

"The change in x, has made us feel dis-empowered and undervalued. It has been a kick in the teeth resulting in my hands never feeling so tied as they do today. If only the decision makers talked to us before changing x…I thought we were on the same team"

At UHD, eighteen per cent who accessed the FTSU team described this theme and predominantly as a result of excessive workload and staffing levels. Moreover, it is also well documented that there are considerable system pressures across the healthcare sector alongside the cost-of-living crisis; both having an impact on worker wellbeing.

Research tells us that until triggers are addressed such as staffing/working environment, the symptoms of feeling overwhelmed will not improve. This is particularly difficult in a financially challenged healthcare system.

4.2 Outcome of referrals

Table 6 illustrates the outcome of referrals once they were made to the FTSU team. Of those referrals, 34% of cases were escalated to the line manager to investigate and action. In 40% of cases, the member of staff was signposted to experts in the field of the concern such as HR, OH,

or other including infection control, risk and governance or our networks. Five percent were escalated to director/executive level.

Table 6: Outcome of referrals received by FTSU team

		Poole	RBCH	Total UHD
Line manager		66	74	**140**
FTSU advice		43	41	**84**
Escalate to Chief/Director		7	15	**22**
Signpost	HR	31	46	**77**
	Other	38	51	**89**
TOTAL		**185**	**227**	**412**

Following the Lucy Letby case there were a number of questions raised about how concerns were not listening to or that appropriate and timely action was not taken when concerns were raised. All 180 cases raised to the FTSU team in quarter 1-3 (2023/4) were all closed with no outstanding action.

4.3 Who are raising concerns?

Table 7: Staff who are raising concerns to the FTSU team.

2023/4	Total UHD	No of staff (as of May 23)
Additional Clinical services*	36	2129
Additional Professional#	8	350
Admin and clerical	93	2147
AHP	38	809
Estates and Ancillary	23	710
Healthcare scientists	10	189
Medical and Dental	28	1519
Nursing/Midwife	131	3044
Students	7	101
Other	1	
Anon	37	
TOTAL	**412**	**10 998**
BAME	89	

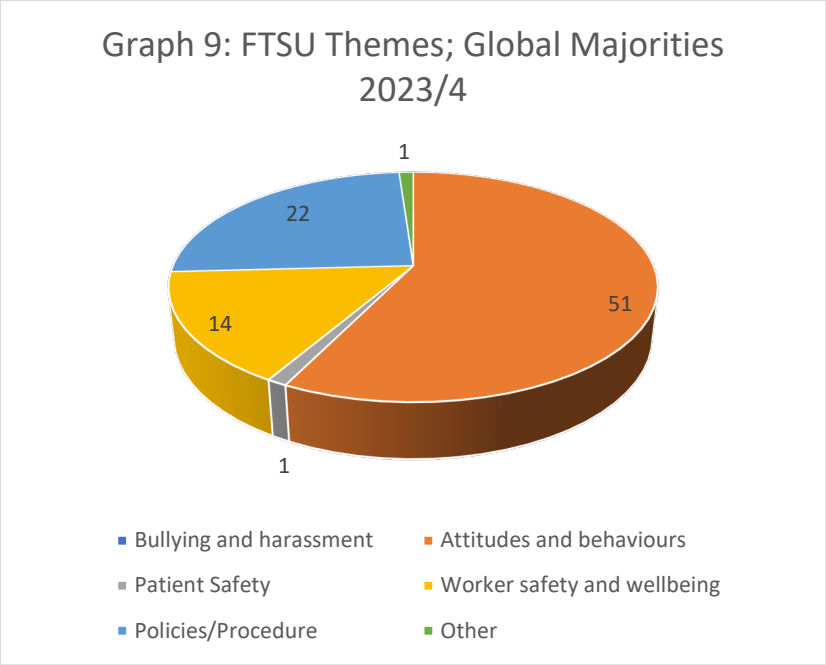
*Additional clinical services includes staff directly supporting those in clinical roles such as Health Care Support Workers (HCSWs), AHP support workers. They have a significant patient contact as part of their role.
#Additional professional scientific and technical include scientific staff including pharmacists, psychologists, social workers

Table 7 shows that our nurses and midwives accounted for the biggest portion (32%) of speaking up cases raised with FTSU team, followed by our administrative staff (23%) and Allied Health Professionals (9%).

Thirty-seven staff felt that they needed to remain anonymous (9%). This is an increase on previous 12months (14 staff; 5% of total referrals) and now is comparable to national figures of 9.3% (NGO annual report, 2023). The FTSU team in 2023/4 held a number of campaigns highlighting routes of referral that staff can make. The UHD app and its facility to make anonymous referrals to the FTSU team was particularly promoted which may explain its increase over the past 12 months.

The Francis Freedom to Speak Up review recognised back in 2015, that minority staff, including ethnic minority workers, feel vulnerable when speaking up, as they may feel excluded from larger groups of workers. Data set out in these reviews, also showed that minority staff groups are more likely to suffer detriment for having spoken up. Since then, the NGO has carried out a number of case reviews at different Trusts across the country which has repeatedly validated this observation and therefore encourages every Trust and FTUSG to ensure that work reaches this group of staff and that their voice is also being heard.

Of the 412 staff who raised a FTSU concern, 22% (89 staff) were from a global majority background. Our most recent data using WRES mapping template, shows the percentage of overall workforce at UHD which is ethnic minority is now 21.5% (March 2023). Using the same calculation for the Bournemouth, Poole and Christchurch area the percentage of ethnic minority staff is 8.67%. This data suggests that our staff are highly represented from ethnic minority groups at UHD and that FTSU is making good progress to reaching and hearing the issues from this staff group.



Data from graph 9 show the predominant theme from our global majorities staff is attitudes and behaviours (51 staff; 57%). Concerns with elements of process and procedure (22 staff; 25%) then followed by staff wellbeing (14 staff; 16%).

"I have never experienced such unprofessional and rude behaviour as an International Medical Dr. It was undignified and made me feel isolated and not want to work at UHD".

It is important to trangulating our FTSU data with our staff survey and specifically Question 25f, which is highly regarded to reflect a speaking up culture. Data from those whom completed the survey show that more staff from a global majority background feel that they work in a culture of speaking up. Nearly 57% felt like this (Table 8).

Table 8: Question 25f	UHD	White	Global majority
If I spoke up about something that concerned me I am confident my organisation would address my concern.	50.80%	49.80%	56.90%

BME: Black Minority Ethnicity/Global Majorities

All staff are signposted to our DEN networks who were also able to support and advise. The FTSU team attend these meetings and forums to support but also to understand and raise issues.

The FTSUG is an integral member of the Equality, Diversity and Inclusion Committee and will continue to work together to improve and support our ethnic minority employee experience.

The FTSU team have also implemented a new development programme for our international educated nursing (IEN) staff. This happens approximately 6 months post initial induction and is the result of feedback from our IENs wanting time and space to reflect on communication and culture since starting in their new workplaces. This programme has been really well evaluated.

4.4 Where are concerns being raised?

Significant effort has been made to ensure that the FTSU team visit and meet all members of staff across each site and the Ambassador model allows for this. Table 9 outlines the concerns raised across our care group structure. The FTSUG monitors this closely so to ensure that all areas are aware of the FTSU service and how to access it.

Table 9: The number of concerns raised in UHD

					23f
Care Group	**Directorate**	**PHT**	**RBCH**	**Total**	
Medical (113)	Emergency and Urgent	3	5	**8**	45.8.9%
	Acute and Ambulatory Medicine	9	4	**13**	45.7%
	Cardiology and Renal	3	1	**4**	57.4%
	Medical specialities	21	14	**35**	53.2%
	Older Persons and Neurosciences	21	32	**53**	53.1%
Surgical (48)	Surgery	5	9	**14**	45.4%
	Anaesthetics	9	8	**17**	48.8%
	Head and Neck	2	6	**8**	51.7%

	Trauma and Orthopaedics	5	3	**8**	46.9%
	Private	0	1	**1**	
WCCSS (108)	Cancer Care	11	3	**14**	57%
	Child Health	14	0	**14**	60.7%
	Women's Health	14	2	**16**	53.7%
	Radiology and Pharmacy	7	7	**14**	53.9%
	Clinical Support	11	18	**29**	50.5%
	Pathology	5	16	**21**	44.1%
Operations (19)	Clinical Site	0	0	0	
	Facilities	4	14	**18**	39.6%
	Partnership, integration and discharge	1	0	**1**	
	Emergency Planning	0	0	**0**	
	Operational Performance	0	0	**0**	
Corporate (87)		26	61	**87**	41.9%
Anon (37)		14	23	**37**	
TOTAL		**185**	**227**	**412**	

Interesting questions can be posed, and future work can be planned when triangulating the data from table 9 looking at the numbers of staff using FTSU route and the speaking up question, 23f on the Staff Survey, which is highly regarded to reflect a speaking up culture. Of concern are those staff whom are not using the FTSU route and have low confidence in raising concerns such as emergency. Further evaluation and future FTSU focus will be key in these areas for 2024.

5.0 Learning and reflections

Whilst each referral will have its own learning, themes can be drawn to help develop and embed into the culture at UHD. The following points are the learning and reflections of the FTSU team based on the information presented today:

- An urgent call for action to develop an invested and accountable civil and respectful cultural programme– looking at a clearer message, its infrastructure and tools to help staff and managers address poor behaviour in a consistent and rapid way.
- Merger is starting to feel real. Frustrations are being cited as final decisions to where/when moves are happening are often late, making practical life arrangements more difficult and stressful.
- Differences between Bournemouth and Poole sites; differences in work, policy and structure. This makes it difficult to feel #TeamUHD.
- Long and painful organisational restructures resulting in prolonged periods of stress for staff resulting often in a drain of talent. Do we invest time at the beginning of any re-structure or organisational change to explain the process and ensure staff wellbeing is in the forefront of minds? Do we share the learning from each department or make the same mistakes?
- Not belonging at our workplace –our overseas workforce feel that their work place is not interested in them as people with little time invested in getting to know them, their skills and journey. This makes forming safe relationships, navigating the work, the NHS way and British culture really difficult. Strong feelings of being mis-understood and judged.
- Struggles with cost of living and financial challenges.

- Being proud of our working environment and yet we have overflowing cigarette butts and litter. Signage remains an issue.
- Do we have robust processes in place to prevent staff feeling at detriment when speaking up and in those circumstances when a worker feels they have suffered detriment do we address this and offer the right support?
- The number of cases which have an element of patient safety is lower at UHD than the national average. Are we confident that we are capturing patient safety concerns or are staff not reporting?
- We hear staff say that they cannot go to their line manager as either they are the issue, or they are not addressing the issue; we need to promote our leaders to attend Compassionate and Inclusive leadership programmes and People Management modules.
- Large management portfolios make it difficult for line managers to be visible with their teams. Teams feel their leaders are too busy to speak with them and line managers are frustrated as they are tied to meetings. Issues are not resolved quickly and often escalate.
- Encourage our leaders to complete HEE/NGO Speak up, listen up and follow up modules on BEAT. There is a national steer to mandate these (speak up module).
- More staff are telling us that they use alternative channels to speak up as they are insecure of raising issues with their line managers. We need to upskill our leaders on how to create psychological safe working environments to speaking up.

6.0 Summary and Next Steps

Speaking up has never been as important as it is today and yet whilst improving, staff tell us that we do not address concerns nor make people feel safe to raise them. It is both futile and results in fear.

At UHD, it is everyone's business to encourage speaking up and to do this we need leaders to create psychologically safe working environments where every voice is heard, celebrated and action occurs.

We are #TeamUHD and collectively we need to Speak Up, Listen Up and Follow Up so to continually improve our culture of safety.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 01 May 2024

Agenda item: 7.3.2

Subject:	Freedom to speak up (FTSU) Strategy 2023-2026
Prepared by:	Helen Martin, Freedom to Speak Up Guardian
Presented by:	Helen Martin

Strategic Themes that this item supports/impacts:	Systems working and partnership ☐ Our people ☒ Patient experience ☐ Quality: outcomes and safety ☒ Sustainable services ☐ Patient First programme ☒ One Team: patient ready for reconfiguration ☐
BAF/Corporate Risk Register: (if applicable)	BAF/ not applicable
Purpose of paper:	Information
Executive Summary:	This paper sets our an ambitious FTSU improvement strategy, with a clear and robust vision for speaking up in UHD until 2026.
Background:	There is an expectation from National Guardian Office (NGO) that each Trust has a clear, robust and ambitious FTSU improvement strategy articulating our speaking up vision and goals. It is best practice that this is then signed off by the senior team/board and requires full buy in from managers to ensure its successful delivery (NHSE, 2022). The strategy was built on national and local drivers, based on a diagnosis of speaking up issues within UHD and known areas for improvement. A detailed workplan sits beneath this strategy which will have planned progress updates.
Key Recommendations:	Approve the FTSU strategy for 2023 to 2026
Implications associated with this item:	Council of Governors ☒ Equality, Equity Diversity and Inclusion ☐ Financial ☐ Health Inequalities ☐ Operational Performance ☐ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☒ Regulatory ☐

	Strategy/Transformation System It is good practice to share our speaking up strategy to our senior leaders and managers to ensure its successful delivery. The strategy sets out why speaking up is important for our people and how it improves the quality of care we deliver to our patients.	☒ ☐
CQC Reference:	Safe Effective Caring Responsive Well Led Use of Resources	☒ ☐ ☐ ☒ ☒ ☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
TMG – for assurance/discussion	06/02/2024	Assurance provided
PCC – for approval	14/02/2024	Approved

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

University Hospitals Dorset
NHS Foundation Trust

Freedom to Speak Up (FTSU)

Strategy 2023 – 2026

If this document is printed – please check in the Policies, Procedures and Guidelines section of the intranet to ensure this is the most up to date version

A) SUMMARY POINTS
This strategy sets out the Trust's Freedom to Speak Up vision and strategy over the next 3 years.
This strategy aims to improve the experience of speaking up at University Hospitals Dorset (UHD)
It outlines how to measure the success of the strategy
B) ASSOCIATED DOCUMENTS
Policy: Freedom to Speak Up policy for the NHS

B) DOCUMENT DETAILS	
Author:	Helen Martin
Job title:	Freedom to Speak Up Guardian (FTSUG)
Directorate:	People Directorate
Version no:	1
Target audience:	All Trust employees including any healthcare professional, non-clinical worker, contractors, agency workers, temporary workers, students, volunteers and former workers.
Approving committee / group:	Trust Board of Directors
Chairperson:	Chair of Board
Review Date:	September 2025

C) CONSULTATION PROCESS			
Version No.	**Review Date**	**Author**	**Level of Consultation**
1	14.12.22	Helen Martin	People and Culture Committee (Workforce Steering Committee)
2	February 2024	Helen Martin	Trust Management Board (6.2.24) and PCC (14.2.24)
3	Sept 2025		

D) VERSION CONTROL						
Date of Issue	**Ver No.**	**Date of Review**	**Nature of Change**	**Approval Date**	**Approval Committee**	**Author**
	2	8.2.24	**Review Date:** following this version review change review date from April 2025 to Sept 2025. **Section 1**; update of national network data **Section 5.1**; update from patient first programme including new UHD vision and strategic aims. **Section 5.2**; update of FTSU model with development of 1yr FTSUG deputy role. **Section 6.1**; update of data from 2023 staff survey.	May 2024	Board of Directors	Helen Martin

			Section 6.2; update of FTSU model at UHD following updated NGO guidance (2023) **Section 6.3;** update FTSU case and data from 2022/23 at UHD. **Section 6.4**; FTSUG stepped down as co-chair South west region in Summer 2023. **Appendix 1:** re-assess EIA from 10.11.23 to 5.1.24			

1.0 Introduction and Purpose

> *"Speaking up is a gift – use it wisely and we can change the NHS for the better"*
> NGO Annual report 2021/22

Sir Robert Francis set out his vision for creating an open and honest reporting culture in the NHS in his 2015 publication "Freedom to Speak Up (FTSU)". He recognised that having a healthy speaking up culture helps protect patients and improves the experience of NHS workers. Listening and responding to people who speak up, and tackling the barriers to speaking up, is a natural ingredient of good leadership and a well led organisation. Consequently, he mandated that each Trust appoint a Freedom to Speak Up Guardian (FTSUG) which has now been part of the NHS standard contract.

Eight years have passed since the publication of the Francis Freedom to Speak Up Review. The speaking up culture of the health sector in England has changed with a network of over 1000 Freedom to Speak Up Guardians in NHS and independent sector organisations, hospices and national bodies. Over 100 000 cases have been raised reflecting how trusted FTSU Guardians (FTSUG) are as additional channel for speaking up (NGO, 2023).

Speaking up benefits everyone. Building a more open culture, in which leadership encourages learning and improvement, leads to safer care and improved patient experience. The purpose of this document is to set out the Freedom to Speak Up vision and strategy over the next 3 years for University Hospitals Dorset (UHD). This document should be read alongside the Trust's Freedom to Speak Up policy for the NHS.

2.0 Definitions

The following definitions apply to this strategy:

Freedom to speak up	A process encouraging staff to raise concerns and speak up to protect patients and improve the experience of NHS workers.
Freedom to Speak up Guardian (FTSUG)	A named person who acts as an independent and impartial source of advice to staff at any stage of raising a concern, with access to anyone in the organisation, including the chief executive, or if necessary, outside the organisation
Freedom to speak up Ambassador	A member of the FTSU team who raises awareness of speaking up and refers cases to the FTSUG if needed.
Vision	An aspirational description of what an organization would like to achieve or accomplish in the mid-term or long-term future.

Objective	A plan that underlies all strategic activities
Strategy	a Board level approved document which identifies the aims and objectives for the Trust in a given subject area

3.0 Roles and Responsibilities

Chief Executive and Chair	Accountable for ensuring that FTSU arrangements meet the needs of the workers in the trust.
Executive lead for FTSU	Lead executive responsible for ensuring latest guidance is applied and ensuring the FTSUG role is implemented and supported.
Non-executive lead for FTSU	Lead non-executive ensuring implementation of latest guidance and alternative support for FTSUG. Oversees speaking up matters regarding board members.
FTSUG	• empower staff to raise concerns within organisations, • provide confidential advice and support to staff in relation to concerns they have about patient safety and/or the way their concerns have been handled, • ensure that organisational policies and processes in relation to the raised concern are in place and followed correctly, • ensure shared learning amongst local/regional/national Networks, • produce reports to monitor the outcomes and impact of FTSU.
FTSU Ambassadors (FTSUA)	Contribute to creating a culture of speaking up where staff feel safe and confident to raise concerns. The FTSUA will work alongside the FTSUG promoting, raising awareness and signposting (including to FTSUG) for support.
National Guardian Office (NGO)	Leads, trains and supports a network of FTSUG in England and provides support and challenge to the healthcare system on speaking up

4.0 The National Perspective

The National Guardian's Office (NGO) is an independent, non-statutory body with the remit to lead culture change in the NHS in England. The NGO do this by supporting a network of FTSUGs within NHS Trusts, Foundation Truss and other organisations disseminating good practice, undertaking case reviews and working across the health system to tackle barriers to speaking up. Its vision is to make speaking up business as usual where speaking up is not only welcomed, but valued as an opportunity to learn and improve.

National Guardian
Freedom to Speak Up

NGO Mission
To make speaking up business as usual throughout the healthcare sector in England

4.1 The NGO Strategic Framework

The NGO Strategic Framework was launched in July 2021 and enables the NGO to build on the achievements of Freedom to Speak Up to date and to respond to wider changes in the healthcare landscape. It sets out a journey towards gaining greater assurance about speaking up culture and the quality and consistency of how the Freedom to Speak Up Guardian role is implemented.

The Strategic Framework is made up of four pillars of support. Under each pillar the framework outlines the focus of the work going forward.

1. workers;
2. FTSUG;
3. leadership and
4. the healthcare system.

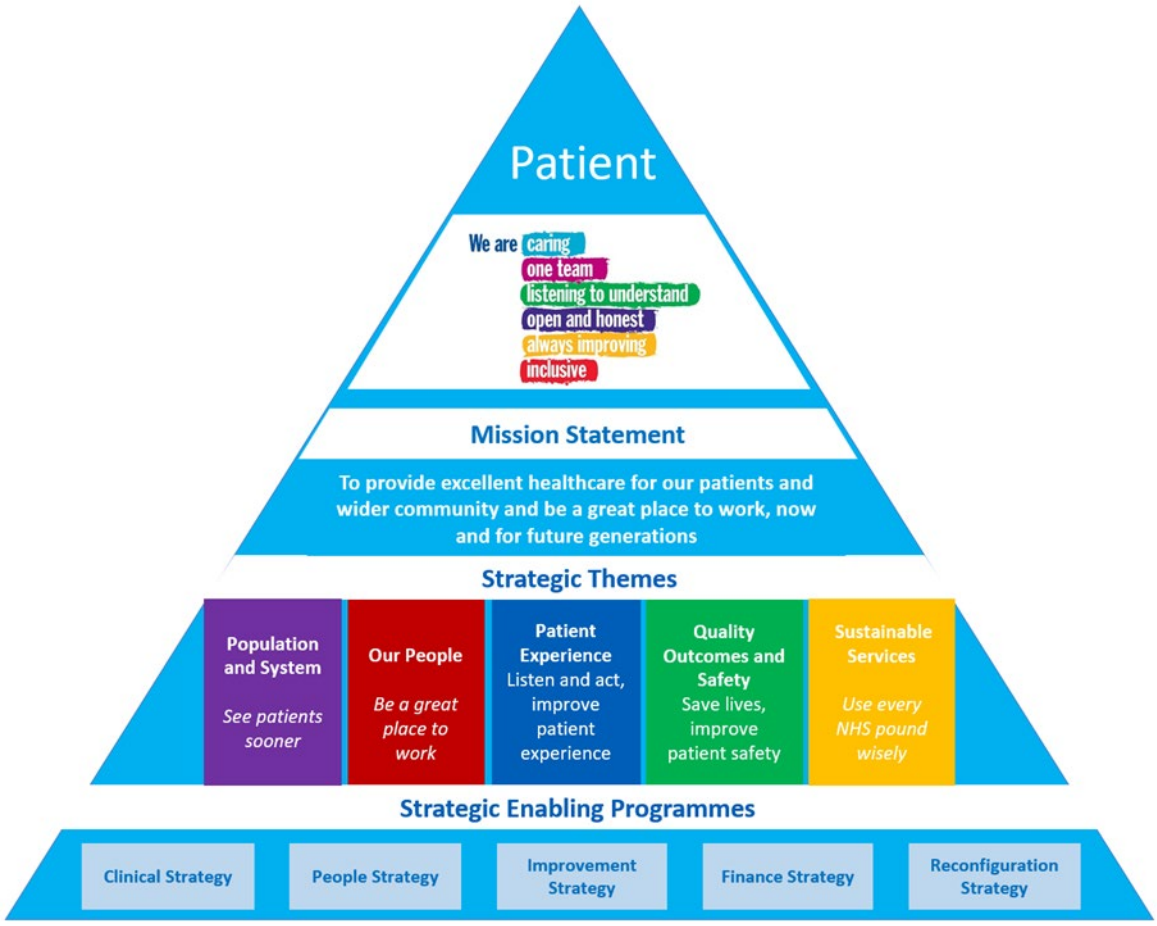
5.0 The Local Perspective

5.1 A Vision for Speaking Up at UHD

Speaking up at University Hospital Dorset (UHD) is the cornerstone of our culture. This is reflected in our set of values following the cultural review undertaken by our cultural champions back in 2020. Our people clearly described the need for a learning rather than blame culture, whereby we are able to make mistakes without feeling afraid to discuss them. Psychological safety and

feeling confident to speak up were seen as contributing to safer, excellent quality care. As a result, UHD are proud to have “I will be open and honest” as one of our values.

In 2023, UHD commenced a Patient first programme; a recognised and proven system for delivering significant long-term change within the NHS. Patient First will help us all by improving the way we work by giving us the tools, techniques and standard approach to identifying and tracking improvement needed. It will give each of us the time, freedom and skills to make positive and long-lasting changes that will benefit ourselves, our colleagues and our patients. There are 5 strategic areas that UHD are focusing on, which each have an objective(s).



Patient first is a long-term approach to building improvement into everything we do. When staff thrive, our patients thrive. Speaking up is integral to this work and we look forward to supporting this moving forward.

5.2 Our FTSU team and FTSU Model at UHD

Our Freedom to Speak Up (FTSU) team provide a route to enable workers to do this when they feel unable to speak to their line manager or use other established processes. The FTSU team have been in place since 2018 and further expanded in 2023 with the introduction of our deputy FTSUG. Our model at UHD allows the FTSU service to be both sustainable and resilient, meeting the demands of our staff

using the FTSU route, but also allow us to contribute to the organisation overcoming the barriers that result in workers feeling that they must come to a guardian in the first place. This network raises awareness and promotes the value of speaking up, listening up and following up and helps address challenges posed by organisation size, geography and the nature of their work as well as support workers, especially those who may face barriers to speaking up. All members of the FTSU team have been key to our success.

5.3 Aim and Commitment of Speaking Up

We want our workers at UHD to feel valued and respected at work and to know that their views are welcomed. By meeting our worker's needs we recognise that this will enable us to deliver the best possible care. Consequently, we are committed to providing the best working environment where speaking up is not only welcomed but valued as an opportunity to learn and improve.

Supporting you to raise concerns
Freedom to speak up

To develop a culture of safety so that we become a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely.

There are many ways that our people can speak up at UHD. This includes your line manager, human resources, using our LERN forms, staff governors, occupational health and our staff networks. You can also speak up with our freedom to speak up team and if you choose this route, they will provide the following commitment to each conversation.

The Freedom To Speak Up commitment

S You're safe and secure to talk to us; we'll support you every step of the way to raise concerns.

P We are all about our people. When we look after each other we give the best to our patients. FTSU are here for you and hearing your voice is our priority.

E We treat all staff equally, empower you to make concerns and enable the trust to make change.

A We will listen and act with integrity to ensure your concerns are heard. We are approachable and here for you.

K We treat you kindly; we know what steps need to be taken when you raise a FTSU concern, we have the knowledge to help make a difference.

Supporting you to raise concerns
Freedom to speak up

The key roles of the FTSU team are:

FTSUG	FTSUA
empower staff to raise concerns within organisations	
provide awareness raising, promoting speaking up within groups, departments and locations.	
Role model values and behaviours associated with speaking up	
Detailed knowledge of local speaking up policy and process including escalation routes and useful contacts	
Provide information on options available and escalate issues that must be acted on involving safety or safeguarding. Understand when to signpost and when to escalate and when to seek support.	
Explore trends from surveys and data and lead link with key stakeholders	Signpost to key stakeholders including FTSUG
Develop and deliver training programmes to new and existing staff	Contribute and deliver training programmes to new and existing staff
Hear FTSU cases	Signpost any staff to FTSUG
Outward facing, leading networks alongside National Guardian Office (NGO) guidance and local merger and CSR plans	
National profile within NGO and supporting/mentoring other organisations	
Develop and deliver reports to monitor the outcomes and impact of FTSU with board and other key stakeholders	
Complete and Submit data to National Bodies including NGO, CQC, NHSI/E	

6.0 Speaking Up Strategy at UHD

A strategy for speaking up was approved by the Board in January 2023, setting out our vision, ambition and aims based on a diagnosis of issues the trust was currently facing in relation to speaking up. This was then updated in January 2024 to align with its patient first programme and new vision, strategic goals and breakthrough objectives. A detailed work plan to measure its delivery within the terms of objectives.

This strategy aligns itself with the four pillars outlined by the NGO (section 4.1) but encompassing the objectives and challenges at UHD. The diagram below outlines the 4 key principles of work for the FTSU team.

6.1 The Workers

It is recognised nationally that more needs to be done to foster a speak up, listen up, follow up culture, where workers are listened to and appropriate action taken as a result. Fear of speaking up and futility, that nothing will change, are still being reported as being the main barriers preventing people to speak up. We see this too at UHD. Indeed, our staff survey in 2022 showed a deterioration in all 4 questions relating to speaking up. Positively, this position has improved in all measures in the staff survey in 2023 however the question highly regarded to reflect a speaking up culture, still shows only 50.63% of staff whom completed the staff survey felt UHD nurtured a speaking up culture. Clearly, there is work still to do.

Speaking up is more than having a FTSU team. Our data shows us that staff at UHD view speak up through the FTSU team as an established channel. Indeed, the number of staff using this channel for speaking up is more than an average (similar sized) trust. This inevitably reflects the increase of size of our organisation following the merger across multiple sites. It is also well documented that at times of significant change such as merger, operational re-structuring, healthcare structural changes or building work will increase workloads for FTSU teams (NHSE, 2022). This is not a position however that we want to be in. We recognise that we will not have speaking up as business as usual if FTSUGs are spending all their time acting as an additional channel rather than working with their organisation to overcome the barriers that result in workers feeling that they must come to a guardian in the first place.

Consequently, we have a vision that **Speaking up at UHD is everyone's business.** We acknowledge that all our leaders, and in fact everyone, needs to welcome, challenge and implement change when speaking up. All levels of our leaders play a vital role for setting the right cultural tone for speaking up and for handling speaking-up matters effectively. They

influence how their teams and colleagues behave and so it is essential that they have to role model the speaking up principles. We are therefore committed to ensure our leaders are given the skills to be compassionate and inclusive by listening up and following up and taking action. We will encourage all our leaders to listen to our teams (with fascination), acknowledge and understand each-other's challenges, empathise and appreciate the frustrations and then support each other so to drive action and change. Creating psychological safe working environments is also key and so we will follow leaders in this field such as Amy Edmondson and her 5 steps to enhance psychological safety including brave leadership, inclusion and acceptance, learning through pilots and experimentation, respectfully challenging the status quo and innovation.

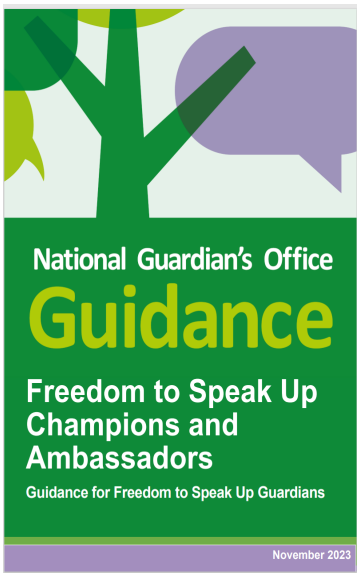
To address this, we will

- Champion speaking up, encouraging that speaking up is everyone's business. #FTSUforEveryone
- Skill all our leaders to speak up, listen up and follow up through our management and leadership programmes and completion of HEE/NGO training modules
- Skill our leaders to create psychological safe working environments for our people to speak up.
- The FTSU team will support workers by reflecting the voice of workers in speaking up reviews, board reports and senior development.
- The FTSU team will support the themes and proactively address the barriers to speaking up
- Support the FTSU model to reflect both reactive and proactive functions of the role.
- The FTSU team will support and contribute to the wider cultural and transformation programme "patient first" to ensure speaking up is embedded in its programme going forward.

6.2 The FTSU team

The FTSU team perform a vital function in the workplace, as evidenced by the year on year increase of referrals at UHD. In 2022/23 nearly 300 cases were raised by the FTSU team and heard by the FTSUG with 100% of staff evaluating the service positively.

In November 2023, the NGO refreshed its guidance on internal networks. UHD set up a network of FTSU Ambassadors back in 2018 with the main purpose of raising awareness and promoting the value of speaking up, listening up and following up. The network also helps address challenges posed by organisation size, geography and the nature of their work as well as support workers, especially those who may face barriers to speaking up. All members of the FTSU team have been key to our success.



Since August 2023, UHD invested further into our speaking up model and created a 1 year post for a deputy FTSUG. This development has allowed the service at UHD be both sustainable and resilient, meeting the demands of our staff using the FTSU route, but also allow us to contribute to the organisation overcoming the barriers that result in workers feeling that they must come to a guardian in the first place.

The success of this invested model will be evaluated in 2024 but initial results show the team are not only handling more speaking up cases but also being able to focus on some proactive projects overcoming barriers to speaking up. Speaking up will not become business as usual if FTSUG are spending all their time acting as an additional channel rather than working with their organisation to overcome the barriers that result in workers feeling that they must come to a guardian in the first place. It is essential that a sustainable future is planned for to meet the needs of our workers undergoing enormous Trust changes across multiple sites and reduce the risk of returning back to a single point of failure with one FTSUG.

It is therefore essential that this strategy provides assurance that the FTSU team are supported, developed and made sustainable for the future. This will be done by;

- Regularly reviewing and updating the training, guidance and support to the FTSU team, nationally from the NGO but also locally from the board.
- Approve a sustainable FTSU model at UHD.

6.3 The Leadership

Our leaders play a significant role in setting the tone for fostering a healthy speak up, listen up and follow up culture. Whilst the insights from our FTSU team can act as an early warning system of where failings might occur and help understand the behaviours and culture that workers experience in practice, it is our leaders who are integral to how we learn, develop and improve. Every leader needs to embrace speaking up so to effectively contribute to the safety and quality of care and improvements in the working environment. This is not universally recognised to be the case in healthcare. Indeed, there is a growing picture nationally of Guardians themselves feeling victimised for doing the job expected of them.

When we explore as to why our staff come to speak with our FTSU team an initial hypothesis was that following significant staff changes in management, staff were not aware of whom to escalate issues to. This has not however appeared to be the case and data from 2022/23, shows us that over 50% of referrals to the FTSU team are because either their line manager was the issue of the concern or that the line manager was aware of the issue but not addressing the issue. Furthermore, 12% staff reported that the reason they came to the FTSU team was because they felt insecure in raising concerns with line managers. A culture of speaking up needs a strong foundation of psychological safety and so needs to be monitored.

This strategy will therefore support our leaders and encourage speak up, listen up and follow up to be a natural leadership behaviour by:

- Supporting the delivery of universal guidance and supportive tools for leaders to enable them to improve speaking up culture within UHD and across the system
- Provide learning to support leaders to recognise and utilise the potential for speaking up to accelerate improvement
- Provide training for workers, including leaders, to promote a speak up, listen up, follow up culture
- Promoting the use of data and intelligence to inform good practice, describing trends and challenges, and encouraging improvement

6.4 The Healthcare

Healthcare System Good practice fails to flourish when it is not supported by each-other. Systemic drivers need to promote effective co-ordinated and consistent speak up, listen up,

follow up cultures. At UHD the FTSUG is the chair for our Dorset Network and recently stepped down as co-chair for the south west FTSUG. Taking the lead in these roles allows UHD to shape our healthcare system and share/learn from best practice. Other roles taken include national mentoring of new FTSUGs and providing guidance to national policy.

We will continue to;

• Promote universal principles for speaking up and their application across the system
• Produce information on good practice and guidance
• Seek to establish a consistent set of metrics that allows speaking up culture to be understood at the organisational, system, and national level
• Bring national bodies together to develop a consistent and supportive response when workers speak up

7.0 Measuring success

There are a number of ways to measure the success of the speaking up strategy. These include:

- increase effective awareness training for all staff so they are clear about what concerns they can raise and how to raise them;
- provide regular communications to all staff (including those permanently employed on a full-time/part-time basis, temporary/ contracted workers and volunteers) to raise the profile and understanding of our speaking up arrangements;
- communicate key findings to staff about the level and type of concerns raised and any resultant actions taken, as is appropriate under the scope of confidentiality;
- share good practice and learning from concerns raised, with the key aim of fostering openness and transparency, such as staff briefings, team meetings and the intranet;
- actively seek the opinion of staff to assess that they are aware of and, are confident in using local processes and use this feedback to ensure our arrangements are improved based on staff experiences and learning;
- use local intelligence from exit interviews as way of example to understand and support staff and provide additional information on how culture can continue to be improved
- obtain feedback from staff who use the service for critical feedback and improvement.

8.0 Summary

Speaking up enhances our working lives and improves the quality and safety of care. Indeed, speaking up benefits everyone and by listening and acting to the views of our people, their improvement ideas and concerns it act as a valuable early warning system. *Speaking up is a gift – use it wisely and we can change the NHS for the better (*NGO Annual report, 2021/22*).* This strategy provides a clear and sustainable direction for UHD, meeting the local and national requirements. Speaking up has never been as important as it is today especially if we are to meet the challenges felt across healthcare. Speaking up needs to be everyone's business.

APPENDIX 1: Equality Impact Assessment

1. Title of document	**Freedom to Speak Up (FTSU); Strategy 2023 – 2026**
2. Date of EIA	5.1.24
4. Directorate/Specialty	People Directorate, Organisational Development

5. Does the document/service affect one group less or more favorably than another on the basis of:

	Yes/No	Rationale
• Age – where this is referred to, it refers to a person belonging to a particular age or range of ages.	No	The strategy applies to all staff working for the trust
• Disability – a person has a disability if they have a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal daily activities.	No	The strategy can be in braille or larger print if needed
• Gender reassignment – the process of transitioning from one gender to another.	No	The strategy applies to all staff working for the trust
• Marriage and civil partnership – marriage can include a union between a man and a woman and a marriage between a same-sex couple.	No	The strategy applies to all staff working for the trust
• Pregnancy and maternity – pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavorably because she is breastfeeding.	No	The strategy applies to all staff working for the trust
• Race – refers to the protected characteristic of Race. It refers to a group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.	No	The strategy applies to all staff working for the trust. The strategy can be made available in an alternative language
• Religion and belief – religion has the meaning usually given to it but belief includes religious and philosophical beliefs including lack of belief (such as Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.	No	The strategy applies to all staff working for the trust.
• Sex – a man or a woman.	No	The strategy applies to all staff working for the trust

• Sexual orientation – whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.	No	The strategy applies to all staff working for the trust
7. If you have identified potential discrimination, are the exceptions valid, legal and/or justified?	N/A	
8. If the answers to any of the above questions is 'yes' then:		**Rationale**
Demonstrate that such a disadvantage or advantage can be justified or is valid.	N/A	
Adjust the policy to remove disadvantage identified or better promote equality.	N/A	

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 01 May 2024

Agenda item: 8.1

Subject:	Fit and Proper Persons Policy
Prepared by:	Yasmin Dossabhoy, Associate Director of Corporate Governance
Presented by:	Yasmin Dossabhoy, Associate Director of Corporate Governance

Strategic Objectives that this item supports/impacts:	Systems working and partnership ☒ Our people ☒ Patient experience ☒ Quality: outcomes and safety ☒ Sustainable services ☒ Patient First programme ☒ One Team: patient ready for reconfiguration ☒
BAF/Corporate Risk Register: (if applicable)	N/A
Purpose of paper:	Decision/Approval
Executive Summary:	The attached draft Fit and Proper Persons Policy, taking into account NHS England's Fit and Proper Framework, is presented to the Board for approval.
Background:	The "fit and proper person" requirement was introduced by Government through Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 5 sets out the requirements for a FPPT, applying to directors and those performing functions of (or equivalent or similar functions to) a director in NHS organisations registered with the CQC. Grounds of unfitness are specified in Part 1 of Schedule 4 to the Regulated Activities Regulations. Responding to the recommendations in the Kark Review, NHS England developed a FPPT Framework to "strengthen/reinforce individual accountability and transparency for Board members, thereby enhancing the quality of leadership within the NHS". The FPPT Framework also takes into account the requirements of the Care Quality Commission (CQC) relating to directors being fit and proper for their roles. The Trust's Fit and Proper Persons Policy has been updated.

Key Recommendations:	To consider and, if appropriate, to approve the Fit and Proper Persons Policy.
Implications associated with this item:	Council of Governors ☒ Equality, Equity, Diversity & Inclusion ☒ Financial ☐ Health Inequalities ☐ Operational Performance ☐ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☐ Regulatory ☒ Strategy/Transformation ☐ System ☐
CQC Reference:	Safe ☒ Effective ☐ Caring ☐ Responsive ☐ Well Led ☒ Use of Resources ☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Board of Directors	03/01/2024	Report presented to the Board for information on the Fit and Proper Persons Framework.

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

University Hospitals Dorset
NHS Foundation Trust

FIT AND PROPER PERSONS POLICY

If this document is printed – please check in the Policies, Procedures and Guidelines section of the intranet to ensure this is the most up to date version

A) SUMMARY POINTS
• To outline the procedure for ensuring that Board Level appointments are compliant with the Fit and Proper Persons Test and for ensuring the Trust meets its statutory obligations with regards to fit and proper persons.
• The policy sets out how the Trust will apply the requirement in recruitment, how the Trust will keep it under review and how the Trust will investigate concerns when they have arisen
•
B) ASSOCIATED DOCUMENTS
• Disclosure and Barring Procedure/Guidance
• Recruitment and Selection Procedure(s)

C) DOCUMENT DETAILS	
Author:	Yasmin Dossabhoy
Job title:	Associate Director of Corporate Governance
Directorate:	Chief Executive's Office
Version no:	V2
Target audience:	All directors, whether executive, non-executive, permanent, interim directors, irrespective of director's Board voting rights, deputy chief officers.
Approving committee / group:	Board of Directors
Chairperson:	Rob Whiteman, Trust Chair
Review Date:	October 2026

D) VERSION CONTROL

Date of Issue	Version No.	Date of Review	Nature of Change	Approval Date	Approval Committee	Author
Oct 2020	V1	Oct 23	New document	April 20	Board of Directors	Company Secretary
April 2024	V2	Oct 2023 – April 2024	Review and update to take account of NHS England Fit and Proper Persons Guidance		Board of Directors	Associate Director of Corporate Governance

E) CONSULTATION PROCESS

Version No.	Review Date	Author	Level of Consultation
1	October 2020	Company Secretary	Shadow Interim Board of Directors
2	April 2024	Associate Director of Corporate Governance	Audit Committee

Contents

Appendices

1. Introduction

1.1 The *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)* (the "Regulations") (as amended), introduced a fit and proper person requirement (Regulation 5) for Directors of health service bodies.

1.2 Under the Regulations, all provider organisations must not appoint or have in place individuals as Directors, or performing the functions of, or functions equivalent or similar to, the functions of a Director unless the individual satisfies certain requirements (Regulation 5(2)).

1.3 University Hospitals Dorset NHS Foundation Trust (the Trust) is required to ensure its Directors are 'fit and proper' to undertake the role and make every reasonable effort to assure itself by all available means.

1.4 In August 2023, NHS England published a Fit and Proper Persons Test (FPPT) Framework. The aim of strengthening the FPPT Framework was to prioritise patient safety and good leadership in NHS organisations. The FPPT Framework notes that:

> *Ensuring high standards of leadership in the NHS is crucial – well-led NHS organisations and better-led teams with both strong teamwork and strong governance translate into greater staff wellbeing and better clinical care. This requires accountable board members with both outstanding personal conduct and professional capabilities to effectively oversee NHS organisations that are often under significant financial restraint and operating in a highly regulated environment with public and political scrutiny.*

1.5 The Framework applies to Board members of NHS organisations, such term being used to refer to:

- Both executive directors and non-executive directors (NEDs), irrespective of voting rights;
- Interim (all contractual forms) as well as permanent appointments; and
- Those individuals referred to as directors within Regulation 5 of the Regulations.

("Board Members").

1.6 There is an expectation that senior leaders set the tone and culture of the organisation, demonstrating the right behaviours to foster a culture of compassion, respect and inclusion and a feeling of belonging as well as encouraging a listening and speaking up culture. As such, when making Director appointments, the Trust's values and candidates' fit to them should be taken into account.

1.7 This policy applies to all Board Members (as defined above).

1.8 For the avoidance of doubt, this policy does not apply to Governors of the Trust. The Trust's Constitution sets out eligibility provisions for holding office as a Governor on the Trust's Council of Governors.

2. Purpose/Policy Statement

2.1 The purpose of this document is to set out the policy statements by which the Trust will support its commitment to the fit and proper person requirements. The

Trust will not permit any individual to hold the post of Director who does not meet the standards required to be approved as a fit and proper person, either on appointment or through changing circumstances.

2.2 The purpose of the Regulations is to ensure that all Board level and Director appointments at NHS bodies carrying on a regulated activity are held responsible for the overall quality and safety of the care provided, for making sure the care meets the existing regulations and effective requirements of the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014,* and that providers and directors can be held to account. Services must be safe, effective, caring, responsive and well-led.

2.3 Regulation 5 sets out the criteria that a Director must meet on appointment, and on an ongoing basis:

- Be of Good Character;
- Have the necessary qualifications, competence, skills and experience for their role;
- Be able, by reason of their health, after reasonable adjustments are made, of properly performing tasks intrinisic to their role;
- Have not been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity; and
- Not be deemed Unfit under Schedule 4, Part 1 of the Regulations.

Providers must also ensure that certain information regarding the individuals is available to the CQC.

2.4 The document Regulation 5: Fit and proper persons: directors published by the CQC in 2018 provides additional guidance to help providers interpret and implement the Regulation. This guidance will be taken into account by the Trust in reviewing an individual's compliance with the FPPT. The document outlines:

- Definitions of misconduct and mismanagement and when proven misconduct or mismanagement should be assessed as 'serious'
- Factors to consider around concerns regarding serious misconduct or mismanagement
- Features that would normally be associated with 'good character' and factors to consider when assessing 'good character'

2.5 The Chair should ensure that the Trust can show evidence that appropriate systems and processes are in place to ensure that all new and existing Board Members are, and continue to be, fit and proper and that no appointments breach any of the criteria set out in Schedule 4 of the Regulations. Such systems and processes include (but are not limited to) recruitment, induction, training, development, performance appraisal, governance committees, disciplinary and dismissal processes. Ultimate accountability for complying with the FPPT Framework resides with the Chair.

2.6 Under the terms of the NHS Provider Licence, foundation trusts must ensure that their directors and governors meet appropriate standards of personal behaviours and technical competence.

3. Definitions

CQC	Care Quality Commission
ESR	The FPPT fields in Electronic Staff Record. It is important to note that: • Information held in ESR about Board Members is accessible by a limited number of senior individuals within the Trust. • There is no access to FPPT information about Board Members in one organisation by another organisation or individual. ESR provides a tool for the Trust to record that testing has been carried out for the Chair, who has overall accountability for the FPPT within the Trust. It also records that testing is complete and enables reports to be run at local level as an audit trail of completed testing and sign off. ESR is not a public register – there is no access to it by the public externally. It is good practice for NHS organisations to report on the high-level outcome of the FPPT assessments in their annual report or elsewhere on their websites; a disclosure statement will be included in the Trust's annual report. The CQC is able to require information to be provided to it under Regulation 5(5) of the Regulations. Access to ESR will also be provided to relevant individuals within the CQC at a local level, where this information is necessary for their roles.
Fit and Proper Persons	Regulation 5 of the Regulations sets out the criteria a Director or equivalent must meet, specifically: • must be of good character; • must have the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed; • must be able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed; • must not have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity; • none of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.
FPPT	Fit and Proper Persons Test.

Good Character	In determining whether a person is of good character, consideration will be given to Schedule 4, Part 2 of the Regulations: • whether they have been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence; and/or • whether they have been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.
Mismanagement	Mismanagement means being involved in the management of an organisation or part of an organisation in such a way that the quality of decision making and actions of managers falls below any reasonable standard of competent management.
Misconduct	The following non-exhaustive list of examples are likely to amount to serious misconduct: • disrespect in the workplace; • failing to comply with lawful instructions; • breach of confidentiality; • fraud or theft; • any criminal offence other than minor motoring offences; • assault; • sexual harassment of staff; • bullying; • victimisation of staff who raise legitimate concerns; • any conduct that can be characterised as dishonesty.
Sign	Signature of documents shown in Appendices 4 to 7 (including, but not limited to, the self-attestation) need not be through a “wet ink” signature, but may be evidenced by electronic means.
Unfit	A person will be deemed “unfit” if they: • are an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged; • are the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland; • are a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986; • have made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it;

- are included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland, or
- are prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

4. Consultation

Please see Consultation Process above.

5. Procedures/Document Content

The procedures underpinning this policy outline the application of the test for new appointments and existing postholders using NHS England's FPPT Framework for Board Members.

5.1 New Appointments

5.1.1 The Trust should be able to demonstrate that appointments of new Board Members are made through a robust and thorough appointment process. A documented full FPPT assessment will be needed for new appointments in Board Member roles, whether permanent or temporary where greater than six weeks.

5.1.2 All appointments will be subject to the individual satisfactorily meeting the FPPT prior to or confirmation of offer of employment/office (or alternatively conditional upon satisfactorily meeting the FPPT requirements). An agreed sign-off process with all relevant checks (Appendix 3) will be carried out prior to final checking by the Chair. This will include completion, by the individual, of a self-attestation (Appendix 4). All offers must be conditional on meeting the statutory requirements.

5.1.3 A failure or refusal by a candidate for appointment to comply with any of the procedures set out in this policy will disqualify the person from the proposed appointment.

5.1.4 If the candidate fails to show that they meet the FPPT, the Trust will withdraw the provisional offer of employment.

5.1.3 As part of conducting the initial appointment process for a Board Member, an inter-authority transfer may be submitted by HR to identify any of the applicant's previous or current NHS service/employment history. Alternatively, other arrangements may be made to collate the relevant information.

5.1.4 Where working with a recruitment agency, the Trust shall ensure that arrangements are clear about which elements are being carried out by which organisation and how this will be evidenced.

5.2 Joint appointments

5.2.1 For joint appointments across different NHS organisations, the full FPPT would need to be completed by the designated host/employing NHS organisation and in concluding their assessment they will need input from the chair of the other contracting NHS organisation to ensure that the Board Member is fit and proper to perform both roles.

5.2.2 The host/employing NHS organisation will then provide a "letter of confirmation" to the other contracting NHS organisation to confirm that the Board member in question has met the requirements of the FPPT.

5.2.3 The chair of the other contracting NHS organisation has the responsibility to keep the host/employing NHS organisation abreast of changes and any matters that may impact the FPPT assessment of the Board Member.

5.2.4 Where there is a joint appointment, the host/employing NHS organisation responsible for the FPPT should also lead on conducting the joint appraisal and ensure adequate input from the other contracting NHS organisation.

5.2.5 Where the joint appointment results in a new board member (for the NHS organisation in question), it will constitute a new appointment and as such, the host/employing NHS organisation should provide a 'letter of confirmation' to the other NHS organisation(s).

5.2.6 For the avoidance of doubt, where two or more organisations employ or appoint (in the case of a chair or Non-Executive Director) an individual for two or more separate roles at the same time, each organisation has a responsibility to complete the Fit and Proper Person Test.

5.2.7 If the FPPT assessment at one organisation finds an individual not to be FPP, the chair should update their counterpart of any other NHS organisation(s) where the individual has a board-level role and explain the reason. To note, the issue at one organisation may be one of role-specific competence, which may not necessarily mean the individual is not FPP at the other organisation.

5.3 Existing Board Members: Annual Review Process

5.3.1 The Trust is responsible for ensuring that relevant individuals continue to meet the FPPT. This shall be done through an annual review, aligned with appraisals. Documentation will include:

- Completion of the self-attestation form (Appendix 4) by the individual;
- Annual checks against the disqualified directors register, bankruptcy and insolvency register, removed charity trustees register and relevant professional registers.

5.3.2 The Chair will review and if satisfied sign – or signify to the contrary (Appendix 5) to confirm that the annual checks have been completed and that the person continues to meet the FPPT.

5.4 Existing Directors: Responsive Review Process

5.4.1 Circumstances may arise where concerns are raised about the Fit and Proper Person status of an individual, either by self-notification, or as a result of concerns

raised by a third party. Should this occur then a review should take place outside of the normal testing schedule.

5.4.2 A full FPPT assessment will be needed when an individual Board Member changes role within the Trust (for instance, if an existing Board Member moves into a new Board role that requires a different skillset). However, in such circumstances, a board member reference check will not be needed.

5.5 Existing Directors: Action required via Annual / Responsive Review process

5.5.1 If an individual is deemed competent but does not hold relevant qualifications, there should be a documented explanation, approved by the Chair, as to why the individual in question is deemed fit to be appointed as a Board member, or fit to continue in role if they are an existing Board Member. This should be recorded in the annual return to the NHS England regional director.

5.5.2 If an individual is deemed unfit (they failed the FPPT) for a particular reason (other than qualifications) but the Trust appoints them or allows them to continue their current employment/engagement as a Board Member, there should be a documented explanation as to why the Board Member is unfit and the mitigations taken, which is approved by the Chair. This should be submitted to the relevant NHS England regional director for review, either as part of the annual FPPT submission for the Trust, or on an ad hoc basis as a case arises.

5.5.3 If an individual is deemed to no longer meet the FPPT (either through the annual review process, or via a responsive review), the Chair will be notified and is responsible for making an informed decision regarding the course of action to be followed.

5.6 Dispute Resolution

5.6.1 Data and information

5.6.1.1 Where a Board Member identifies an issue with data held about them in relation to the FPPT, they should request a review which should be conducted in accordance with local policies in the first instance.

5.6.1.2 Where this does not lead to a satisfactory resolution for the Board Member, the following options are available:

- For the Trust Chair – a further request for review can be made to the Senior Independent Director or Vice Chair who would establish a process proportionate to the matter being considered; for example, establishing a panel with at least one independent member.
- For all other Board Members the options could include:
    - Referring the matter to the Information Commissioner's Office
    - Taking the matter to an employment tribunal (for Executive Director Roles only)
    - Instigating civil proceedings.

5.6.2 Outcome of Fit and Proper Person Test assessment

Where a Board Member disagrees with the outcome of the FPPT assessment and they have been deemed 'not fit and proper,' local policy and Constitution arrangements should be followed in the first instance.:

At any point, employees have the right to take the matter to an Employment Tribunal.

5.7 **Personal Data**

5.7.1 Personal data for board members relating to the Fit and Proper Person Test assessment will be retained in local record systems and on the NHS Electronic Staff Record.

5.7.1 FPPT outcomes must be entered onto ESR so that an ESR FPPT Dashboard can reviewed by the Chair. Once satisfied, the Chair must update and sign off each Board Member on ESR.

5.7.2 An annual submission form (Appendix 6) will be generated for Chair sign off and submitted to the NHS England Regional Director, where the NHS England Fit and Proper Person test central team will collate records from NHSE regions.

5.8 Board Member Reference Request

5.8.1 The Trust will need to request board member references (Appendix 7), and store information relating to these references so that it is available for future checks; and use it to support the full FPPT assessment on initial appointment.

5.8.2 The Trust should maintain complete and accurate Board Member references at the point where the Board Member departs, irrespective of whether there has been a request from another NHS employer and including in circumstances of retirement. Both the initial and Board Member references should be retained locally.

5.8.3 Board member references will apply as part of the FPPT assessment when there are new board member appointments, either internal to a particular NHS organisation, internal to the NHS, or external to the NHS. This applies whether permanent or temporary where greater than six weeks; specifically:

- New appointments that have been promoted within an NHS organisation.
- Existing board members at one NHS organisation who move to another NHS organisation in the role of a board member.
- Individuals who join an NHS organisation in the role of board member for the first time from an organisation that is outside of the NHS.
- Individuals who have been a board member in an NHS organisation and join another NHS organisation not in the role of board member, that is, they take a non-Board level role.

6. Roles and Responsibilities

Role	Has responsibility for
Chair	Overall accountability for arrangements in their organisation • ensure assessments carried out for Board members on appointment and annually, and at any time that something new comes to light • ensure that the Board Member Reference is completed for any Board member who leaves the Board for whatever reason, whether or not a reference has been requested • conclude on assessments for the whole Board (executive and non-executive, permanent or temporary, voting or non-voting) and update Electronic Staff Record • submit annual summary to relevant regional director

Senior Independent Director	• carrying out the Fit and Proper Person Test assessment for the Chair; • undertaking investigations into any concerns raised about the Chair (with the support of the Company Secretary Team)
HR and Company Secretary Teams	Support Chair in establishing arrangements for the Fit and Proper Person Test and specifically for: • accessing and entering information onto Electronic Staff Record • testing elements of Fit and Proper Person test assessment and recording outcome and evidence for Chair to review and conclude • completing the annual submission form
Chief Executive	• carry out initial assessment of the Fit and Proper Person Test for executive board members and share with the chair for overall assessment of board member Fit and Proper Person status • support the Chair
Directors	• giving their consent, on request, to the pre-employment checks described in Appendix 3; • providing evidence of their qualifications, experience and identity documents on appointment or on request to confirm the competencies relevant to the position; • confirming that they are a fit and proper person on appointment (by signing the declaration provided in Appendix 4 for new directors) and thereafter on an annual basis; • identifying any issues which may affect their ability to meet the statutory requirements on appointment and bringing any issues on an on-going basis to the Chair
Staff	• raising any concerns via the appropriate Trust policies and procedures, for example through the Freedom to Speak Up - Raising Concerns Policy.
NHS Regional Directors	Oversight role covering elements of: • appointment and initial Fit and Proper Person Test assessment • receipt of the annual Fit and Proper Person Test submission forms • where required, in relation to disputes and appeals

7. Training

7.1 There is no mandatory training associated with this policy. Ad hoc training sessions based on an individual's training needs will be defined within their annual appraisal or job plan.

8. Monitoring Compliance and Effectiveness of the Document

8.1 Compliance with the document will be monitored in the following ways:

8.1.1 Review of all Board Members' ongoing compliance with Fit and Proper Persons requirements as set out in this policy;

8.1.2 In addition to the monitoring arrangements described above the Trust may undertake additional monitoring of this policy as a response to the identification of any gaps or as a result of the identification of risks arising

from the policy prompted by incident review, external reviews, or other sources of information and advice.

8.1.3 Every three years, the Trust shall have an internal audit to assess the processes, controls and compliance supporting the FPPT assessments. The internal audit should include sample testing of FPPT assessment and associated documentation.

8.1.4 An annual update to a meeting of the Board in public shall be provided to confirm whether the requirements for FPPT assessment have been satisfied.

8.1.5 In the exceptional circumstances of there being any outcome from a Non-Executive Director or Chair assessment as not "fit and proper", the Council of Governors shall be informed.

9. Supporting Documents and References

9.1 This policy should be read in conjunction with:

9.1.1	The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014;
9.1.2	Regulation 5: Fit and Proper Persons: Directors and Regulation 20: Duty of Candour (Care Quality Commission);
9.1.3	NHS Employers Employment Check Standards;
9.1.4	Insolvency Act 1986;
9.1.5	Safeguarding Vulnerable Groups Act 2006;
9.1.6	Police Act 1997;
9.1.7	Constitution for the Trust;
9.1.8	Fit and Proper Persons Regulations in the NHS – what do providers need to know (NHS Providers);
9.1.9	Fit and Proper Persons Requirement for Directors (NHS Employers);
9.1.10	NHS Constitution
9.1.11	NHS guiding principles
9.1.12	NHS values
9.1.13	The Nolan Principles of Standards in Public Life

9.2 The Trust's HR Policies (as relevant).

11. Dissemination

This policy will be made available on the policies section of the Trust's intranet.

12. Approval & Ratification

This policy is to be approved by the Board of Directors of the Trust.

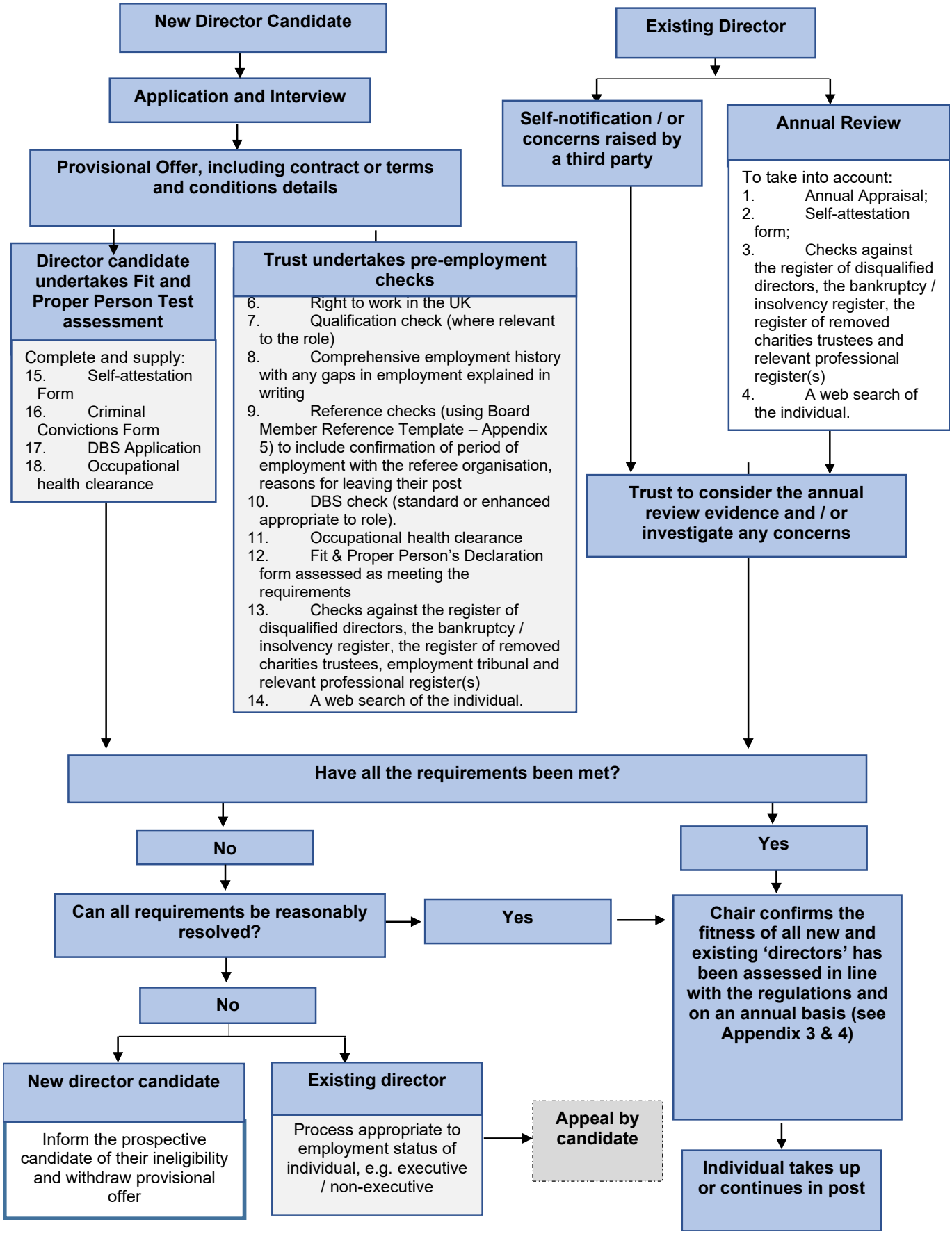
13. Review

13.1 This policy will be reviewed in three years as set out in the Document Control Policy, or more frequently in the event of a major change to the law or any other circumstances which has an impact on the procedural document in question, at which point a review will take place as soon as reasonably practicable.

14. Equality Impact Assessment

14.1 Please refer to Appendix 6.

Appendix 1: Fit and Proper Person Test Process



Appendix 2: Regulation 5 – Schedule 3: Information required in respect of persons employed or appointed for the purposes of a regulated activity

1. Proof of identity including a recent photograph.

2. Where required for the purposes of an exempted question in accordance with section 113A(2)(b) of the Police Act 1997(**1**), a copy of a criminal record certificate issued under section 113A of that Act together with, after the appointed day and where applicable, the information mentioned in section 30A(3) of the Safeguarding Vulnerable Groups Act 2006 (provision of barring information on request)(**2**).

3. Where required for the purposes of an exempted question asked for a prescribed purpose under section 113B(2)(b) of the Police Act 1997, a copy of an enhanced criminal record certificate issued under section 113B of that Act together with, where applicable, suitability information relating to children or vulnerable adults.

4. Satisfactory evidence of conduct in previous employment concerned with the provision of services relating to—

(a) health or social care, or

(b) children or vulnerable adults.

5. Where a person (P) has been previously employed in a position whose duties involved work with children or vulnerable adults, satisfactory verification, so far as reasonably practicable, of the reason why P's employment in that position ended.

6. In so far as it is reasonably practicable to obtain, satisfactory documentary evidence of any qualification relevant to the duties for which the person is employed or appointed to perform.

7. A full employment history, together with a satisfactory written explanation of any gaps in employment.

8. Satisfactory information about any physical or mental health conditions which are relevant to the person's capability, after reasonable adjustments are made, to properly perform tasks which are intrinsic to their employment or appointment for the purposes of the regulated activity.

9. For the purposes of this Schedule—

(a) "the appointed day" means the day on which section 30A of the Safeguarding Vulnerable Groups Act 2006 comes into force;

(b) "satisfactory" means satisfactory in the opinion of the Commission;

(c) "suitability information relating to children or vulnerable adults" means the information specified in sections 113BA and 113BB respectively of the Police Act 1997.

Appendix 3: Fit and Proper Person Test checklist

Fit and Proper Person Test Area	Record in Electronic Staff Record	Local evidence folder	Recruitment Test	Annual Test	Executive Director	Non-Executive Director	Source	Notes
First name	✓	✓	✓	x – unless change	✓	✓	Application and recruitment process.	Recruitment team to populate Electronic Staff Record. For NHS-to-NHS moves via Electronic Staff Record / Inter-Authority Transfer/ NHS Jobs. For non-NHS – from application – whether recruited by NHS England, in-house or through a recruitment agency.
Second name/surname	✓	✓	✓	x – unless change	✓	✓		
Organisation (ie current employer)	✓	x	✓	N/A	✓	✓		
Staff group	✓	x	✓	x – unless change	✓	✓		
Job title Current Job Description	✓	✓	✓	x – unless change	✓	✓		
Occupation code	✓	x	✓	x – unless change	✓	✓		
Position title	✓	x	✓	x – unless change	✓	✓		

Fit and Proper Person Test Area	Record in Electronic Staff Record	Local evidence folder	Recruitment Test	Annual Test	Executive Director	Non-Executive Director	Source	Notes
Employment history Including: • job titles • organisations/ departments • dates and role descriptions • gaps in employment	✓	x	✓	X	✓	✓	Application and recruitment process, CV, etc.	Any gaps that are because of any protected characteristics, as defined in the Equality Act 2010, do not need to be explained. The period for which information should be recorded is for local determination, taking into account relevance to the person and the role. It is suggested that a career history of no less than six years and covering at least two roles would be the minimum. Where there have been gaps in employment, this period should be extended accordingly.

Fit and Proper Person Test Area	Record in Electronic Staff Record	Local evidence folder	Recruitment Test	Annual Test	Executive Director	Non-Executive Director	Source	Notes
Training and development	✓	✓	✓	✓	✓	*	Relevant training and development from the application and recruitment process; that is, evidence of training (and development) to meet the requirements of the role as set out in the person specification. Annually updated records of training and development completed/ongoing progress.	* NED recruitment often refers to a particular skillset/experience preferred, e.g. clinical, financial, etc, but a general appointment letter for NEDs may not then reference the skills/experience requested. Some NEDs may be retired and do not have a current professional registration. At recruitment, organisations should assure themselves that the information provided by the applicant is correct and reasonable for the requirements of the role. For all board members: the period for which qualifications and training should look back and be recorded is for local determination, taking into account relevance to the person and the role. It is suggested that key qualifications required for the role and noted in the person specification (e.g. professional qualifications) and dates are recorded however far back that may be. Otherwise, it is suggested that a history of no less than six years should be the minimum. Where there have been gaps in employment, this period should be extended accordingly.
References Available references from previous employers	✓	✓	✓	X	✓	✓	Recruitment process	Including references where the individual resigned or retired from a previous role

Fit and Proper Person Test Area	Record in Electronic Staff Record	Local evidence folder	Recruitment Test	Annual Test	Executive Director	Non-Executive Director	Source	Notes
Last appraisal and date	✓	✓	✓	✓	✓	*	Recruitment process and annual update following appraisal	* For Non-Executive Directors, information about appraisals is only required from their appointment date forward. No information about appraisals in previous roles is required.
Disciplinary findings That is, any upheld finding pursuant to any NHS organisation policies or procedures concerning employee behaviour, such as misconduct or mismanagement	✓	✓	✓	✓	✓	✓	Reference request (question on the new Board Member Reference). Electronic Staff Record (high level)/ local case management system as appropriate.	The new BMR includes a request for information relating to investigations into disciplinary matters/ complaints/ grievances and speak-ups against the board member. This includes information in relation to open/ ongoing investigations, upheld findings and discontinued investigations that are relevant to Fit and Proper Person Test. This question is applicable to board members recruited both from inside and outside the NHS.
Grievance against the board member	✓	✓	✓	✓	✓	✓		
Whistleblowing claim(s) against the board member	✓	✓	✓	✓	✓	✓		
Behaviour not in accordance with organisational values and behaviours or related local policies	✓	✓	✓	✓	✓	✓		

Fit and Proper Person Test Area	Record in Electronic Staff Record	Local evidence folder	Recruitment Test	Annual Test	Executive Director	Non-Executive Director	Source	Notes
Type of Disclosure and Barring Service disclosed	✓	✓	✓	✓	✓	✓	Electronic Staff Record and DBS response.	Frequency and level of Disclosure and Barring Service in accordance with local policy for board members. Check annually whether the Disclosure and Barring Service needs to be reapplied for. Maintain a confidential local file note on any matters applicable to Fit and Proper Person Test where a finding from the Disclosure and Barring Service needed further discussion with the board member and the resulting conclusion and any actions taken/required.
Date Disclosure and Barring Service received	✓	✓	✓	✓	✓	✓	Electronic Staff Record	
Date of medical clearance* (including confirmation of OHA)	✓	x	✓	x – unless change	✓	✓	Local arrangements	
Date of professional register check (eg membership of professional bodies)	✓	x	✓	✓	✓	x	E.g. NMC, GMC, accountancy bodies.	
Insolvency check	✓	✓	✓	✓	✓	✓	Bankruptcy and Insolvency register	Keep a screenshot of check as local evidence of check completed.
Disqualified Directors Register check	✓	✓	✓	✓	✓	✓	Companies House	
Disqualification from being a charity trustee check	✓	✓	✓	✓	✓	✓	Charities Commission	
Employment Tribunal Judgement check	✓	✓	✓	✓	✓	✓	Employment Tribunal Decisions	

Fit and Proper Person Test Area	Record in Electronic Staff Record	Local evidence folder	Recruitment Test	Annual Test	Executive Director	Non-Executive Director	Source	Notes
Social media check	✓	✓	✓	✓	✓	✓	Various – Google, Facebook, Instagram, etc.	
Self-attestation form signed	✓	✓	✓	✓	✓	✓	Template self-attestation form	
Sign-off by Chair/Chief Executive	✓	x	✓	✓	✓	✓	Electronic Staff Record	Includes free text to conclude in Electronic Staff Record fit and proper or not. Any mitigations should be evidence locally.
Other templates to be completed								
Board Member Reference	✓	✓	x	X	✓	✓	Template BMR	To be completed when any board member leaves for whatever reason and retained career-long or 75th birthday, whichever latest.
Letter of Confirmation	x	✓	✓	✓	✓	✓	Template	For joint appointments only
Annual Submission Form	x	✓	✓	✓	✓	✓	Template	Annual summary to Regional Director
Privacy Notice	x	✓	x	X	✓	✓	Template	Board members should be made aware of the proposed use of their data for Fit and Proper Person Test
Settlement Agreements	x	✓	✓	✓	✓	✓	Board member reference at recruitment and any other information that comes to light on an ongoing basis.	Chair guidance describes this in more detail. It is acknowledged that details may not be known/disclosed where there are confidentiality clauses.

Appendix 4: Fit and Proper Person Test annual/new starter self-attestation

Fit and Proper Person Test annual/new starter* self-attestation

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

I declare that I am a fit and proper person to carry out my role. I:

- am of good character
- have the qualifications, competence, skills and experience which are necessary for me to carry out my duties
- where applicable, have not been erased, removed or struck-off a register of professionals maintained by a regulator of healthcare or social work professionals
- am capable by reason of health of properly performing tasks which are intrinsic to the position
- am not prohibited from holding office (eg directors disqualification order)
- I have not been convicted of a criminal offence and sentenced to imprisonment of three months or more
- been un-discharged bankrupt nor have been subject to bankruptcy restrictions, or have made arrangement/compositions with creditors and has not discharged
- I do not appear on any 'barred' list.
- have not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.

The legislation states: if you are required to hold a registration with a relevant professional body to carry out your role, you must hold such registration and must have the entitlement to use any professional titles associated with this registration. Where you no longer meet the requirement to hold the registration, any if you are a healthcare professional, social worker or other professional registered with a healthcare or social care regulator, you must inform the regulator in

question. Should my circumstances change, and I can no longer comply with the Fit and Proper Person Test (as described above), I acknowledge that it is my duty to inform the chair.	
Name and job title/role:	
Professional registrations held (ref no):	
Date of DBS check/re-check (ref no):	
Date of last appraisal, by whom:	
Signature of board member:	
Date of signature of board member:	
For chair to complete	
Signature of chair to confirm receipt:	
Date of signature of chair:	

*Delete as appropriate

Appendix 5: Fit and Proper Persons Requirement – Annual Checklist for existing Directors

Name	
Position	

Item	Checked by (Initials)	Any relevant information to note
Fit and Proper Persons Requirement self-declaration signed and returned (appendix 4)		
Disqualified Directors Check		*(date to be noted)*
Bankruptcy & insolvency check		*(date to be noted)*
Removed Charity Trustees check		*(date to be noted)*
Financial Conduct Authority *where individual has worked for an organisation regulated by the Financial Conduct Authority (FCA)*		*(date to be noted)*
Employees Tribunal		*(date to be noted)*
Where appropriate, relevant professional registers		
Web search results		

_____

I confirm that the above checks have been undertaken and I am satisfied the individual named above is assessed to be a “fit and proper person” to continue in their appointed role.

Trust Chair	Name	Signature	Date

Appendix 6 - Annual NHS Fit and Proper Person Test submission reporting template

NAME OF ORGANISATION	NAME OF CHAIR	FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST:

Part 1: Fit and Proper Person Test outcome for board members including starters and leavers in period

Name	Date of appointment	Position	Confirmed as fit and proper?		Leavers only	
			Yes/No	Add 'Yes' only if issues have been identified and an action plan and timescale to complete it has been agreed	Date of leaving and reason	Board member reference completed and retained? Yes/No

Add additional lines as needed

Part 2: Fit and Proper Person Test reviews / inspections

Use this section to record any reviews or inspections of the Fit and Proper Person Test process, including Care Quality Commission, internal audit, board effectiveness reviews, etc.

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed
Care Quality Commission				
Other, eg internal audit, review board, etc.				

Add additional lines as needed

Part 3: Declarations

DECLARATION FOR UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST [YEAR]
For the Senior Independent Director/Deputy Chair to complete:

Fit and Proper Person Test for the chair (as board member)	Completed by (role)	Name	Date	Fit and proper? Yes/No

For the chair to complete:		
Have all board members been tested and concluded as being fit and proper?	Yes/No	If 'no', provide detail:
Are any issues arising from the Fit and Proper Person Test being managed for any board member who is considered fit and proper?	Yes/No	If 'yes', provide detail:

As Chair of [organisation], I declare that the Fit and Proper Person Test submission is complete, and the conclusion drawn is based on testing as detailed in the Fit and Proper Person Test framework.

Chair signature:	
Date signed:	

For the regional director to complete:	
Name:	
Signature:	
Date:	

Appendix 7 - Board Member Reference

[Date]

Human resources officer/name of referee

Recruitment officer

External/NHS organisation receiving request

HR department initiating request

Dear [HR officer's/referee's name]

Re: [applicant's name] - [ref. number] – [Board Member position]

The above-named person has been offered the board member position of [post title] at University Hospitals Dorset NHS Foundation Trust. This is a high-profile and public facing role which carries a high level of responsibility. The purpose of NHS boards is to govern effectively, and in so doing build patient, staff, public and stakeholder confidence that the public's health and the provision of healthcare are in safe hands.

Taking this into account, I would be grateful if you could complete the attached confirmation of employment request as comprehensively as possible and return it to me as soon as practically possible to ensure timely recruitment.

Please note that under data protection laws and other access regimes, applicants may be entitled to information that is held on them.

Thank you in advance for your assistance in this matter.

Yours sincerely

[Recruitment officer's name]

Board Member Reference request for NHS Applicants:

To be used only AFTER a conditional offer of appointment has been made.
Information provided in this reference reflects the most up to date information available at the time the request was fulfilled.

1. Name of the applicant (1)	
2. National Insurance number or date of birth	

3. Please confirm employment start and termination dates in each previous role

A:(if you are completing this reference for pre-employment request for someone currently employed outside the NHS, you may not have this information, please state if this is the case and provide relevant dates of all roles within your organisation)
B: (As part of exit reference and all relevant information held in Electronic Staff Record under Employment History to be entered)

Job Title:
From:
To:

Job Title
From:
To:

Job Title:
From:
To:

Job Title:
From:
To:

Job Title:
From:
To:

4. Please confirm the applicant's current/most recent job title and essential job functions (if possible, please attach the Job Description or Person Specification as Appendix A):

(This is for Executive Director board positions only, for a Non-Executive Director, please just confirm current job title)

5. Please confirm Applicant remuneration in current role (*this question only applies to Executive Director board positions applied for)*	Starting:	Current:

6. Please confirm all Learning and Development undertaken during employment: *(this question only applies to Executive Director board positions applied for)*		
7. How many days absence (other than annual leave) has the applicant had over the last two years of their employment, and in how many episodes? ***(only applicable if being requested after a conditional offer of employment)***	Days Absent:	Absence Episodes:
8. Confirmation of reason for leaving:		
9. Please provide details of when you last completed a check with the Disclosure and Barring Service (DBS) (This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)		

Date Disclosure and Barring Service check was last completed.	Date	
Please indicate the level of Disclosure and Barring Service check undertaken (basic/standard/enhanced without barred list/or enhanced with barred list)	Level	
If an enhanced with barred list check was undertaken, please indicate which barred list this applies to	Adults □ Children □ Both □	
10. Did the check return any information that required further investigation?	Yes □	No □
If yes, please provide a summary of any follow up actions that need to/are still being actioned:		
11. Please confirm if all annual appraisals have been undertaken and completed (This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)	Yes □	No □
Please provide a summary of the outcome and actions to be undertaken for the last 3 appraisals:		
12. Is there any relevant information regarding any outstanding, upheld or discontinued complaint(s) or other matters tantamount to gross misconduct or serious misconduct or mismanagement including grievances or complaint(s) under	Yes □	No □

any of the Trust's policies and procedures (for example under the Trust's Equal Opportunities Policy)? (For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)		
If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:		
13. Is there any outstanding, upheld or discontinued disciplinary action under the Trust's Disciplinary Procedures including the issue of a formal written warning, disciplinary suspension, or dismissal tantamount to gross or serious misconduct that can include but not be limited to: • **Criminal convictions for offences leading to a sentence of imprisonment or incompatible with service in the NHS** • **Dishonesty** • **Bullying** • **Discrimination, harassment, or victimisation** • **Sexual harassment** • **Suppression of speaking up** • **Accumulative misconduct** (For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)	Yes □	No □
If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:		

14. Please provide any further information and concerns about the applicant's fitness and propriety, not previously covered, relevant to the Fit and Proper Person Test to fulfil the role as a director, be it executive or non-executive. Alternatively state Not Applicable. (Please visit links below for the Care Quality Commission definition of good characteristics as a reference point) (7)(12)

Regulation 5: Fit and proper persons: directors - Care Quality Commission (cqc.org.uk)

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (legislation.gov.uk)

15. The facts and dates referred to in the answers above have been provided in good faith and are correct and true to the best of our knowledge and belief.

Referee name (please print): …….. Signature: ……

Referee Position Held:

Email address: Telephone number:

Date:

Data Protection:

This form contains personal data as defined by the Data Protection Act 2018 and UK implementation of the General Data Protection Regulation). This data has been requested by the Human Resources/ Workforce Department for the purpose of recruitment and compliance with the Fit and Proper Person requirements applicable to healthcare bodies. It must not be used for any incompatible purposes. The Human Resources/Workforce Department must protect any information disclosed within this form and ensure that it is not passed to anyone who is not authorised to have this information.

13. Equality Impact Assessment

1. Title of document	Fit and Proper Persons Policy		
2. Date of EIA			
3. Date for review			
4. Directorate/Specialty	Company Secretary Team		
5. Does the document/service affect one group less or more favorably than another on the basis of:			
		Yes/No	**Rationale**
• Age – where this is referred to, it refers to a person belonging to a particular age or range of ages.		No	
• Disability – a person has a disability if they have a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal daily activities.		No	
• Gender reassignment – the process of transitioning from one gender to another.		No	
• Marriage and civil partnership – marriage can include a union between a man and a woman and a marriage between a same-sex couple.		No	
• Pregnancy and maternity – pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavorably because she is breastfeeding.		No	
• Race – refers to the protected characteristic of Race. It refers to a group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.		No	
• Religion and belief – religion has the meaning usually given to it but belief includes religious and philosophical beliefs including lack of belief (such as Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.		No	
• Sex – a man or a woman.		No	

• Sexual orientation – whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.	No	
7. If you have identified potential discrimination, are the exceptions valid, legal and/or justified?	N/A	
8. If the answers to any of the above questions is 'yes' then:	**Yes**	**Rationale**
Demonstrate that such a disadvantage or advantage can be justified or is valid.		
Adjust the policy to remove disadvantage identified or better promote equality.		

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 01 May 2024

Agenda item: 8.2

Subject:	Independence of Non-Executive Directors
Prepared by:	Yasmin Dossabhoy, Associate Director of Corporate Governance
Presented by:	Rob Whiteman, Trust Chair

Strategic Objectives that this item supports/impacts:	Continually improve quality Be a great place to work Use resources efficiently Be a well led and effective partner Transform and improve	☐ ☐ ☐ ☒ ☐
BAF/Corporate Risk Register: (if applicable)	N/A	
Purpose of paper:	Decision/Approval	
Executive Summary:	The attached draft paper sets out the Board's determination on the independence of non-executive directors and the formal annual report statement on the independence of non-executive directors for 2023/2024.	
Background:	NHS England's Code of Governance, provision B.2.6 provides that the Board should identify in the Trust's annual report each non-executive director it considers to be independent. The Board should determine whether the director is independent in character and judgment and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the director's judgment. The Board should explain its reasons if these or other relevant circumstances apply and the Board nonetheless considers that the non-executive director is independent.	
Key Recommendations:	To consider and, if appropriate, to approve the statement on the independence of the non-executive directors.	
Implications associated with this item:	Council of Governors Equality, Equity, Diversity & Inclusion Financial Health Inequalities Operational Performance People (inc Staff, Patients) Public Consultation Quality Regulatory	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

	Strategy/Transformation System	☐ ☐
CQC Reference:	Safe Effective Caring Responsive Well Led Use of Resources	☐ ☐ ☐ ☐ ☒ ☐

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

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

University Hospitals Dorset NHS Foundation Trust

Report on Independence of non-executive directors
(Code of Governance for NHS Provider Trusts B.2.6)

Introduction

Under paragraph B.2.6 of NHS England's Code of Governance for Provider Trusts, the Board of Directors should identify in its annual report each non-executive director it considers to be independent.

Assessment

In determining the independence of non-executive directors, the Board of Directors has considered whether there are relationships or circumstances which are likely to affect or could appear to effect a non-executive director's judgement including if the director:

- has been an employee of the trust within the last two years; *None have*.
- has, or has had within the last two years, a material business relationship with the trust either directly, or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust; *None have.*
- has received or receives additional remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme, or is a member of the trust's pension scheme; *None have.*
- has close family ties with any of the trust's advisers, directors or senior employees; *None have.*
- holds cross-directorships or has significant links with other directors through involvement in other companies or bodies; *None have.*
- has served on the board of the trust for more than six years from the date of their first appointment; *None have.*
- is an appointed representative of the trust's university medical or dental school. *Not Applicable.*

Recommendation

The Board approves the assessment and statement that each non-executive director is considered to be independent.

March 2024

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 01 May 2024

Agenda item: 8.3

Subject:	Register of Directors' Interests
Prepared by:	Ewan Gauvin, Acting Deputy Company Secretary
Presented by:	Rob Whiteman, Trust Chair

Strategic Themes that this item supports/impacts:	Systems working and partnership ☒ Our people ☒ Patient experience ☒ Quality: outcomes and safety ☒ Sustainable services ☒ Patient First programme ☒ One Team: patient ready for reconfiguration ☒
BAF/Corporate Risk Register: (if applicable)	N/A
Purpose of paper:	Information
Executive Summary:	The register of directors' interests is presented to the Board for annual review.
Background:	The National Health Service Act 2006 (Schedule 7 20(1)) provides that a public benefit corporation must have a register of interests of the directors. The register is updated as necessary throughout the year and is available at all times on the Trust's website. https://www.uhd.nhs.uk/about-us/our-performance/board-governance
Key Recommendations:	To note the register.
Implications associated with this item:	Council of Governors ☒ Equality, Equity Diversity and Inclusion ☐ Financial ☐ Health Inequalities ☐ Operational Performance ☐ People (inc Staff, Patients) ☐ Public Consultation ☐ Quality ☐ Regulatory ☒ Strategy/Transformation ☐ System ☐

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

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

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

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

REGISTER OF BOARD OF DIRECTORS' INTERESTS

The following interests, as at 24 April 2024, were declared by the Board of Directors of University Hospitals Dorset NHS Foundation Trust:

NAME AND TITLE	INTEREST REGISTER
Pankaj Davé Non-Executive Director	• Board Trustee – Royal College of Surgeons of England
Judith Gillow MBE Non-Executive Director	• Specialist Professional Advisor – Care Quality Commission • Mentor/Coach for Overseas NHS Fellows – Improving Global Health, Health Education England • Volunteer – Milford-on-Sea Community Café • Company Secretary – A.W.R Electronics
Siobhan Harrington Chief Executive	• Brother – Chief Executive of ELEMIS Limited ELEMIS body and beauty products received as a gift to staff (£106,000)
Fiona Hoskins Acting Chief Nursing Officer	• None
John Lelliott OBE Non-Executive Director	• Non-Executive Director – Environment Agency • Non-Executive Director – Covent Garden Market Authority • Board member – The Capitals Coalition • Trustee – Centre for Sustainable Healthcare • Trustee – Royal Agricultural Benevolent Institution • Trustee – JTL Training • Daughter – Pharmacist • Son-in-law - Pharmacist
Dr Helena McKeown Non-Executive Director	• Trustee – Salisbury City Almshouse and Welfare Charities • Medical Director: Professional Development and Quality – Royal College of General Practitioners • Dorset LMC Member – Wessex Local Medical Committees Limited • Medical Womens Federation – South-West Regional Representative • General Practitioner – Gillingham Medical Centre

NAME AND TITLE	INTEREST REGISTER
	• Appraiser – NHS England South East • Senior Appraiser – NHS England South West
Mark Mould Chief Operating Officer	• Director of Concept Works Ltd (property rental company) 50% share. • Wife owns iSkincare Ltd (Aesthetic Company) • Wife owns jointly with daughter iSkin Secrets Ltd • Daughter – Masters in Nursing • Daughter – Zero Hours Admin Bank Contract with UHD • Director – Private Health University Hospitals Dorset Limited • Director – The Bournemouth and Poole Healthcare Trust • Trustee – The Bournemouth and Poole Healthcare Trust
Pete Papworth Chief Finance Officer	• Director – The Bournemouth and Poole Healthcare Trust • Director – Private Health University Hospitals Dorset Limited • Trustee – The Bournemouth and Poole Healthcare Trust • Wife – HR Business Partner at Dorset Healthcare University NHS Foundation Trust
Sharath Ranjan Non-Executive Director	• Independent Governor – Solent University
Richard Renaut Chief Strategy and Transformation Officer	• Wife a Pharmacist - includes bank shifts at UHD and part time for a Dorset Primary Care Network • Director - The Bournemouth and Poole Healthcare Trust • Director - Private Health University Hospitals Dorset Limited • Trustee - The Bournemouth and Poole Healthcare Trust
Tina Ricketts Chief People Officer	• None
Prof Clifford Shearman OBE Non-Executive Director	• Independent Non-Executive Director - Spire Health Care Group PLC • Company Secretary - Wessex Medical Reporting Limited • Emeritus Professor of Vascular Surgery - University of Southampton
Claire Whitaker CBE Non-Executive Director	• Chief Executive – Southampton Forward • Director – Triangle Consultants Ltd • Director – Aster Homes Ltd • Director – Aster Property Ltd • Director – Seriously Inclusive Ltd

NAME AND TITLE	INTEREST REGISTER
	• Director – In All Seriousness Music Ltd • Trustee – Enham Trust
Rob Whiteman CBE Trust Chair	• Chief Executive – Chartered Institute of Public Finance and Accountancy • Director – CIPFA Business Ltd • Director – Lilliput Advisory Ltd • Director – CCAB Ltd • Chair – BD Group - Director: BD Corporate Cleaning Ltd - Director: BD Service Delivery Ltd - Director: Barking & Dagenham Trading Partnership Ltd - Director: BD Together Ltd - Director: BD Management Services Ltd - Director: Londoneast-UK Ltd • Board member – Theatre Royal Stratford East - Director: Pioneer Theatres Ltd • Non-Executive Director – Residential Secure Income PLC • Non-Executive Director – Koru Project Community Interest Company • Senior Advisor – Newton Europe • Non-Executive Director – Queen Mary University of London *(from 1 July 2024)*
Dr Peter Wilson Chief Medical Officer	• None

Standing Attendees

Dr David Broadley Medical Director for Integrated Care	• Partner – Rosemary Medical Centre, Poole • Board Member – Poole Central PCN
Prof John Vinney Associate Non-Executive Director	• Director – Bournemouth University • Director – Bournemouth University Innovations

In compliance with section B, 2.14 of the code of governance for NHS provider trusts, no full-time executive director holds more than one non-executive directorship of another trust or organisation of comparable size and complexity, and not the chairship of such an organisation.

24 April 2024

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 01 May 2024

Agenda item: 8.4

Subject:	Membership of Board Committees
Prepared by:	Yasmin Dossabhoy, Associate Director of Corporate Governance
Presented by:	Rob Whiteman, Trust Chair

Strategic themes that this item supports/impacts:	Systems working and partnership ☒ Our people ☒ Patient experience ☒ Quality: outcomes and safety ☒ Sustainable services ☒ Patient First programme ☒ One Team: patient ready for reconfiguration ☒
BAF/Corporate Risk Register: (if applicable)	N/A
Purpose of paper:	Decision/Approval
Executive Summary:	From 1 May 2024, the membership of the Board Committees is proposed as follows: **Appointments and Remuneration Committee** *(unchanged)* Rob Whiteman, Trust and Committee Chair Pankaj Davé, Non-Executive Director Judy Gillow, Non-Executive Director John Lelliott, Non-Executive Director Helena McKeown, Non-Executive Director Sharath Ranjan, Non-Executive Director Cliff Shearman, Non-Executive Director Claire Whitaker, Non-Executive Director **Audit Committee** *(unchanged)* Judy Gillow, Non-Executive Director and Chair John Lelliott, Non-Executive Director Cliff Shearman, Non-Executive Director Claire Whitaker, Non-Executive Director **Charitable Funds Committee** *(unchanged)* Claire Whitaker, Non-Executive Director and Chair Pankaj Davé, Non-Executive Director Helena McKeown, Non-Executive Director Tina Ricketts, Chief People Officer Pete Papworth, Chief Finance Officer

	Finance & Performance Committee *(unchanged)* John Lelliott, Non-Executive Director and Chair Pankaj Davé, Non-Executive Director Sharath Ranjan, Non-Executive Director Claire Whitaker, Non-Executive Director Mark Mould, Chief Operating Officer Pete Papworth, Chief Finance Officer Richard Renaut, Chief Strategy & Transformation Officer **People & Culture Committee** (*amendment to membership and to quorum)* Pankaj Davé, Non-Executive Director and Chair Judy Gillow, Non-Executive Director Sharath Ranjan, Non-Executive Director Tina Ricketts, Chief People Officer Mark Mould, Chief Operating Officer In addition, the Chief Nursing Officer and Chief Medical Officer will be standing invitees and usually in attendance. The Terms of Reference shall be amended such that membership of the People & Culture Committee will comprise three Non-Executive Directors, the Chief People Officer and the Chief Operating Officer. Meetings of the Committee shall be quorate if there are at least three members present, which shall include at least one Non-Executive Director and one Executive Director. **Population Health & System Committee** *(amendment to membership)* Helena McKeown Non-Executive Director and Chair Judy Gillow, Non-Executive Director Sharath Ranjan, Non-Executive Director Richard Renaut, Chief Strategy & Transformation Officer The Terms of Reference shall be amended such that membership of the Committee will comprise three Non-Executive Directors and the Chief Strategy & Transformation Officer. **Quality Committee** *(amendment to membership and to quorum)* Cliff Shearman, Non-Executive Director and Chair Judy Gillow, Non-Executive Director Helena McKeown, Non-Executive Director Mark Mould, Chief Operating Officer Fiona Hoskins, Acting Chief Nursing Officer *(for the period of her acting, including prior to 1 May 2024)* until Sarah Herbert commences her role with the Trust as Chief Nursing Officer Peter Wilson, Chief Medical Officer Tina Ricketts, Chief People Officer, will be a standing invitee to the Committee.

	The Terms of Reference shall be amended such that Membership of the Quality Committee will comprise three Non-Executive Directors (one of whom will be a member of the Audit Committee) the Chief Nursing Officer, the Chief Medical Officer and the Chief Operating Officer. Meetings of the Committee shall be quorate if there are at least four members present, which will include the Chair (or a Non-Executive Director deputy), and two Executive Directors, one of whom must be the Chief Medical Officer or Chief Nursing Officer.
Background:	Under the Constitution, the Board shall approve the appointments to each of the Committees which it has formally constituted.
Key Recommendations:	To approve, with effect from 1 May 2024 (or as otherwise stated), the Board Committee membership and amendments to the Committees' Terms of Reference as outlined above.
Implications associated with this item:	Council of Governors ☐ Equality, Equity, Diversity & Inclusion ☒ Financial ☒ Health Inequalities ☒ Operational Performance ☒ People (inc Staff, Patients) ☒ Public Consultation ☒ Quality ☒ Regulatory ☒ Strategy/Transformation ☒ System ☒
CQC Reference:	Safe ☐ Effective ☐ Caring ☐ Responsive ☐ Well Led ☒ Use of Resources ☐

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

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

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS – PART 1 MEETING

Meeting Date: 01 May 2024

Agenda item: 8.5

Subject:	Board's balance, completeness and appropriateness statement
Prepared by:	Yasmin Dossabhoy, Associate Director of Corporate Governance
Presented by:	Rob Whiteman, Trust Chair

Strategic themes that this item supports/impacts:	Systems working and partnership ☒ Our people ☒ Patient experience ☒ Quality: outcomes and safety ☒ Sustainable services ☒ Patient First programme ☒ One Team: patient ready for reconfiguration ☒
BAF/Corporate Risk Register:	N/A
Purpose of paper:	Decision/Approval
Executive Summary:	Under the Code of Governance for NHS Provider Trusts, the Board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the Trust. This statement should be available on the Trust's website. The purpose of this paper is to for the Board to consider and, if thought fit, approve the proposed updated statement to be included on the Trust's website.
Background:	Pursuant to section C.4.2 of the Code of Governance for NHS Provider Trusts, the Board "should make a clear statement about its own balance, completeness and appropriateness to the requirements of the Trust". This, along with a description of each director's skills, expertise and experience should be available on the Trust's website. The Board is asked to consider the following statement: **A statement about the balance, completeness and appropriateness of the Board of Directors – April 2024** The Board currently comprises the Trust Chair, Chief Executive, six other Executive Directors and seven other Non-Executive Directors. In addition, the Trust has an

	Associate Non-Executive Director and a Medical Director – Integrated Care who attend meetings of the Board. The Board is of the opinion that the Trust is led by an effective Board, as the Board is collectively responsible for the exercise of the performance of the Trust. It also considers that no individual group or individuals dominate the meetings of the Board. There is a clear separation of the roles of the Trust Chair and the Chief Executive. The Trust Chair has responsibility for the running of the Board, setting the agenda and for ensuring that all directors are fully informed of matters relevant to their roles. The Chief Executive has responsibility for implementing the strategies agreed by the Board and for managing the day-to-day business of the Trust. The Board considers that the Non-Executive Directors bring a wide range of business, commercial, financial and clinical knowledge required for the successful direction of the Trust. All of the Non-Executive Directors are considered to be independent in accordance with the *Code of governance for NHS provider trusts*. All directors are subject to an annual review of their performance and contribution to the management and leadership of the Trust. Diversity is a vital part of the continued assessment and enhancement of board composition, and the Board recognises the benefits of diversity amongst its members. At the present time, the Board is satisfied as to its balance, completeness and appropriateness and will keep these matters under review.
Key Recommendations:	The Board is asked to consider and if thought fit approve the statement about its own balance, completeness and appropriateness to the requirements of the Trust.
Implications associated with this item:	Council of Governors ☐ Equality, Equity, Diversity & Inclusion ☐ Financial ☐ Health Inequalities ☐ Operational Performance ☐ People (inc Staff, Patients) ☐ Public Consultation ☐ Quality ☐ Regulatory ☒ Strategy/Transformation ☐ System ☐
CQC Reference:	Safe ☐ Effective ☐ Caring ☐

	Responsive	☐
	Well Led	☒
	Use of Resources	☐

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

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

Appendix - Attendance at Part 1 Board Meetings

Part 1		24 May 2023	26 July 2023	27 September 2023	29 November 2023	03 January 2024	06 March 2024
Present	Karen Allman						
	Pankaj Dave						
	Peter Gill				A		
	Judy Gillow	A			A		
	Philip Green						
	Siobhan Harrington						
	John Lelliott						
	Irene Mardon						
	Helena McKeown						
	Stephen Mount						
	Mark Mould						
	Pete Papworth						
	Sharath Ranjan						
	Richard Renaut						
	Cliff Shearman						
	Paula Shobbrook				D		
	Caroline Tapster						
	Claire Whitaker						
	Rob Whiteman						
	Peter Wilson					D	
In Attendance (excl Governors, members of public and non-Standing Invitees)	David Broadley						
	James Donald						
	Yasmin Dossabhoy						
	Fiona Hoskins						
	Ewan Gauvin						
	Becky Jupp						
	Sarah Locke						
	Judith May						
	Helena McKeown						
	Claire Rogers						
	Claire Whitaker						
	John Vinney	A		A			
Was the meeting quorate?		Y	Y	Y	Y	Y	Y