University Hospitals Dorset
NHS Foundation Trust

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

BOARD OF DIRECTORS – PART 1 MEETING

Wednesday 6 March 2024

9:30 – 12:15

In the Boardrooms at Poole Hospital and

via Microsoft Teams

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

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

BOARD OF DIRECTORS – PART 1 HELD IN PUBLIC

The next meeting of the University Hospitals Dorset NHS Foundation Trust Board of Directors Part 1 will be held at 9:30 on Wednesday 6 March 2024 in the Boardrooms at Poole Hospital and via Microsoft Teams.

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

Rob Whiteman
Chairman

AGENDA – PART 1 PUBLIC MEETING

9:30 on Wednesday 6 March 2024

Time	Item		Method	Purpose	Lead
9:30	**1**	Welcome, Introductions, Apologies & Quorum	**Verbal**		**Chair**
	2	Declarations of Interest	**Verbal**		**Chair**
	3	Patient Story	**Verbal**	**Discussion**	**CNO**
9:50	**4**	**MINUTES**			
	4.1	For Accuracy and to Agree: Minutes of the Board of Directors Meeting held on 3 January 2024	**Paper**	**Approval**	**Chair**
	4.2	Matters Arising - Action List – *none outstanding*	**Verbal**	**Information**	**Chair**
9:52	**5**	**TRUST CHAIR AND CHIEF EXECUTIVE UPDATES**			
	5.1	Trust Chair's Update	**Verbal**	**Information**	**Chair**
	5.2	Chief Executive Officer's Report	**Paper**	**Information**	**CEO**
10:05	**6**	**STRATEGY, RISK AND PERFORMANCE**			
	6.1	Integrated Quality, Performance, Workforce, Finance and Informatics Report *Questions to the Executive Team by exception*	**Paper**	**Assurance**	**Execs**
	6.2	Quality Committee – Chair's Report – January and February 2024 • Actions in response to a case of providing inadequate nutrition • Maternity Safety Champions Report *(to be presented by Director of Midwifery)*	**Verbal** **Verbal** **Paper**	**Assurance** **Assurance** **Assurance**	**Committee Chair**

		• Mortality Report • Quality Impact Assessment Report	**Paper** **Verbal**	**Assurance** **Assurance**	
	6.3	People and Culture Committee – Chair's Report – February 2024 • Safe Staffing Report • Maternity Safe Staffing Report • Guardian of Safe Working Hours Report • Car Parking Policy and Standard Operating Procedure	**Verbal** **Paper** **Paper** **Paper** **Paper**	**Assurance** **Assurance** **Assurance** **Assurance** **Approval**	**Committee Chair**
	6.4	Finance and Performance Committee – Chair's Report – January and February 2024 • Estates Masterplan • Green UHD Plan	**Verbal** **Paper** **Paper**	**Assurance** **Approval** **Approval**	**Committee Chair**
	6.5	Population Health and System – Chair's Report – January 2024	**Verbal**	**Assurance**	**Committee Chair**
	6.6	Audit Committee – Chair's Report – January 2024	**Verbal**	**Assurance**	**Committee Chair**
	6.7	Charitable Funds Committee – Chair's Report – February 2024	**Verbal**	**Assurance**	**Committee Chair**
	6.8	Risk Register: review of significant risks; new risks 12 and above	**Paper**	**Approval**	**CNO**
11:35	**7**	**PEOPLE AND CULTURE**			
	7.1	Patient First	**Paper**	**Review**	**CNO**
11:40	**8**	**ITEMS FOR APPROVAL**			
	8.1	Transforming Care Together – Terms of Reference	**Paper**	**Approval**	**CSTO/ COO**
	8.2	Risk Management Strategy	**Paper**	**Approval**	**CNO**
	8.3	Engagement Policy – Board of Directors and Council of Governors	**Paper**	**Approval**	**CoSec**
	8.4	Annual Objectives	**Paper**	**Approval**	**CSTO**
	8.5	Register of Use of Seal	**Paper**	**Information**	**CoSec**

	9	Any Other Business	**Verbal**	**Discussion**	**Chair**
	10	Reflections on the Board Meeting	**Verbal**	**Discussion**	**Chair**
11:55	**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 3 March 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 1 May 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

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

Items for Next Board Part 1 Agenda

Standing Reports

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

Quarterly Reports

- Mortality Report
- Quality Impact Assessment Report
- Guardian of Safe Hours Report

Bi-annual/Annual Reports

- Board Assurance Framework
- Board Assurance Framework – 7 Day Services
- Freedom to Speak Up
- Gender Pay Report
- Going Concern
- Key Areas of Judgment and Estimation within Annual Accounts
- Annual Operational Plan
- Compliance with Code of Governance and Licence Conditions

- Independence of Non-Executive Directors
- Board Meeting Schedule

AGENDA – PART 2 PRIVATE MEETING

12:30 on Wednesday 6 March 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			
	17.1	For Accuracy and to Agree: Minutes of the Board of Directors Meeting held on 7 February 2024	Paper	Approval	Chair
	17.2	Matters Arising – Action List	Paper	Review	Chair
12:40	18	UPDATES			
	18.1	Chief Executive Officer's Update	Verbal	Information	CEO
	18.2	Escalations from Committee Chairs (not already covered in Part 1)	Verbal	Information	Committee Chairs
13:00	19	STRATEGY AND FINANCE			
	19.1	Draft Operational Budget and Medium Term Financial Plan	Paper	Review	CFO
	19.2	Wessex Fields	Paper	Review	CSTO
13:45	20	QUALITY AND PEOPLE			
	20.1	Serious Incident Report	Paper	Review	CMO
13:50	21	ITEMS FOR APPROVAL			
	21.1	Private Patients	Paper	Approval	CFO
	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 1 May 2024 at 11:45.			

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 Accounts – draft
- Annual certificates
- Annual Governance Statement
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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 3 January 2024 at 9:00 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
	Irene Mardon	Acting Chief People Officer
	Helena McKeown	Non-Executive Director
	Mark Mould	Chief Operating Officer
	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
	Claire Whitaker	Non-Executive Director
In attendance:	Colin Blebta	Public Governor
	Robert Bufton	Public Governor
	Sharon Collett	Lead Governor
	Sue Comrie	Appointed Governor
	Samantha Dean	Deputy Sister
	Yasmin Dossabhoy	Associate Director of Corporate Governance
	Karen Fernley	Matron *(until the end of BoD003/24)*
	Ewan Gauvin	Corporate Governance Manager
	Kate Goyder	Paediatric Consultant *(until the end of BoD003/24)*
	Keith Mitchell	Public Governor
	Matt Hodson	Deputy Chief Nursing Officer
	Becky Jupp	Deputy Chief Medical Officer
	Susanne Lee	Public Governor
	Hannah Leonard	NHS Dorset
	Andrew McLeod	Public Governor
	Tina Ricketts	Observer
	Josie Roberts	Lead for Childrens Community Nursing Services *(until the end of BoD003/24)*
	Jeremy Scrivens	Public Governor
	Diane Smelt	Public Governor
	Alexander Taylor	Consultant
	Lorraine Tonge	Director of Midwifery
	Kani Trehorn	Staff Governor
	Michaela Turton	Project Manager
	Daniel Webster	Medical Director - WCCSS
	Whitehurst, Michele	Public Governor

4 members of the public in attendance

BoD 001/24	**Welcome, Introductions, Apologies & Quorum** Rob Whiteman welcomed everyone to the meeting, including Tina Ricketts who was observing the meeting and would be joining the Trust as Chief People Officer from 26 February 2024. Apologies were received from the following member: • Peter Wilson *(represented by Becky Jupp).* The meeting was declared quorate.
BoD 002/24	**Declarations of Interest** Rob Whiteman reported that he had been appointed as a trustee and director of Theatre Royal Stratford East. No existing interests in the matters to be considered were declared. In addition, no further interests were declared.
BoD 003/24	**Patient Story** Paula Shobbrook introduced the Patient Story, relating to the Trust's virtual ward for paediatrics. She introduced Josie Roberts, Karen Fernley and Kate Goyder, with apologies having been sent by a parent who was due to join but was unwell. A video was presented to the Board. Karen Fernley, Josie Roberts and Kate Goyder outlined some of the benefits and outcomes for patients and their families. Kate Goyder explained the focus upon "medium sick" patients being taken out from areas where there were children that needed critical care. A&E and the children's assessment unit could refer directly to the virtual ward. Thanking the team, Siobhan Harrington commented upon her visit prior to Christmas, commending the multi-disciplinary teamwork and spirit. She enquired about next steps and the proposed direction going forward. Responding to this, Kate Goyder explained that the Trust's virtual ward was more aligned to the Royal College of Paediatrics view, which was hospital led down. There were also virtual wards that were run as primary care up, with GPs being able to refer directly. There was potential for primary care expansion. In addition, there were neonatal opportunities. It was important not to be overly enthusiastic beyond budgetary constraints, with it being important to have sufficient staff and be appropriately funded to operate safely. The team had presented nationally and had exhibitions of the ward, with others who were seeking to establish virtual wards looking to replicate. Josie Roberts outlined that recently the virtual ward had been successfully opened to A&E in Poole to help with waiting times. This would also be considered for Bournemouth hospital. Thanking the team, Judy Gillow enquired how parents were being prepared and supported for readmissions. Kate Goyder explained that this was through the staff with excellent nurses having been recruited and education days having been held with common communication scenarios discussed. The average length of stay on a paediatric ward was less than 24 hours. A common readmission was bronchiolitis, an illness that became worse before improving. There was a well established readmissions process. Children that did not meet the criteria for the virtual ward could also be re-admitted through the children's assessment unit. Adding to this, Josie Roberts outlined that parents/carers were provided with the relevant tools and supported. Karen Fernley explained the additional safety netting given. Cliff Shearman echoed Judy Gillow's thanks for the impressive service and patient story. He enquired about the local appetite and how the service had changed relationships with community primary care, in particular. Kate

	Goyder responded that the virtual ward had not interacted with primary care, per se, with this not having been within the remit. An outline plan for the future, though, would be to approach GP services. Considerable data had been collected with hotspot areas identified. Primary care educational buy-in would be important prior to opening up primary care referrals. The right patients needed to be on the ward. If a GP group were interested, there may be potential for running an antibiotic hub from there. Josie Roberts explained that virtual ward sat within the wider children's community nursing services and therefore under the primary care umbrella. This helped with communication. One of the challenges was having sufficient physical space – for example, to house the children's community nursing. Referencing comments earlier in the meeting, Sharath Ranjan enquired whether the opportunities had been evaluated financially alongside the benefits of patient safety. Adding to this, Pete Papworth noted the point made that developing the service did not mean that there would be empty beds, but rather that pinch points were reduced. He asked how the service could be expanded to a point where ultimately the paediatric bed base could be reduced and therefore the existing funding repatriated to alleviate the budgetary constraints. Kate Goyder explained that from a nursing perspective, there was not full staffing, this being a national challenge. It was not at the stage of being able to close beds. The Board NOTED the Patient Story. *(Josie Roberts, Karen Fernley and Kate Goyder left the meeting).*
BoD 004/24	**For Accuracy and to Agree: Minutes of the Part 1 Meeting of the Board of Directors held on 29 November 2023** Referring to page 13 of the minutes of the Part 1 meeting held on 29 November 2023, Helena McKeown referenced her suggestion that the Board needed to focus upon monitoring whether there was an increased risk in death if people were waiting for four or five hours for assessment in A&E. Responding to this, Becky Jupp commented upon the Deteriorating Patient Group that was in place. Sean Weaver's team were linking with ED and with mortality. As it currently stood, there was no direct link between breach of the four-hour safety standard and increased mortality. However, work was ongoing. Paula Shobbrook confirmed that this would continue to be monitored through the Quality Committee. The minutes of the Part 1 meeting of the Board of Directors held on 29 November 2023 were APPROVED as an accurate record.
BoD 005/24	**Matters Arising – Action List** It was noted that there were no outstanding actions.
BoD 006/24	**Trust Chair's Update** Rob Whiteman presented the Trust Chair's Update highlighting that: • In her Chief Executive's Update, Siobhan Harrington would comment on the industrial action. He expressed appreciation for the work of the Executive Team and staff to deal with the situation as effectively as possible. • He had received consistent feedback that the end of the Part 1 meeting of the Board felt rushed. Going forward, Part 1 meetings of the Board would be extended by 45 minutes. • The Chief Executive Officer's Report noted that Peter Gill had left the Trust at Christmas: everyone wished him well in his new ventures. This would affect the composition of the Board. Siobhan Harrintgon had informed Rob Whiteman that the number of voting Executives

	would be reduced in future from eight to seven. Taking this into account, with Caroline Tapster having stood down as a Non-Executive Director in December 2023, he reported that there were no current plans to recruit to her vacancy. • A joint meeting of the Boards of Dorset County Hospital, Dorset HealthCare and the Trust would be taking place shortly. • He had visited the hospital considerably during Christmas and the New Year period. It had struck him how frequently concerns were raised about security and dealing with mental health issues. He and Siobhan Harrington had discussed this at length; the Executive Team were considering how arrangements for staff and patient safety could be improved where mental health issues were occurring on a regular basis. The Board NOTED the Trust Chair's Update.
BoD 007/24	**Chief Executive Officer's Report** Siobhan Harrington introduced the Chief Executive Officer's Report, highlighting that: • As she had been walking around the Trust talking to staff about the new year, she considered that the previous year had been challenging but one in which progress had been made. She could not reassure people that the year ahead would be less challenging. The current round of industrial action with junior doctors had started that day and would be the longest period of industrial action by junior doctors. She thanked everyone for the response and team spirit across the Trust. Looking after patient safety and staff was paramount. • From a national perspective, there was a high focus on ambulance handovers. • The latest information had been published on the Trust's position from the perspective of the NHS Single Oversight Framework for quarter two, with it currently being in segment three. She outlined the implications as well as the reasons for the Trust being in segment three. • Regionally, a level three incident commenced on 20 December 2023 and would run until 8 January 2024 during the industrial action. This would mean increased oversight. • The Trust's Care Quality Commission (CQC) well led inspection had previously been postponed. It would be important to be prepared and the Trust was working towards that. • It was critical that the pace continued with Patient First. Clinical teams had commenced their training. • The Integrated Performance Report, which would be presented later in the meeting, highlighted those areas where there were performance challenges and those where progress was being made. Financial challenges both within the Trust and the Dorset system continued; efforts were being made to achieve a balanced financial position at year end although this had challenges. It would be important to create time to have more detailed financial recovery plans for the coming three years to become more sustainable. • Transforming Care Together was about making things better for patients – it was not about the buildings. Highlights included the Dorset Pathology Hub having been opened and the catering changes across the Trust. Approximately 65 weeks remained until the first services would be delivered from the BEACH building.

	• Joint programme arrangements were being put in place for the Electronic Patient Record, working with Somerset. • Staff and team awards were given out shortly before Christmas 2023. Referencing the press coverage about the innovative approach at Guys and St Thomas' to theatre usage, Pankaj Davé enquired whether this had been considered within Dorset. In addition to seminars that had taken place in the south west region referenced by Siobhan Harrington, Mark Mould added that a discussion had taken place with Guys and St Thomas' about their approach including from a staffing perspective. The Trust had undertaken some work in ophthalmology to try and test the concept. An innovation event would be taking place in January 2024 with trauma and orthopaedics to explore use of capacity in the Derwent in a different way for high volume lists, with surgeons working across a number of theatres. He was looking forward to the event, working with the region and support from the national team. Rob Whiteman sought clarification that these opportunities were currently being explored but were not yet impacting upon the Trust's performance. Mark Mould confirmed this, adding that it was being progressed further into areas where there were known capacity opportunities alongside a few challenges to reduce waiting time for patients. Referencing page 25 of the Chief Executive Officer's Report, Judy Gillow expressed her thanks for the increase in staff engagement. It was important to the Trust's culture that there was an increase in numbers of staff who provided their feedback on the Trust's services. Noting increasing staff sickness and use of agency and temporary staff, though, she had been surprised at the uptake on flu and Covid vaccinations. Responding to this, Siobhan Harrington expressed her disappointment in uptake rates. However, many staff had their vaccinations elsewhere with the data not having been captured by the Trust. Learning would be considered for the following year. Multiple weekends had been run and there continued to be opportunities for staff to have their vaccines. Emphasising the importance of having the vaccines, Paula Shobbrook confirmed that proactive planning for the following year's Covid and flu vaccinations would commence in the next month. The Board NOTED the Chief Executive Officer's Report.
BoD 008/24	**Integrated Performance Report (IPR)** Rob Whiteman invited Mark Mould, Becky Jupp and Paula Shobbrook to provide an initial introduction to the Trust's performance and key issues. Mark Mould emphasised that behind everything in the IPR that was discussed was a person. November and December 2023 had been recognised nationally as a challenging period. An increase in activity, admissions and acuity had been seen. He commented upon infection prevention and control (IPC) where a dramatic impact on capacity would have been expected but had been managed well. Paula Shobbrook referenced that there had been a number of outbreaks and Covid had been increasing; a balanced, risk based approach to IPC had been taken. The operational landscape had continued to remain challenged through December 2023. Becky Jupp commented positively upon the Hospital Standardised Mortality Ratio having decreased for the past two months, being below 100. With increased pressure across the organisation, this led to a number of different responses. From a capacity perspective, there was an increase in the number of open escalation beds. Through their regular walkarounds, Paula Shobbrook and Becky Jupp had observed the increase in patient acuity and dependency in the hospitals. This aligned with some of the fundamentals

	of care metrics within the IPR. However, teams were working together well and a positive safe staffing ratio had been maintained. Considerable work was being undertaken to reduce agency expenditure and focus more on bank staff. With 50 funded escalation beds open and at times up to 90 beds open, this impacted upon the medical teams. Becky Jupp referenced the help from the organisation by cohorting some frail elderly patients onto a single ward to concentrate the expertise. There were good, effective handovers on both sites, enabling a flexible approach. Paula Shobbrook noted, though, that there had been seven mixed sex accommodation breaches, attributable to the Trust focusing upon safety. This was explained to patients. Referencing the earlier presentation about virtual wards, Mark Mould added that escalation beds were expensive and alternatives to inpatient beds needed to be considered. He outlined a number of areas where such alternatives were scaling up. A significant number of patients with no criteria to reside (NCtR) remained. A number of multi agency discharge events had been held in December 2023. Paula Shobbrook expressed it having been helpful to have colleagues from community hospitals and local authorities together to meet face to face and talk through some of the challenges and unblock some of the constraints across the system. Mark Mould added that coming up to Christmas, the number of individuals with NCtR had quite significantly reduced. However, going through the Christmas and new year period, the number had again increased. Further discussions would need to take place with NHS Dorset about this. Notwithstanding the scale of the efforts in relation to industrial action recovery and managing the integration of the hospitals with emergency and planned care, it was to be celebrated that the Trust's waiting list had significantly declined. The number of patients waiting over 78-weeks had been maintained even with the industrial action. 87% of patients who were waiting over 65 weeks by the end of March 2024 were no longer waiting for an appointment. 90% of patients were receiving their diagnostics within 6 weeks. Paula Shobbrook also commended the work undertaken in relation to patient experience and engagement. In addition, the Trust had received a maternity Insight visit, with the feedback having been very positive. Becky Jupp recognised the consultant and support team – particularly nursing staff and allied health professionals – working together to support the Trust's services. Referencing the increase in staff engagement and staff working together well during industrial action, Claire Whitaker enquired whether there was any learning. Noting the pressures upon the senior team, she also enquired about their wellbeing. Siobhan Harrington responded that prioritisation had been important and the value of one team, which was also good preparation for the organisation's transformation. There were indicators in the IPR that the Executive Team wanted to be better for patients, such as the four hour standard in the urgent and emergency care pathway. Patient First encouraged the Trust to prioritise and, for example, to reduce the length of meetings. Industrial action impacted upon interpersonal relationships; it was therefore paramount to focus upon staff engagement. Turnover and vacancy rates had decreased. From the Executive Team perspective, people had taken holidays over Christmas and the New Year, which was important for downtime. Thanking the team for their work, particularly related to reduction in waiting lists, John Lelliott enquired whether there was anything that had been learned

	from other Trusts about why the Trust was an outlier for NCtR. Responding to this, Mark Mould elaborated that the Dorset system was an outlier, with the Trust and Dorset County as contributors. The solution was through the system. The learning related to the blockage with the capacity into which people were to be moved. Leading up to the Christmas period, everyone working together. Blending the capacity in a different way had helped. This included the interim care team linking with a private provider and community services to be able to put packages of care together. It was also necessary to step into spaces as organisations where there had been previous reluctance. Rob Whiteman referenced him having asked Mark Mould approximately a year prior about the majority of NCtR being lack of capacity, but with some as a result of the Trust's own processes of people not being ready for discharge sufficiently quickly. He asked whether this was now similar from the perspective of the Trust's processes. Answering this, Mark Mould considered that the Trust had moved on. Adding to this, Siobhan Harrington referenced this being demonstrated by the improvement of length of stay in the IPR. Noting the external context, Cliff Shearman commended the performance reflected in the IPR. Quality and safety were key. He was re-assured by the mortality data and the continued improvement of fractured neck of femur (#NOF). However – as discussed at the meeting of the Quality Committee - moderate patient safety incidents were markedly increased. He enquired whether this was an indicator of the pressures upon the team which should be addressed and whether it could potentially lead to more serious incidents as such pressure increased. Responding to Cliff Shearman's comments, Mark Mould informed the Board that in December 2023 the Trust had achieved 60% for #NOF, with the national average being 58%. In relation to the number of moderate patient safety incidents, Paula Shobbrook referred to this being a core area of focus for the Quality Committee. She considered that the number of incidents being reported was positive from the perspective of the culture of staff feeling safe to speak up. If there were concerns about an area – such as queuing within ED and providing corridor care, the Executive Team were speaking with staff and patients. Patients and their families had been understanding of the situation within the acute services. With the changes to incident reporting, themes were being considered and associated improvements. Adding to this, Becky Jupp reported that while the number of moderate harms had increased over November 2023, there had been fewer scoping panels due to the industrial action. It could be that when the cases proceeded to scoping, they would be downgraded. In addition, there could be multiple reports from one incident. It was only at scoping that the alerts could be removed or combined. Helena McKeown commended the Executive Team and their approach to seeing patients and carers. She requested clarification about the theatre utilisation rate remaining below the national target. Mark Mould outlined that the Trust was working towards an 80% touch time and potentially going into 2024-25 moving towards the 85% touch time. There was a theatre programme in place, engagement with the teams that had the lowest touch time was occurring. During industrial action, activity had to be removed; full theatres were being operated but cases were lost on individual theatres. Currently, cases were being lost within lists as there were times when it was not possible to get patients into beds to be able to step down in recovery in a timely manner. In addition, Helena McKeown expressed concern at the number of risks 15+ increasing on the register. Siobhan Harrington explained that the Trust was managing a significant number of higher risks. The focus for the Board was

	on the controls and mitigations in relation to those risks and whether improvement was seen over time. Responding to a comment from Helena McKeown in relation to learning from elsewhere in relation to NCtR, Siobhan Harrington referenced the national discharge team had been working with the Dorset system. It was important to have discussions with system colleagues at the Board to Board meetings as relationships within the system would be essential in making improvements. Inviting Pete Papworth to report on the financial position, Rob Whiteman asked that as part of his report he speak to the scale of the Trust's escalation beds in comparison to other trusts. Rob Whiteman indicated that he appreciated that having 90 escalation beds must mean that ambulance handovers were quicker but questioned the value for money and whether it made a difference to outcomes and the quality of care. Pete Papworth reported that as at the end of November 2023, the Trust reported a deficit of nearly £17m, this being £13m off plan. This was driven by £7m of elective income loss, £3m of energy cost inflation and £3m of escalation. This was, however, an improvement upon the October 2023 position. It reflected the additional funding received in recognition of the industrial action costs. In relation to elective recovery income, the national team had now accepted the Trust's submission and had agreed to reduce its recovery threshold to 100%. Together with the improved data capture, this this was expected to largely eliminate the £7m reported elective income loss to date. He therefore anticipated reporting a significantly improved financial position the following month. He also provided an update on the Dorset system forecast deficit. Considerable risk remained, including relating to the assumption of there being no further industrial action, with there since having been further industrial action. A request had been made to reassess the financial impact of that action with submissions to be made as part of the month nine data set. It was currently unknown whether there would be additional funding or an allowable movement away from the forecast deficit of £12m. Irrespective of the industrial action, within the forecast, the continuation of the escalation beds that were open at a particular point in time had been included in the forecast. However, these had been increased further during December 2023, giving rise to further financial pressure against the forecast. Consequently, there was not certainty that the Trust would achieve a balanced financial position at year end. In response to Rob Whiteman's question about the Trust's benchmarking against other organisations for use of escalation beds, Pete Papworth confirmed that the Trust's use of escalation beds was not inconsistent with other trusts. The Trust had taken the approach of enabling ambulances to turn around more quickly, accepting patients into the organisation and accepting the financial and some of the clinical risk of such escalation beds. Adding to this, Mark Mould reported that there were currently 89 open escalation beds, with 50 people in ED waiting for beds and 230 people with NCtR. It was important to continue to work with system partners and for patients to be in those settings in which it was safer for them to be. Referencing the continued ongoing action being taken by the Trust, Siobhan Harrington highlighted both the need to manage risk dynamically as a system and daily conversations taking place. Judy Gillow enquired whether the challenges were with community beds in community hospitals, beds in nursing and care homes or care workers to support people in their homes. Mark Mould explained that individuals were on pathways, with different resource required depending upon the applicable pathway, referencing also the capacity challenges elsewhere in the system.

	Paula Shobbrook cited numerous examples of the detail considered by the Trust across each pathway to manage those aspects within its control in a streamlined manner. Summarising, Siobhan Harrington outlined that the ask was for patients and residents to be in the right place in the system. There was potentially more opportunity for the Board to influence the conversation to ensure that patients were in the right place within the system. However, it was also important to be realistic, with resetting occurring following the pandemic and the NHS and social care all being in a difficult position. Pete Papworth also commented upon the higher cost associated with patients not being in the most suitable setting. He updated the Board on the current status in relation to the planning guidance. There would need to be different approaches to financial savings going forward, with a focus needed upon the delivery of recurrent efficiencies. The Board NOTED the Integrated Performance Report.
BoD009/24	**Quality Committee – Chair's Report – December 2023** Cliff Shearman, Chair of the Quality Committee, outlined that the Committee had discussed a number of items on the current Board agenda, including the Maternity Safety Champions Report, Maternity Incentive Scheme, Mortality Report and Patient Experience and Engagement Strategy. The Committee regularly received a CQC update, including progress on the 69 recommendations made. Of those, there were 10 to be concluded, with focus being placed upon those. Lorraine Tonge presented the Maternity Safety Champions Report adding that the external review with Somerset of perinatal mortality review tool (PMRT) cases from January to July had correlated to the Trust's own learning, with no new learning identified. Paula Shobbrook reported that a regular meeting took place between her, Caroline Tapster, Lorraine Tonge and other colleagues including the neonatal team. It was also beneficial to have conversations in walkabouts with safety champions. Inviting Lorraine Tonge to comment, she added that the teams were open and honest during those walkabouts. Lorraine Tonge presented the Maternity Incentive Scheme report. She referenced the significant increase in the elements released mid-year and the consequent challenges with achieving all of them. In relation to those actions partially met, she added: • Safety action 4 – not met were the obstetric locum assessments and audits, driven by the impact of medical workforce gaps, industrial action and the limited timeframe to implement the standard. New systems and processes were being put in place. The BAPM standards for neonatal consultants were not met. The new standard required 7 neonatal consultants. All clinical work was prioritised and babies given safe care. The additional neonatal consultant required further funding. • Safety action 6 – CTGs were being completed; however, the audit showed that the documentation of the 60 minute requirement for the second CTG review was not being met. Immediate actions had been taken with improvements being made. Paula Shobbrook added that the Trust had been very close in a number of elements, with industrial action having impacted. In discussion, Hannah Leonard at NHS Dorset, highlighted it was believed that 50% of trusts in the region would not be declaring compliance. Paula Shobbrook considered that this was partly related to the timing at which NHS Resolution had released the

	standards. She reassured the Board that not declaring compliance with the MIS safety actions did not mean that the unit was unsafe. For example, PROMPT training occurred each year and midwives had met compliance, but the wider team were not released together to make this multidisciplinary. Alex Taylor explained that good progress had been made by the team; however, the root cause for the outcome was being 15% short of medical workforce, with this impacting all domains. Thanking the team, Pete Papworth reminded the Board of the requirement for the Trust to overpay the NHS clinical negligence scheme premium by 10%, with it being fully received back if all of the standards were met (circa £650,000). The Trust's financial forecast and submission had assumed that this would be achieved. There was broad discussion about the impact of the shortage in medical workforce, morale and retention. Pete Papworth queried also whether there was a potential opportunity to pay staff to undertake the additional training. Hannah Leonard commented that: • For each Trust that did not successfully receive its return of contribution, there was a share of those monies as well. • There was a benefit to re-investing some of the money returned to achieve the actions for the following year. • From an external perspective, the Trust had performed well with the training ask. • She would draw more attention to section 4 in relation to the clinical workforce planning, which could have been helped with the clinical teams outside of maternity. Recognising the hard work of the teams, Judy Gillow commented that she considered that the CTG reviews were within the Trust's control, with a need for a target of by when this would be achieved. Paula Shobbrook clarified that the CTGs were being undertaken, with the issue being the documentation. She and Judy Gillow would be focused upon supporting the team. Action plans were in place and would be submitted to NHS Dorset. Paula Shobbrook confirmed that no changes were expected to be made to a draft report from BDO which had been made available to members of the Board. The Board APPROVED the Maternity Incentive Scheme declaration and authorised Siobhan Harrington to sign it on behalf of the Board. The Board NOTED the Quality Committee Chair's Report and the Maternity Safety Champions Report.
BoD010/24	**Finance and Performance Committee – Chair's Report – December 2023** John Lelliott presented the Finance and Performance Committee Chair's report, noting that: • Mark Mould had covered earlier in the meeting a number of the issues. • From the perspective of finance, the Committee had discussed the need to review the medium term financial plan and activity that the Trust should consider not undertaking. • The Committee had considered the recast business case for the Pathology Hub and in future would be receiving a report on the lessons learned. • A summary of the action plans for ED had been presented to the Committee.

	• An area of focus for the Committee going forward would be IT – not only electronic patient record (EPR), but other elements impacting the Trust's performance. • The Committee had also received reports in relation to the strategic options for Wessex Fields, Dorset Estates Partnership and the private patients strategy. The Board NOTED the Finance and Performance Committee Chair's Report.
BoD010/24	**Patient Experience and Engagement Strategy** Paula Shobbrook presented the Patient Experience and Engagement Strategy, highlighting: • The positive work in this area, which was one of the Trust's strategic objectives. • Much of the work had been done in partnership, with consultation taking place both externally and internally across the Trust. • The care objectives of continuous feedback, focusing relentlessly on improvement, recognising people and excellent partnership. Tina Ricketts enquired whether it may help staff to reference the care objectives as priorities instead to avoid confusion with the strategic objectives. Supporting the co-creation with patients and representatives, Richard Renaut commented upon the need for the key performance indicators to be aligned for the coming year, with this work currently being undertaken. These would then fit with the IPR and the strategic objectives. The Board APPROVED the Patient Experience and Engagement Strategy.
BoD011/24	**Risk Register** Paula Shobbrook introduced the Risk Register. She drew attention to *RiskID 1924* noting that the Patient First Steering Group had proposed reduction of the risk initially set at 16 to 12 for adopting the Patient First approach across the Trust. Mark Mould presented *RiskID* 1977. He confirmed that mitigations had been put in place, with the report referencing a point in time. Additional transport journeys had been commissioned until 14 January 2024 with there being clarity about the additional capacity across both Bournemouth and Poole hospital sites. The costs were currently being borne by NHS Dorset. Close working with NHS Dorset was taking place, with optimism that the risk would de-escalate from 15 promptly. Noting that the detail of the risks were discussed at the relevant Committees, Paula Shobbrook referred to the highest rated risks relating back to the conversations that had taken place earlier in the meeting. Further discussions would take place by the Board in relation to EPR. Referencing the non-emergency patient transport (NEPTS), Helena McKeown commented upon different approaches to and the actual need in all cases for hospital transport. Responding to this, Paula Shobbrook confirmed that further detail would be provided through the Quality Committee. However, the Trust did not automatically provide NEPTS for patients. The majority made their own way to and from hospital. However, there were, for example, vulnerable patients that required support and help. In addition to ambulances and transport services, there was work with voluntary partners to support these needs. Commenting upon the good work being undertaken but with there being an ongoing environment of staffing shortages and financial challenges, Pankaj Davé emphasised the importance of teams investing time in considering

	innovative ways of working. However, in the current climate, his concern was the ability to create space for staff to have that time. Responding to this, Paula Shobbrook outlined that doing things differently, engaging teams in the right way, getting alongside patients and staff and shifting culture was the right thing to do for patient safety and staff satisfaction. Stopping things to create time would be challenging but would be delivered through strategic deployment and reduction. The Board APPROVED the Risk Register Report.
BoD012/24	**Patient First** Paula Shobbrook presented the Patient First Report. Commenting upon her experience at another organisation, Tina Ricketts emphasised the importance of having a reduced number of priorities, with each member of staff understanding how they contributed to those. Also, different parts of the organisation may have a different state of leadership readiness; therefore the baseline assessment was needed. The Board NOTED the Patient First Report.
BoD013/24	**Fit and Proper Persons** The Board NOTED the Fit and Proper Persons report.
BoD014/24	**Sexual Safety Charter** Paula Shobbrook introduced the Sexual Safety Charter, with the Trust signing up to the Domestic Abuse and Sexual Violence Charter being APPROVED by the Board.
BoD015/24	**Any Other Business** No further items were raised.
BoD016/24	**Reflections on the meeting** Rob Whiteman expressed that he would provide his reflections on the meeting at the end.
BoD017/24	**Questions from the Council of Governors and Public arising from the agenda** No questions had been received in advance from the Council of Governors or members of the public. Referencing staff recruitment and motivation, Robert Bufton, Public Governor, said that he had commented previously upon staff car parking and the costs of it, staff concessions in the restaurant and the use of the maternity hospital at Poole for staff. He enquired whom he should approach about ideas such as those. Responding to this, Rob Whiteman confirmed that it would be Tina Ricketts once she joined the Trust as Chief People Officer. Sue Comrie enquired whether the role of active companions, which had been stood down during Covid, may be re-introduced. Thanking her and all volunteers that supported across the Trust's hospitals, Paula Shobbrook confirmed that work was in progress to introduce new roles for volunteers, including the Narnia project. In response to a comment from Sue Comrie in relation to primary care, Mark Mould explained that the Trust had a responsibility to provide primary care services out of hours Monday to Friday and on Saturday and Sunday. A contract was in place to provide such services on the Trust's site for patients directed through 111. However, working with David Broadley, Medical Director – Integrated Care, consideration was being given to how the capacity

	could be better used to support individuals being directed to the correct service at the correct time. Referring to Robert Bufton's earlier comment in relation to staff car parking, Richard Renaut reported that many staff were taking up the discounted bus offer, particularly the lowest paid staff and those who wanted a greener option. He also commented upon the action being taken at Bournemouth hospital, working with the council, to change the operation of the traffic light signals. Major changes would also be seen to the traffic through the opening of the new road at the rear of Bournemouth hospital, which would benefit staff and patients.
BoD018/24	**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 6 March 2024 at 9:30 via Microsoft Teams.

CHIEF EXECUTIVE'S REPORT
MARCH 2024

As I write, we are completing the latest 5 days of industrial action by junior doctors. A huge thank you to our teams for maintaining a focus on patient safety and looking after each other. The ongoing impact is continuing to result in delays in people being seen for treatment and also patients needing to be cancelled and rebooked. We will continue to hope that these issues over pay can be resolved at a national level whilst working to mitigate the ongoing impact for patients and the Trust.

8 March 2024 is International Women's Day and I will be supporting two separate events to champion a more inclusive world for women. Given the considerable proportion of women in the NHS workforce, this is an important day to celebrate the input of women in the workplace and at home. This year the theme of International Women's Day is "Let's Inspire Inclusion."

I would like to take this opportunity to note that this is Paula Shobbrook's final Board meeting here at UHD. I would like to thank her for her amazing contribution to the Trust and her personal support over the last 21 months. Paula has however been at UHD and before then at Royal Bournemouth and Christchurch hospitals for 13 years in total. She was also acting chief executive of UHD from 1 April 2022 to 31 May 2022. She has been an incredible role model across the Trust and Dorset and more widely. She will be greatly missed and we will ensure she is celebrated over her final month with us before she formally retires.

1. National Picture

1.1 NHS England has published a letter about the implementation of Martha's Rule in the NHS which gives more details about the phased approach, beginning with at least 100 adult and paediatric acute provider sites who already offer a 24/7 critical care outreach capability. We await further details on how we will be asked to express an interest in being part of phase one or future phases.

1.2 We are currently preparing our plans for 2024-25 whilst awaiting the formal guidance to be published.

2. Quality & Safety

2.1 Death of a patient in our care

I want to acknowledge the sad case of the death of a patient in our care which was reported in the media, following an out of court settlement in January 2023. The 56-year-old man, who had Down's syndrome and dementia, died from pneumonia at Poole hospital in 2021.

My sincere condolences are with the family and we apologise for the failings that resulted in his death. We have implemented a number of changes following this and have shared these with the family.

This case was reviewed through the serious incident process, including external oversight with the ICB. This found that there was no plan for enteral feeding by the medical team and there was a failure in communication processes to escalate this. A

number of recommendations were made, including the development of an agreed pathway for requesting medical opinions and reviews of patients for both young and older who are admitted to orthopaedic and surgical specialities. We have also reviewed how nursing and therapy staff escalate concerns both within their own discipline and when they feel they are not able to access the medical support required. These actions have been reviewed and presented at our Quality Committee which will be reported later in this meeting.

2.2 Helipad RBH

On 17 November 2023, the decision was made to temporary close the RBH Helipad following the publication and review of the Air Accident Investigation Board (AAIB) report into the fatal accident at Derriford (Plymouth) Hospital. During the review it was apparent due to the proximity of uncontrolled traffic on the adjacent public highway and on-site car parking, that there was a potential risk of a similar accident occurring at RBH and any immediate actions would not mitigate the gaps in control.

Work has been undertaken to review the Helipad Standard Operating Procedure to ensure that the identified risks were mitigated. Throughout we have consulted with our key stakeholders including the Dorset and Somerset Air Ambulance Service.

On 16 February 2024 following a rigorous review and test flights, a decision was made to re-open the RBH helipad. The current operational hours for the helipad are 07:00hrs – 22.00hrs. Once additional staff are trained, the operational hours will be extended to 07.00hrs to 02.00hrs.

2.3 Mass Musculoskeletal Clinic

On 27 January 2024, 144 patients attended the first of three scheduled mass clinics.

The patient experience survey result of 9.2/10 was representative of some of the excellent feedback after the event, where patients and staff reported good outcomes and a positive perception overall. Patient comments mentioned a well organised “exciting and dynamic” atmosphere and a “professional and caring” service.

As a result of the day, Poole sites longest wait was reduced by 9 weeks to 55.

The next mass clinic took place in Christchurch on 25 February, supported by Dorset Mind, Diabetes UK, Live-Well Dorset, BU Physiotherapy students, DCH volunteers, a member of DCH staff, Dorset MSK Surgical Interface Service, and UHD Occupational Therapists and administrative staff. Over 100 patients were seen.

3. Performance & Finance

The integrated performance report demonstrates the challenging environment in which we are currently operating. We continue to see marginal improvements to our urgent and emergency care pathways and flow through the organisation. However, there are consistently high numbers of patients who do not meet the criteria to reside in an in-patient bed, which results in high occupancy levels. A plan to reduce escalation beds has been agreed for the last six weeks of 2023/24, this requires partners to support reducing no criteria to reside patients (NCtR) to deliver safety.

On planned care waiting times, we continue to reduce waiting times for patients. Our

cancer waiting times are also improving.

We have entered a six-week sprint period to the end of March, and have asked teams to do their very best to deliver the following:

- Achieve the 4-hour safety standard for patients attending ED
- Ensure no patient is waiting longer than 78 weeks for elective care, and reduce those waiting over 65 weeks
- Maintain the Trust's excellent performance on diagnostics.
- Deliver a further improvement in cancer waiting times

The Dorset ICS submitted a forecast deficit of £12 million through the H2 planning process and continues to pursue additional opportunities to reduce costs and achieve this. There is currently a risk of circa £8.5 million with further plans being developed to mitigate this.

The Trust has reported a year-to-date deficit of £15.9 million representing an adverse variance to plan of £13.3 million. This has been driven by a reduction in elective income (£1.4 million), energy cost inflation (£4.1 million); and unfunded escalation costs (£5 million). Additional income is anticipated as part of the Dorset ICS H2 plan, to mitigate this deficit by 31 March; however this remains dependent upon the achievement of the overall ICS planned deficit of £12 million.

4. Transformation

There are 57 weeks to go until maternity services move from St Mary's to Poole to the BEACH building at RBH. Our service ready and patient ready programmes continue alongside the building ready programme. Our Transforming Care Together Board Steering group has convened and work continues at pace.

Engaging with patients and public on communicating and discussing the changes is incredibly important through this year. We have completed changes on stroke and cardiac pathways and are finalising the detail on changes to the treatment investigation units.

5. Electronic Health Record (EHR)

The Outline Business Case for an EHR is progressing with colleagues from Somerset with meetings planned to review the strategic, commercial, management and economic cases. The specification is also nearing sign off with a plan to present the business case to the Board for approval in April 2024. Once the case is with the Region for approval, a more detailed pre-market engagement will take place with demos and discussions with the suppliers. At this point we will increase the clinical and operational engagement with the programme before procurement launches.

6. Workforce

6.1 Tina Ricketts – Chief People Officer

I am pleased to announce the arrival of Tina Ricketts the new chief people officer for UHD. Tina is a fellow of the Chartered Institute of Personnel and Development and has been a Director of Human Resources within the NHS since 2011. Over the last 15 years, she has held a range of senior management positions within the health and care system in Gloucestershire.

Tina has successfully obtained the Investors in People accreditation for her last three employers winning regional awards for HR best practice. She has a special interest in leadership development and is an accredited assessor for the NHS leadership Framework, Leadership Qualities Framework, and Pi Coaching for Behaviour and Results.

I would also like to offer my great thanks to Irene Mardon, interim chief people officer who has worked in the position until Tina's arrival. Her commitment and enthusiasm have been greatly appreciated.

6.2 Chief Nursing Officer recruitment

I am pleased to inform the Board that we have completed the recruitment process for a chief nursing officer and are finalising the details.

6.3 Staff Survey Results

The staff survey results will be published on 7 March 2024.

6.4 People Pulse Survey

1129 staff responded to the People Pulse survey in January, over 10% of the workforce and exceeding best practice response rates. Thank you to all those who completed the survey. We have been reviewing the results and during the challenging winter period and additional pressures we have all been managing, our results have improved over the previous survey. We scored the highest when compared to other comparator trusts in answer to the statement "we support each other." The results are overwhelmingly moving in a positive way, however, there are areas where we do need to improve. We were lower than other trusts for "I feel well informed about important changes in my organisation." As such we are reviewing our methods to share information and communicate throughout the trust, in particular we are considering how we share and hear back on issues which we know are causing concern around service moves. The fact that we have such clear messages from the staff helps us to prioritise what we need to do as a matter of urgency.

6.5 Events in March

Thrive Live, our first UHD Wellbeing Fair, is a week-long event across UHD focused on nurturing the wellbeing of our colleagues. The program encompasses a diverse array of seminars, webinars, health assessments, and guidance sessions designed to empower our staff to prioritise self-care and foster mutual support. Talks include Understanding Burnout; You Matter Too; Wellbeing essentials; and Financial Wellbeing Advice. I am encouraging all colleagues to actively participate and engage.

We will also be recording many of our events and sharing them online for staff to access in their own time. This will create a lasting Thrive Live legacy. I thank all colleagues who have been involved with the planning.

6.6 Staff Excellence Awards

In December 2023 and January 2024 the following staff were nominated and won Excellence Awards.

- Evelyn Boyes — Volunteer
- Keith Waller — Charge Hand Porter
- John De Guzman — AEC Surgery
- Nathan Chapman — Respiratory Physician Associates
- Trisha Rafferty — Patient Administration, Main Outpatient Department

My thanks and congratulations to them all.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 06 March 2024

Agenda item: 6.1

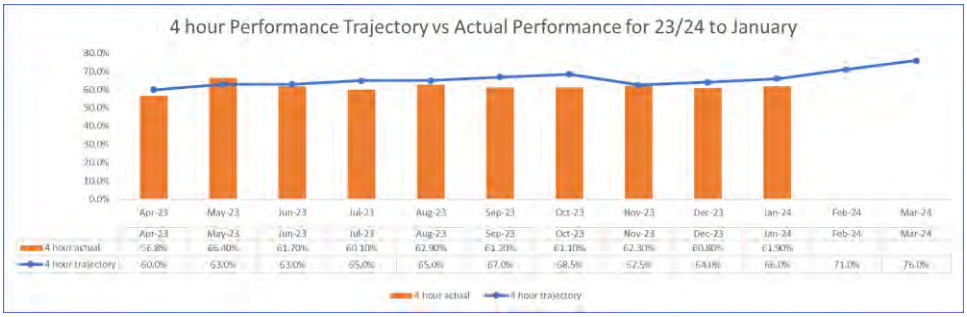
Subject:	Integrated Performance Report (Safety, quality, experience, workforce and operational performance)
Prepared by:	Executive Directors, Alex Lister, Leanna Rathbone, Judith May, David Mills, Fiona Hoskins, Dr. Matthew Hodson, Irene Mardon, Jo Sims, Andrew Goodwin
Presented by:	UHD Chief Officers

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 January 2024 - Appendix A
Purpose of paper:	Assurance
Executive Summary:	The impact of energy cost inflation, overall unfunded escalation capacity and a reduction in the elective income reflecting lower than planned activity is driving the challenging Trust financial position, resulting in a year-to-date adverse variance of £13.3 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 £2.8 million cost of the December and January Industrial Action is an allowable variance to this forecast. It should be emphasised that considerable risk remains inherent within this forecast and focused effort is required by all NHS system partners to achieve the revised outturn projection. Emergency Department (ED) attendances are consistent with December 2023, significantly higher than January 2023. Performance has seen a marginal improvement since December 2023 of just over 1% but remains off trajectory (61.9% against a trajectory of 64%).

	ED crowding and delays to move to beds for admitted patients remains as key factor, which correlates with ongoing high levels of No Criteria to Reside (NCtR) patients in the hospitals resulting in high occupancy levels. January 2024 saw sustained high levels of NCtR, peaking at >270 patients. We continue our internal actions on improving time of day discharge noting >20% of patients were discharged before midday in January. A UHD developed draft plan to reduce escalation beds has been agreed for the last six weeks of Q4 2023/24, this requires partners to support reducing NCtR to deliver safety. A quality impact assessment has been completed to support this process. January 2024 also saw a further increase in the number of escalation beds opened, with an average of 95 escalation beds open across our sites. Agreement was reached that 40 of the escalation beds would be funded by the ICB and is now in the ICS financial forecast, however as at 14th February there are over 100 escalation beds in use at UHD. This position impacts on Same Day Emergency Care (SDEC) capacity, elective services, and ongoing long waits for beds in our emergency departments. Ongoing challenges are presented to elective recovery due to a further 6 days of industrial action by Junior Doctors at the beginning of January 2024 impacted on elective recovery.
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. • Providing SPC training to operational leads who compile the narrative against the data included within the report. ***We recognize as a Trust Board that behind every single metric 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 January 2024 is 61.9% against a revised trajectory of 64%. The trajectory is required to achieve 76% by March 2024 and sustain thereafter.** • January was a challenging month factoring in the industrial action early in the month and ongoing crowding due to reduced flow. • Whilst there was a marginal improvement in 4-hour performance, flow out of the department was challenging with a subsequent impact on ED crowding, which has contributed to increased mean time in the department as well as time to admit.

- There was a slight drop in performance for the number of Ambulances waiting longer than 60 minutes up to 733 vs 711 in December, which is consistent with January 2023.
- The total number of handovers that were over 60 minutes in January was 16.7%, an increase of 3% from last month.
- Based on the 15-minute ambulance handover standard Poole reported a total of 1005 hours lost, and RBH 1188 hours in January.

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



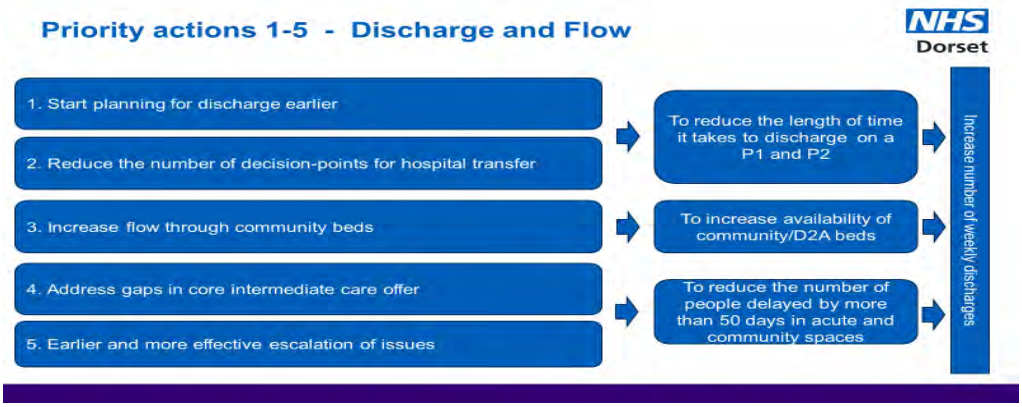
Review of the Trust's internal trajectory and delivery timeline has been signed off, maintaining the requirement to achieve the 76% standard by March 2024. This remains a high risk and is articulated in the Risk Register and BAF.

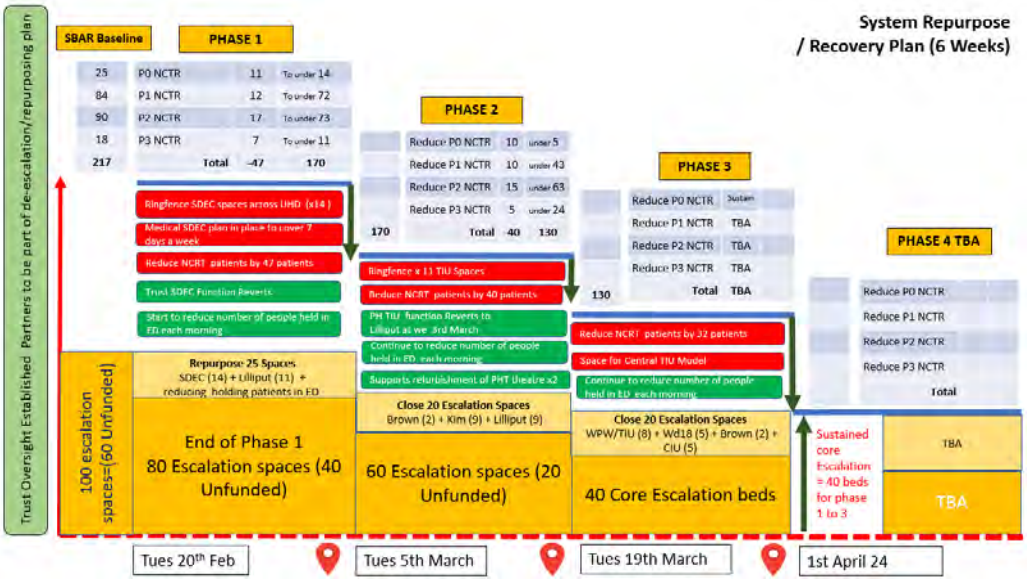
Improvement Actions

- Executive-led weekly enhanced support meetings continue, adopting the NHSE Tier 1 recovery methodology from February 2024.
- Single working plan shared with Finance and performance committee (Jan 2024)
- The revised fortnightly UEC Programme Board using the patient first methodology reporting to TMG. Engagement and plans are being monitored. A suite of metrics is in place.
- A 3-phase draft space reduction plan supports the prioritisation focused on re-instating services displaced by escalation – SDEC, TIU, Day case areas parts of which will support improved admitted flow.

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.
2. **Clinical Workforce capacity:** Improving capacity in our Ambulatory Care Area (ACA) Clinician and working through medial workforce capacity plans.
3. **Senior clinical assessment** - Continuing 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 high levels of escalation beds/spaces open, with an average of 95 escalation beds open (40 core funded and 55 unfunded), and increasing beds occupied by patients with No Criteria to Reside. There was a transient offset with the Derwent closed between 24 December to 8 January 2024 to enable staffing to support escalation capacity.** We have seen peaks of 50 patients across our emergency departments waiting for beds (Dec 2023 and Jan 2024). 'Crowded' emergency departments present a risk of harm to patients and impacts on the Emergency Departments' ability to function. The largest factor driving occupancy remains patients with No Criteria to Reside (NCtR), with further work progressing to support reduced occupied bed days for CTR. Improvements in UHD data capture demonstrated an improvement in reported NCtR from a mean of 255 in July 2023 to <209 in September, however for January this increased to a mean of 235. January has seen NCtR peak at 271 at midnight on 6th January 2024. <u>Improvement Actions</u>: Executive conversations are ongoing between partners to address the ongoing NCtR position in Dorset, a five-point plan has been agreed for Q4, UHD has worked through the changes needed internally to support these actions and has met with LA and community partners to agree the impact of these changes on the interface between UHD & partners.  Additional internal actions are in place to continue to optimise discharges: • Long Length of Stay meetings for patients over 21 days, with weekly meetings to review all patients >100 days (many of whom require complex care packages or providers) and those that the discharge teams are unable to progress. • Review of Organisational weekend capacity • UHD have drafted a system 3 phase de-escalation plan for unfunded capacity for consideration alongside system partners. This plan was shared with part 2 of the Board in January 24 and is currently being shared internally

	and with system partners to agree the final version and approach. The plan is proposed to link to system actions and start mid-February. • A deep dive into the challenges of hospital flow was also presented to the UHD Quality Committee in January 2024. 
Referral to Treatment (RTT) (1 Advised, 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.** **Advise (1) Ongoing challenges are presented to elective recovery due a further six days of industrial action by Junior Doctors in January 2024 and the bed pressures described above. As a consequence of lost capacity, the number of patients waiting >78 weeks on an RTT pathway increased (move from 57 to 86 patients).** **Assure (1) The Trust remains on a positive trajectory to deliver a reduction in the Referral to Treatment (RTT) waiting list in 2023/24 and has maintained an improvement in 18 Week RTT performance at 60.3%.** • Industrial action in January 2024 resulted in the following cancelled or unbooked activity: 99 ordinary inpatient cases; 209 daycases; and 420 outpatient appointments. • The H2 2023/24 revised planning trajectories for long waiters, did not include adjustments for industrial action, therefore patients waiting >78-week waits on an RTT pathway increased above plan to 86 (January trajectory 24). • A sustained reduction in the cohort of patients who will breach 65-week waits if not seen or treated by March 2024 continues, with the cohort size of 2,522 remaining at the end of January (compared to 3,863 in December). This is a 93.8% reduction in the cohort since 31 March 2023. • A further overall reduction in the total referral to treatment (RTT) waiting list in January 2024 was also delivered to 67,983 (6.8% reduction since March 2023).

- Further industrial action by Junior Doctors has been announced for the end of February 2024 which will continue to put at risk the long waiter trajectories for 2023/24.
- NHS England have released updated guidance on reporting requirements of community service pathways in RTT datasets. To allow for consolidated reporting of community services activity, these pathways should be recorded in relevant Community datasets and should be excluded from the RTT data submissions.

Planning requirement	Dec 23	January 24	
Referral to treatment 18-week performance	59.8%	60.3% ▲	National Target 92%
Eliminate > 104 week waits	0	0	Plan Trajectory 0 by March 2023
Eliminate >78 week waits	57	86 ▲	Plan Trajectory 0 by March 2023
Eliminate >65 week waits	1,313	1,220 ▼	Plan trajectory 1009 January 2024
Hold or reduce >52+ weeks	3,879	3,722 ▼	Plan Trajectory 4,054 by January 2024
Stabilise Waiting List size	68,967	67,983 ▼	Plan trajectory 76,589 January 2024

Improvement actions are detailed within the Integrated Performance report and include:

- Prioritising patients at risk of breaching 65 weeks before March 2024.
- 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.
- Productivity improvement trajectories are in place for the remainder of 2023/24 related to theatre utilisation rates and outpatient efficiency.
- Performance trends are showing that the theatre case opportunity target can be achieved within current processes. January 2024 performance demonstrated improvement compared to December 2023. Theatre utilization rates remain below the national target (85%) but an in-month improvement in January 2024 was delivered.
- Reduced variation in the outpatient DNA rate has also been delivered in 2023/24 year to date but the lower process control limit remains above the target. The Trust plans to switch on text reminders across all clinics in February 26th 2024, unless a clinically led opt-out rationale is provided by specialty teams (currently 54% of all clinics have text reminders switched on).

Assure (2): The percentage of fractured NOF patients operated on within 36 hours of admission demonstrated improvement in January 2024

- January performance for time to theatre for fractured neck of femur (# NoF) patients improved, whereby 88% of patients achieved surgery within 36

hours of being fit for surgery and 73% of patients were operated on within 36 hours from admission.

- Overall trauma admissions remained elevated compared to January 2023 with 366 admissions in January 2024, including 93 with fractured neck of femur (NoF) (compared to 89 in December 2023).
- e-Trauma 'go live' completed 15 January 2024.

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 (3) Provisional performance against the Cancer Faster Diagnosis Standard (FDS) in January 2024 is 72.9% and demonstrates the Trust's recovery of performance following a reduction in November 2023.

- The FDS position is recovering, with December 2023 performance increasing to 66.6% due to an improvement in Gynaecology. Skin performance has also improved following pressures in demand and workforce capacity in Quarter 3 2023/24. This is supporting an overall improved provisional position of 72.9% for January 2024, which meets the revised operational planning trajectory.
- 62 day performance for December was finalised at 64.4% which is a small deterioration from November 2023 due to capacity challenges earlier in the quarter. This is expected to improve in Q4.
- The Trust continues to deliver against the regional expectations on reducing the over 62-day backlog. The final position for January 2024 reduced to 236 against a trajectory of 250. A trajectory is in place to reduce further to 220 by March 2024.
- 31D performance was achieved in December reporting 96.2%. The provisional performance for January 2024 is 94% (target 96%). This standard is being impacted by surgical capacity within Skin and a recovery plan is in place to deliver the standard consistently.

KPI	Target	Sep 23 FINAL	Oct 23 FINAL	Nov 23 FINAL	Dec 23 FINAL	Jan 24 Prov
28 Day Faster Diagnosis Standard	75%	64.7%	67.0%	64.3%	66.6%	72.9%
31 Day Standard	96%	94.7%	96.7%	96.4%	96.2%	94.0%
62 Day Standard	85%	60.2%	68.9%	65.8%	64.4%	57.6%

Improvement actions are detailed within the IPR and include:

- Iron Deficiency Anaemia (IDA) service to complete a deep dive and recovery plan to support the Upper GI position.
- Referral numbers are being monitored daily in response to the royal family announcing cancer diagnoses.
- Additional weekend hysteroscopy clinics in Gynaecology throughout Q4 2023/24 to sustain the improved performance position.
- Rapid recovery plan developed in Colorectal to mitigate against nursing capacity challenges.
- Written communication and education being provided to primary care to ensure the new post-menopausal bleeding pathway that was implemented in November 2023, is utilised fully.

<table>
<tr><td></td><td>

- Elective recovery funding will support additional insourcing and waiting list initiative capacity in Dermatology in January 2024 whilst Tele-dermatology and the pilot AI proposal is operationalised.

</td></tr>
<tr><td>DM01 (Diagnostics report) (1 Advise)</td><td>

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

Advise (1) The DM01 standard has achieved 88.2% of all patients being seen within 6 weeks of referral; 11.8% of diagnostic patients seen >6weeks in January 2024. Industrial action in January 2024 has contributed to a reduction in performance (1% reduction).

1% of patients should wait more than 6 weeks for a diagnostic test
<table>
<tr><th>January</th><th>Total Waiting List</th><th>< 6weeks</th><th>> 6 weeks</th><th>Performance</th></tr>
<tr><td>UHD</td><td>11,668</td><td>10,296</td><td>1,372</td><td>11.8%</td></tr>
</table>

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

</td></tr>
<tr><td>Health Inequalities (1 Advise)</td><td>

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

Advise (1)
Waiting list by Index of Multiple Deprivation (IMD) Analysing elective waits in Quarter 4, 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.
Waiting list by age band: There is variation between age and length of wait on the waiting list with the greatest variation between 0-19yrs and 20+ age bands. The level of variation between 0-19yrs and older age bands has increased from 2 weeks in Quarter 3 2023/24 to 5 week in Q4 to date. Ongoing monitoring during the quarter is in place to assess whether this variation is maintained.
Waiting list by ethnicity: 10.8% of patients on the waiting list are from community minority ethnicity groupings. An analysis of the median weeks waiting by ethnicity grouping identifies a 2 week variation between patients within community minority groups and White British populations in Quarter 4. This is unchanged since Q3 2023/24.
The Dorset elective health inequalities group is working to understand the statistical significance of these variances.
Emergency dept. attendances by Index of Multiple Deprivation (IMD) Attendances are lowest in deprivation deciles 1-3.

</td></tr>
<tr><td>Maternity (1 Advise)</td><td>

Advise (1) There are 3 areas currently flagging as red RAG rated:

- 3rd /4th degree tears although within normal variance range
- Apgar <7 at 5 minutes-increased over last two months
- Prompt Training -below 90% compliance

</td></tr>
</table>

	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) *Escherichia coli*** Increased *Escherichia coli* blood stream infections noted in January 2024. No immediate concerns or themes identified. The IPC team continue to review cases and monitor. **Advise (2) *Clostridioides difficile* Cases** *Clostridioides difficile* cases in January 2024 remain static, no periods of increased incidents. No outbreaks identified. Case numbers in line with national trends. Infection Control continue to monitor. **Advise (2) Hospital Associated cases trend** **HCAI Trends by month** Organism / Feb-23 / Mar-23 / Apr-23 / May-23 / Jun-23 / Jul-23 / Aug-23 / Sep-23 / Oct-23 / Nov-23 / Dec-23 / Jan-24 MRSA / 0 / 0 / 1 / 0 / 0 / 0 / 0 / 0 / 0 / 0 / 1 / 0 MSSA / 1 / 1 / 4 / 6 / 8 / 4 / 4 / 5 / 5 / 4 / 1 / 3 C Diff / 4 / 5 / 5 / 8 / 19 / 11 / 4 / 8 / 8 / 4 / 8 / 7 E Coli / 7 / 14 / 5 / 8 / 17 / 14 / 8 / 11 / 11 / 11 / 8 / 17 • Cases of COVID-19 and Influenza A have increased over January 2024 with limited bay closures due to a risk-based approach in place. • The team continue to assess themes as part of the PSIR Framework • The IPC Group met in January 2024 and reviewed the Risks, IPC Board Assurance Framework and incidents for over Quarter 3 of 2023/24 and associated assurances in relation to IPC practices were given.
Clinical Practice Team ***(4 Advise)***	**Clinical Practice Team:** **Advise (1) Moving and Handling - Essential Core Skills** The challenges to meet the face-to-face level two training requirements for clinical staff continues. The risk register entry remains at 10 (moderate). The development of an eLearning Level 2 package is being progressed; with filming undertaken in January 2024. There have been unforeseen challenges which the team are working through to get this completed earlier. **Falls prevention & management**: **Advise (2)** Falls in month remain static in the number of serious falls incidents in month, with four reported; of these three were reported as moderate and one severe fall. The 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 with a view to the recruitment of an additional substantive Band 6 TVN. **Advise (4) Pressure Ulcers:** Ten new category three pressures ulcers, and one category four pressure ulcer were reported in month which are following the appropriate investigation process and learnings identified. 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, this needs further embedding.
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 January 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 being commenced in February 2024. **Advise (2) Friends and Family Test (FFT)** The volume of FFT being received has been the highest recorded, with Patient Experience Team and BI now managing the SMS FFT Service using Dr Doctor platform. Cessation of the contract with an external provider for SMS occurred on the 1 January 2024. UHD SMS FFT is a more cost-effective solution which means that we can now achieve SMS messaging to all patients who use our services. has seen a sustained high satisfaction score. The Trust overall positive score has been above the upper control limit for six consecutive months. **Advise (3) Mixed Sex Accommodation Breaches** There were 38 occurrences of MSA in January 2024 affecting 38 patients overall – continued monitoring of areas continues with care group matrons.
Nurse Staffing: (5 Advise, 2 Assure)	**Care Hours per Patient Day (CHPPD):** **Advise (1) January 2024** CHPPD for registered nurses remained stable at 4.4 at an organisational level. **Red Flag Reporting:** **Assure (1)** Twenty-eight 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)** Nurse agency lead time reduced from 14 days to 7 days from January as planned. **Assure (3)** As part of system work, the agency pay rate card did reduce by 15 % for registered nurses from January 2024.

Workforce Performance:	**Strategic goal: To significantly improve staff experience, engagement and retention**
CPO Headlines:	
People Operations: (1 Alert, 2 Advise)	**Industrial Action** **Alert (1)** The British Medical Association ('BMA') and the Hospital Consultants and Specialists Association ('HCSA') intend to call their Junior Doctor members to take industrial action during February 2024. The BMA will strike between 07:00 on Saturday 24 February until 23:59 on Wednesday 28 February. The HCSA will strike between 06:59 on Saturday 24 February until 06:59 on Thursday 29th February 2024. **Health Care Support Worker (HCSW) Re-Banding 2-3** **Advise (1)** A Dorset system wide agreement has been reached with trade unions to implement a fair deal for employees. This will be implemented in March 2024 with backpay from 1st April 2023, together with a recognition payment for long HCSW service. **Advise (2)** New band 3 pay rates are to be introduced for bank workers with effect from March 2024.
Occupational Health and Wellbeing (1 Alert, 1 Advise)	**Staff Vaccination Programme** **Alert (1)** The UK Health Security Agency (UKHSA) reported a steady rise in measles following its risk assessment for resurgence in the UK. Occupational Health are working closely with the Infection Control and Public Health Teams on the preparation for a potential Measles outbreak in Dorset. **Advise (1)** Autumn Covid vaccination program has concluded nationally. The Flu Vaccination program continues. UHD staff continue to be able to access the flu vaccine. The uptake remains static as previously reported - 36% of front-line workers have had Covid vaccination, 39% of front-line working have had the flu vaccination.
Workforce Systems (1 Advise)	**Medical Rostering Project** **Advise (1)** There are currently 122 Consultants and SAS Doctors booked onto Health Rota Job Planning training and 23 Non-Clinical Staff. Currently, 45 Consultants and SAS Doctors are trained to complete Job Plans on Health Rota. The Deputy Chief Medical Officer, Medical Staffing and Rostering teams are actively driving uptake. It is expected that all 626 Consultants and SAS Doctors are trained to input their job plans into Health Rota by March 2024.

Temporary Workforce (2 Advise)	**Temporary Staffing Controls** **Advise (1)** Direct engagement for all medical locums is in the planning, to ensure that all locums are engaged with through the Locum's Nest portal. Service areas will be unable to set localised high rates as Locums Nest will work to the agreed rate card. An agreed escalation process will be implemented and rolled out within the constraints of the Locums Nest system. **Nursing Bank Incentive Scheme** **Advise (2)** Nursing Bank incentive scheme has ceased and the organisation has seen no significant decrease in shift uptake or increase in agency usage as a result. A new targeted workforce scheme has been implemented for escalation areas, but this has not yet been stepped up.
Training and Education (1 Alert)	**Room Bookings** **Alert (1)** Increase in requests for room bookings in site Education Centres. This will increase with the moves to the BEACH building to include Maternity mandatory training which is an on-site requirement. Risk Register (number 2026). This impacts on both medical and non-medical staff training.
Resourcing (4 Assure, 1 Advise)	**International Nurse Recruitment** **Assure (1) -** A budget plan to meet the needs for international recruitment across all staff groups has been developed by the Corporate Finance team, and is in the process of being approved, which includes provision for Medical and Nurse recruitment, and recruitment to other clinical staff groups, such as Allied Health Professionals and HealthCare Scientists where required. There has been no further update on NHSI financial support for International Nurse Recruitment beyond December 2023. **Recruitment** **Assure (2)** All requests for recruitment and extensions to contracts are being reviewed via the revised Vacancy Review Process, with the Executive Team approving any posts being added to the funded establishment or requiring additional funding. The 'criticality' review score and as well as confirmation of any alternative recruitment option is required for all requests being submitted. Weekly reporting is being submitted to the ICB as agreed. **Assure (3) –** Recruitment activity for Healthcare Support Workers continues, with 112 interviews and 71 assessments taking place during the month of January. At a recent Saturday Recruitment Day, 62 candidates were interviewed and offered on the day. Our next meeting with the NHS Direct Support Team is scheduled for Friday 9th February 2024. **Right to Work in the UK** **Assure (4)** The audit of Right to Work checks for all current staff and bank workers is reaching a conclusion. Revised processes and reporting is in place to maintain high levels of compliance. **Honorary Contracts for Employment** **Advise (1) –** There is a need to review the processes involved in recording and managing Honorary contracts, given the greater mobility and frequency of such arrangements both between NHS Organisations and from other external organisations**.** A Task and Finish group will meet later this month.

Organisational Development ***(4 Advise)***	**Leadership** **Advise (1)** Application deadline for BU Senior Leaders Apprenticeship to be extended to 1st March 2024. New cohort of Leadership in Action commences in February, for 17 participants. **Team Development** **Advise (2)** New restrictions on use of external venues significantly impacting ability to work with large teams. Bespoke BI Directorate team session designed and delivered. Review of feedback from UHD Team Month to align future resources. **Culture and Engagement** **Advise (3)** January People Pulse concluded with 1129 responses with Trust and Directorate reports expected in February 2024. **Freedom to Speak up** **Advise (4)** Updating FTSU strategy 2023-26 following its initial approval in January 2023, to include references to Patient First Programme. The issue of detriment is a key area currently being examined together with HR Business Partners, to ensure a robust process is developed around this. In January, the FTSU team received 43 referrals and remains a well-used channel to raise concerns. A total of 323 referrals since April 2023 with elements of behavior being the predominant theme.
Trust Finance Position ***(1 Alert, 5 Advise)***	**Strategic goal: To return to recurrent financial surplus from 2026/27** **Alert (1): Forecast Outturn Risk** 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 £2.8 million cost of the December and January Industrial Action is an allowable variance to this forecast. It should be emphasised that considerable risk remains inherent within this forecast and focused effort is required by all NHS system partners to achieve the revised outturn projection. **Alert (2): Capital Programme** A formal request has been submitted to the national capital team to re-profile £19.1 million of capital funding into future years. This reflects the current forecast expenditure profile of the acute Re-configuration (STPW1) programme. Should this request not be supported, the Trust would be a considerable risk as this funding cannot be drawn down in advance of spend and would therefore be lost. **Advise (1): Revenue Position**

	At the end of January 2024 the Trust has reported a deficit of £15.9 million against a planned deficit of £2.6 million representing an adverse variance of £13.3 million. This is mainly due to a reduction in elective income of £1.4 million reflecting lower than planned activity; energy cost inflation of £4.1 million; and unfunded escalation costs of £5 million. Premium cost pay overspends within Care Groups have been partially off-set by additional bank interest and reduced depreciation charges. **Advise (2): Cost Improvement Programme** Efficiency savings of £14.9 million have been achieved against a target £25.8 million. Current savings plans total £18.3 million representing a shortfall of £15 million and a recurrent shortfall of £21.4 million. In addition to targeting further savings for the current year, increasingly, the focus is shifting to the development of plans for next financial year. **Advise (3): Cash** As at 31 January 2024 the Trust is holding a consolidated cash balance of £67.3 million which is fully committed against the future Capital Programme. The balance attracts Government Banking Services interest of 5.14% at current rates, together with a PDC offset benefit of 3.5%. **Advise (4): Public Sector Payment Policy** In relation to the Public Sector Payment Performance the Trust is currently delivering performance of 90.5% 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	February 2024	Pending
Quality Committee (Quality)	February 2024	Pending
Finance & Performance Committee (Operational / Finance Performance)	February 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: January 2024
Meeting Month: March 2024

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Achievements

In 2023/24 the achievements to date have been

- NHS E Safe Learning Environment Charter was launched on 7th February a s 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 April 2023.
- No patients are waiting over 2 years for treatment and fewer patients are at risk of waiting over 65 weeks.
- A reduction in the number of patients overdue a follow up outpatient appointment
- More patients are receiving same day emergency care.
- UHD is consistently performing as the top Trusts in the south west for diagnostic (DM01) performance.

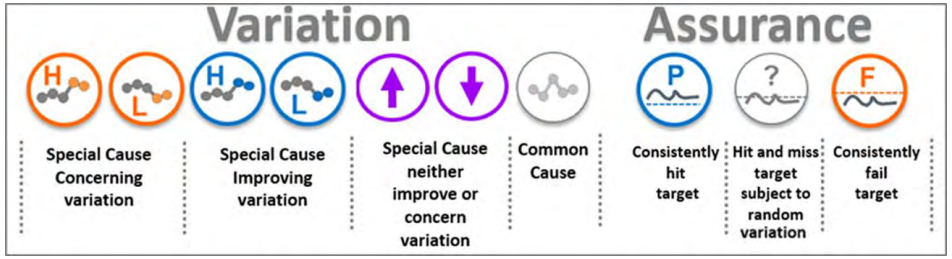
Performance at a Glance Indicators (1)

			standard	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
SAFE																		
Quality	Presure Ulcers (Hospital Acquired Cat 3 & 4)			8	9	7	5	8	9	5	12	7	7	15	13	13
	Inpatient Falls (Moderate +)			9	3	3	4	2	5	1	3	4	6	2	6	3
	Medication Incidents (Moderate +)			0	1	0	0	0	1	1	1	2	2	3	2	10
	Patient Safety Incidents (All)			1382	1204	1400	1291	1352	1356	1459	1447	1469	1383	1375	1298	1307
	Hospital Acquired Infections	MRSA		1	0	0	1	0	0	0	0	0	0	0	1	0
		MSSA		3	1	1	4	6	8	4	4	5	5	4	1	3
		C Diff		6	4	5	5	8	19	11	4	8	8	4	8	7
		E. coli		10	7	14	5	8	17	14	8	11	11	11	8	17
EFFECTIVE																		
Mortality	HSMR In Month (UHD)	Latest Oct 23	(source HED)	109.5	107.6	104.3	111.5	108.9	105.4	107.32	111.3	101	114.86			
	Patient Deaths in Hospital			273	217	259	238	228	215	196	227	200	252	232	281	245
	Deaths within 36hrs of Admission			38	37	32	36	41	34	33	43	25	35	40	45	23
	Deaths within readmission spell			23	23	16	22	21	18	26	31	20	27	20	23	18
CARING																		
	Complaints Received			92	84	86	73	95	88	37	41	47	65	89	81	62
	Complaint Response Rate (55 Days)			52.5%	51.4%	47.4%	53.2%	69.8%	51.5%	23.6%	29.8%	12.5%	18.8%	40.0%	57.4%	55.7%
	Friends & Family Test			91.1%	92.7%	90.3%	90.9%	91.8%	91.0%	93.8%	94.4%	94.4%	95.1%	94.8%	94.4%	94.1%
WELL LEAD																		
Safety	Risks 12 and above on Register			38	41	38	38	40	43	43	43	45	43	45	46	43
	Risks 15 and above on Register			20	20	19	19	20	21	20	22	23	23	23	23	22
	Red Flags Raised*			41	43	38	21	43	25	19	13	20	15	13	15	28
People	Turnover			14.9%	14.7%	13.9%	13.8%	13.7%	13.4%	12.9%	12.3%	12.1%	11.7%	11.2%	11.0%	11.05%
	Vacancy Rate			7.0%	6.4%	6.0%	6.0%	7.0%	8.1%	9.1%	8.2%	7.7%	6.9%	6.3%	6.32	
	Sickness Rate			4.8%	4.7%	4.8%	3.9%	3.7%	3.9%	4.1%	4.1%	4.3%	4.8%	4.6%	4.4%	4.5%
	Statutory and Mandatory Training			86.31%	86.81%	86.98%	87.84%	88.45%	89.41%	89.70%	89.75%	89.25%	88.88%	88.92%	88.93%	88.91%
	Appraisal Compliance - Values Based			52.10%	52.82%	53.56%	1.22%	4.66%	11.97%	23.80%	34.82%	53.33%	60.82%	63.79%	63.77%	64.20%
	Appraisal Compliance - Medical & Dental			59.08%	60.82%	59.52%	60.07%	60.61%	62.03%	60.91%	58.25%	55.9%	57.66%	57.29%	56.14%	59.24%
	Temporary Hours Filled by Bank			52.4%	55.3%	53.5%	57.6%	57.1%	53.1%	53.6%	54.2%	51.0%	51.8%	53.1%	52.4%	53.50%
	Temporary Hours Filled by Agency			18.6%	19.9%	19.2%	20.3%	21.6%	24.4%	26.3%	25.2%	26.8%	26.2%	27.8%	27.0%	24.60%
	Agency Pay as Proportion of Total Pay			6.4%	5.7%	3.6%	5.1%	4.1%	4.6%	4.7%	4.5%	5.0%	5.1%	4.5%	4.9%	5.31%

Performance at a Glance Indicators (2)

		standard	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	
RESPONSIVE																
RTT	18 week performance %	92%	55.4%	54.3%	53.8%	52.6%	54.3%	55.1%	55.4%	57.0%	57.6%	59.7%	60.8%	59.8%	60.3%	
RTT	Waiting list size	76,589 (Jan 24)	71,230	72,522	72,770	74,557	74,500	74,483	75,884	73,727	73,726	70,914	69,158	68,967	67,983	RAG based on trajectory
RTT	No. patients waiting 52+ weeks	4,054 (Jan 24)	3,565	3,861	4,100	4,380	4,813	4,574	4,613	4,501	4,426	4,199	4,196	3,879	3,722	RAG based on trajectory
RTT	No. patients waiting 65+ weeks		1,127	1,147	1,070	1,249	1,242	1,053	1,122	1,293	1,234	1,331	1,271	1,313	1,220	
RTT	No. patients waiting 78+ weeks	0	395	274	96	112	97	32	34	43	43	47	59	57	86	RAG based on trajectory
RTT	No. patients waiting 104+ weeks	0	10	0	0	0	0	0	0	0	0	0	0	0	0	RAG based on trajectory
Outpatients Theatre	Theatre utilisation (capped) - main	98%	71%	71%	65%	72%	73%	73%	73%	74%	75%	75%	74%	71%	73%	
Outpatients Theatre	Theatre utilisation (capped) - DC	91%	69%	67%	57%	69%	74%	73%	72%	72%	74%	74%	75%	75%	76%	
Outpatients Theatre	NOFs (Within 36hrs of admission - NHFD)	85%	49%	24%	67%	54%	33%	37%	37%	31%	47%	43%	56%	60%	73%	
Outpatients Theatre	**Outpatient metrics**															
Outpatients Theatre	Overdue Follow up Appts		34,863	34,756	34,302	31,778	31,057	30,594	29,622	27,619	27,946	27,493	26,506	26,733	26,506	
Outpatients Theatre	% DNA Rate	5%	7.5%	6.5%	7.1%	7.6%	6.5%	6.1%	6.2%	6.3%	6.2%	6.3%	5.9%	6.2%	5.9%	
Outpatients Theatre	Patient cancellation rate		10.6%	10.8%	9.2%	8.9%	11.3%	11.6%	11.0%	11.3%	11.6%	11.8%	11.2%	12.3%	11.3%	
Outpatients Theatre	% non face to face (telemedicine) attendances	25%	20.8%	21.3%	18.5%	18.6%	18.6%	17.5%	17.4%	17.5%	17.1%	17.0%	17.3%	17.4%	17.5%	
DM 01	**Diagnostic Performance (DM01)**															
DM 01	% of >6 week performance	1%	10.7%	7.4%	7.0%	8.4%	6.0%	7.7%	9.4%	13.2%	12.1%	10.4%	9.3%	10.8%	11.8%	
Cancer	28 day faster diagnosis standard	75%	65.0%	71.0%	75.4%	71.2%	70.2%	71.9%	60.1%	54.7%	64.7%	67.0%	64.3%	66.6%	72.6%	*Jan cancer position predicted*
Cancer	62 day standard	85%	63.6%	61.9%	65.4%	67.0%	62.7%	60.2%	63.0%	57.1%	60.2%	68.9%	65.8%	64.4%	*55.0%*	
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%	
Emergency Dept	Arrival time to initial assessment	15	11.0	15.0	13.0	16.0	19.0	22.0	24.0	16.0	16.0	21.0	19.0	19.0	20.0	
Emergency Dept	Clinician seen <60 mins %		31.6%	25.7%	26.1%	31.6%	27.6%	35.6%	20.3%	27.2%	26.1%	27.7%	32.2%	31.9%	31.3%	
Emergency Dept	Patients >12hrs from DTA to admission	0	234	294	211	220	82	13	59	2	-	-	70	294	483	
Emergency Dept	Patients >12hrs in dept		1108	1443	1238	849	637	504	871	723	857	882	851	1271	1681	
SWAST	Ambulance handovers		3602	3360	3988	4007	4102	4015	4268	4447	4238	4433	4295	4456	4394	
SWAST	Ambulance handover 30-60mins breaches		714	663	829	721	625	684	750	824	874	1046	1139	1248	1238	
SWAST	Ambulance handover >60mins breaches		728	882	900	698	345	383	615	588	677	805	551	711	733	
Patient Flow	Bed Occupancy (capcity incl escalation)	85%	93.1%	94.1%	94.5%	93.6%	92.3%	94.4%	94.6%	93.5%	95.3%	95.8%	96.7%	95.3%	96.4%	
Patient Flow	Stranded patients:															
Patient Flow	Length of stay 7 days		564	582	543	523	502	480	474	476	500	502	526	534	566	
Patient Flow	Length of stay 14 days		366	387	355	337	322	294	295	308	310	318	331	339	370	
Patient Flow	Length of stay 21 days	108	250	269	255	235	223	199	202	220	211	220	220	231	266	
Patient Flow	Non-elective admissions		5693	5165	6203	5690	6288	6347	6223	6233	6141	6551	6519	6214	6538	
Patient Flow	> 1 day non-elective admissions		3673	3202	3881	3612	3826	3783	3863	3821	3779	4065	3934	3909	3981	
Patient Flow	Same Day Emergency Care (SDEC)		1979	1963	2316	2078	2458	2560	2358	2410	2310	2393	2458	2157	2391	
Patient Flow	Conversion rate (admitted from ED)	30%	30.90%	27.79%	28.30%	29.70%	29.90%	31.60%	28.70%	28.60%	30.70%	32.50%	32.90%	30.50%	28.47%	

Statistical Process Control (SPC) – Explanation of Rankings



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

Quality Outcomes & Safety Patient Experience

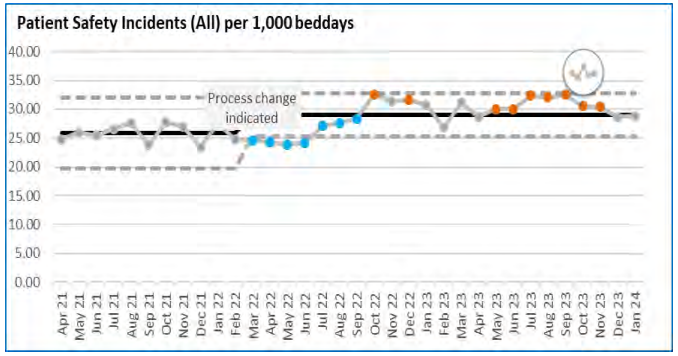
University Hospitals Dorset
NHS Foundation Trust

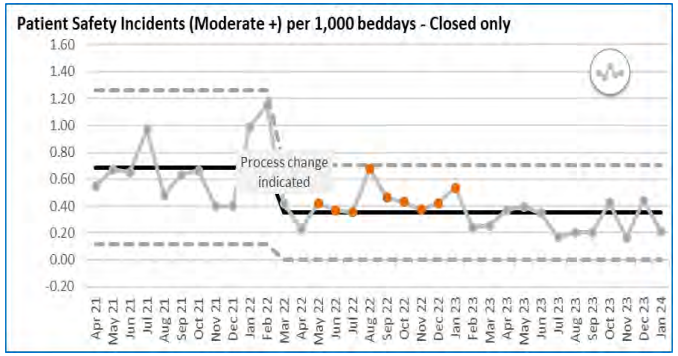

Professor Paula Shobbrook
Chief Nursing Officer/ Deputy CEO
Dr Peter Wilson
Chief Medical Officer

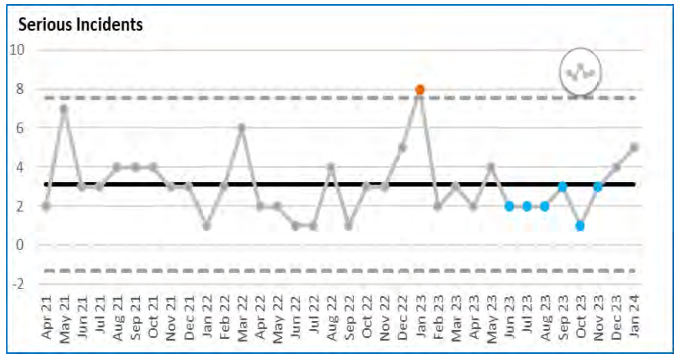
Operational Leads:
Jo Sims – Associate Director Quality, Governance and Risk
Matthew Hodson – Deputy Chief Nursing Officer (IPC, Clinical practice and Patient Experience)
Sean Weaver – Clinical Lead for Mortality
Fiona Hoskins – Deputy Chief Nursing Officer (Workforce & Safeguarding)
Sarah Macklin -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

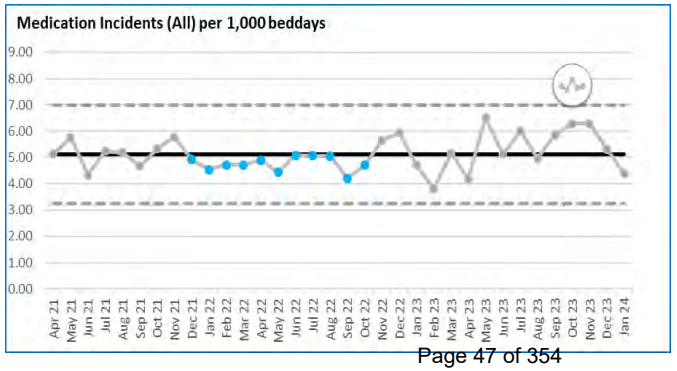
Committees:
Quality Committee

Quality (1) – Safe









Background/target description

To improve patient safety.

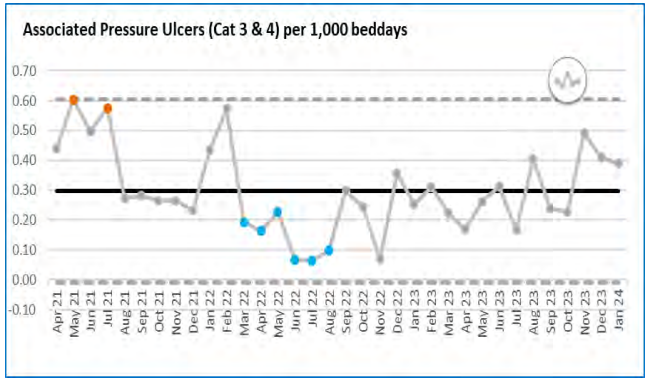
Performance

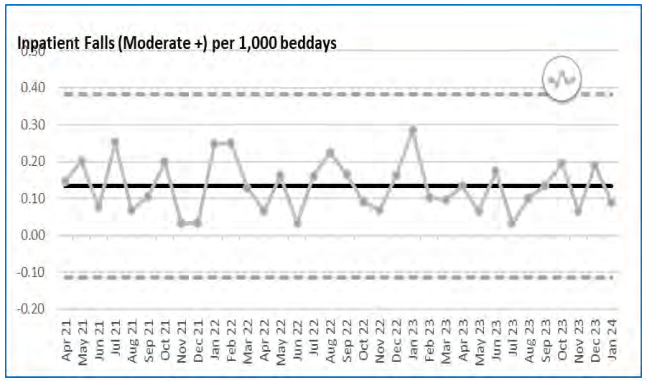
- No significant trends or changes in IPR reported metrics in month (Jan 24 position).
- Redesign of IPR and Quality Dashboard metrics to report on PSIRF themes and trends being discussed with BI Team
- Successful transition to new Learning from Patient Safety Events (LFPSE) Forms and national platform on the 30/11/23. LFPSE redefines the definition of a patient safety incident and therefore the Trust reporting profile is likely to change over the next few months. This will be closely monitored by the Quality and Risk Team who continue to provide awareness training across the Trust on the new forms and the importance of reporting and learning from patient safety events, including near misses and potential LERN issues.

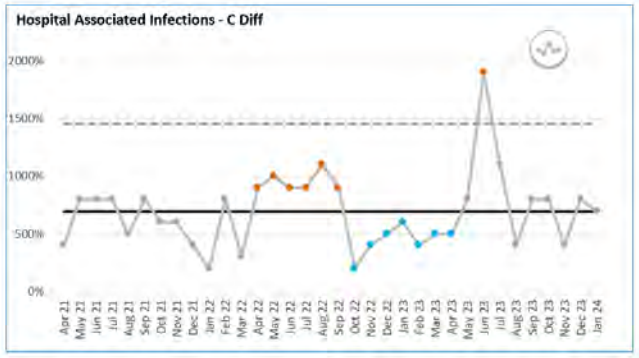
Key Areas of Focus

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

Quality (2) – Safe







Background/target description

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

Performance

Clinical practice:

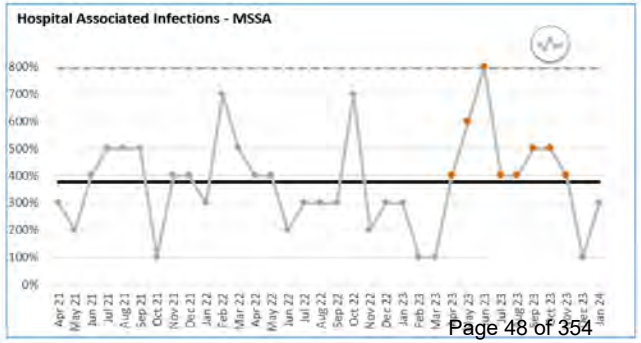
- There have been ten new category three pressure ulcers and one new category four pressure ulcer reported in month, which are following the appropriate investigation. Common cause variation continues.
- There has been a static number of serious* falls incident in month with four falls reported (three moderate and one severe), these falls will follow the appropriate follow-up as per the patient safety framework investigation. Common cause variation continues.

Infection Prevention and Control

- Increased *Escherichia coli* blood stream infections noted in January 2024. No immediate concerns or themes identified. The IPC team continue to review cases and monitor.
- *Clostridioides difficile* cases in January 2024 remain static, no periods of increased incidents. No outbreaks identified. Case numbers in line with national trends. Infection Control continue to monitor.
- Cases of COVID-19 and Influenza A have increased over January 2024 with a risk-based approach in place to limit bay/ward closures.
- 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.

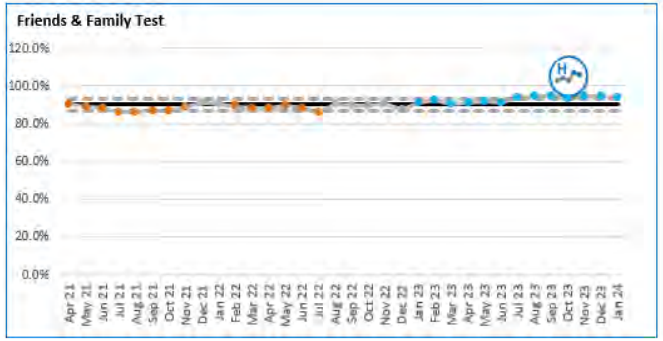


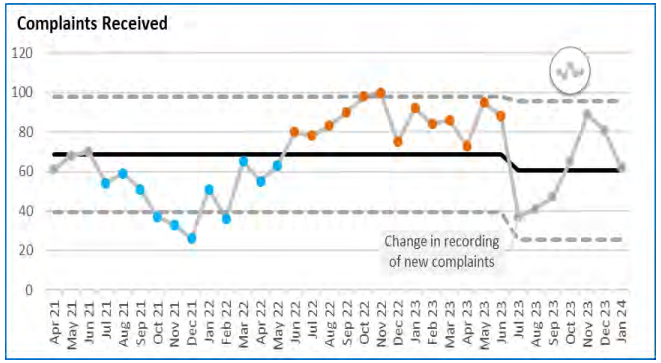
HCAI Trends by month

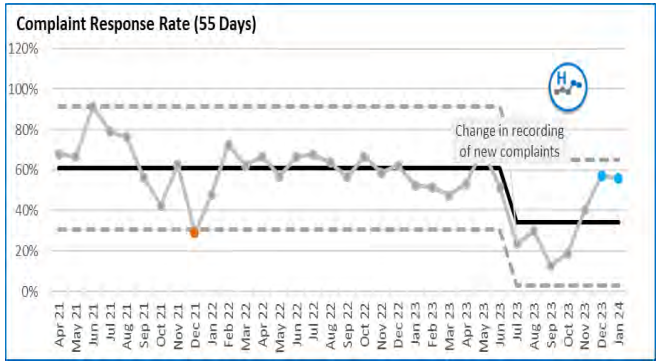
Organism	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
MRSA	0	0	1	0	0	0	0	0	0	0	1	0
MSSA	1	1	4	6	8	4	4	5	5	4	1	3
C Diff	4	5	5	8	19	11	4	8	8	4	8	7
E Coli	7	14	5	8	17	14	8	11	11	11	8	17

*Categorised as Moderate or Severe

Quality (3) – Caring







PALS and Complaints Data for January 2024:

Overview:

565 PALS concerns raised

- 36 new formal complaints
- 26 Early Resolution complaints (ERC) processed.
- The number of complaints that were responded to and closed in January was 88.

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 improving variation.

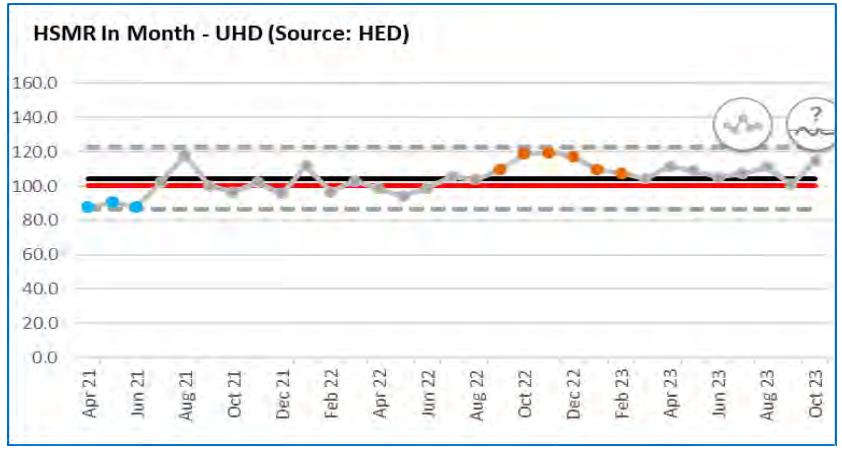
Friends and Family Test (FFT)

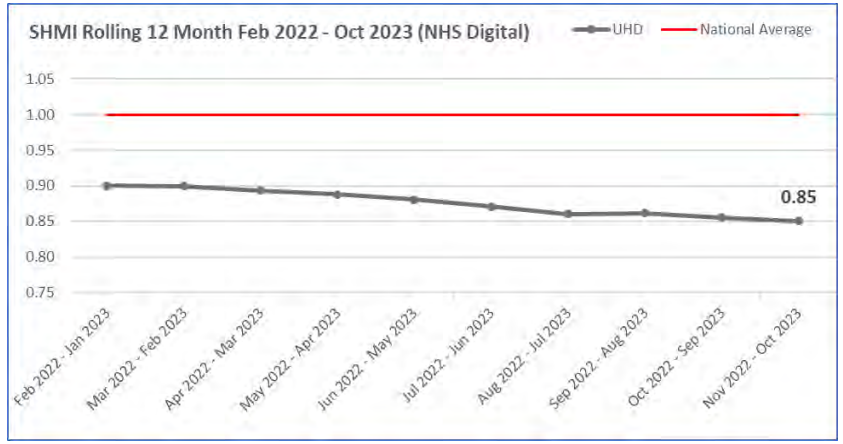
FFT results: Testing of the UHD text messaging exclusively delivered SMS messaging from 01 January 24, seeing a sustained increase in the number of FFT responses being received. More clinical areas are now receiving FFT results. The Trust overall positive score has been above the upper control for seven consecutive months and remains above the average score. Seen in the SPC chart as special cause improved variation.

Mixed Sex Accommodation Breaches

There were 38 occurrences of MSA in January 2024 affecting 38 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.

We have changed our data supplier from Telstra Health to HED - which 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 0.85.

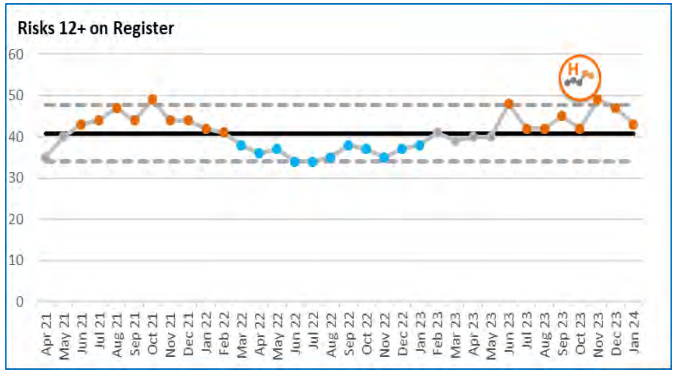
We are working with the coders to ensure that we are accurately capturing our data, especially for patients receiving palliative care who significantly influence our mortality statistics.

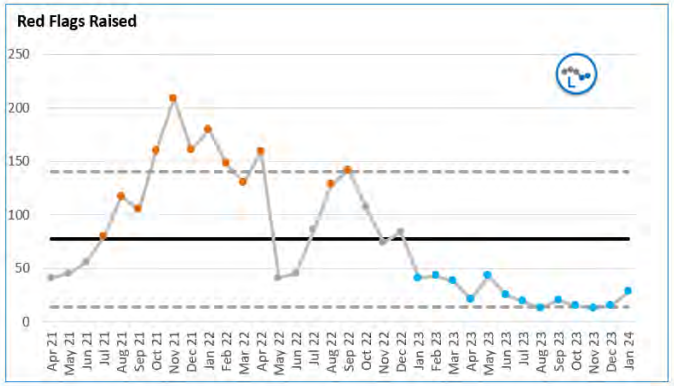
Our coding timeliness has changed meaning that our closed data is one month behind the latest data. This is causing some initial issues with the reporting of alerts and this should be resolved by next month.

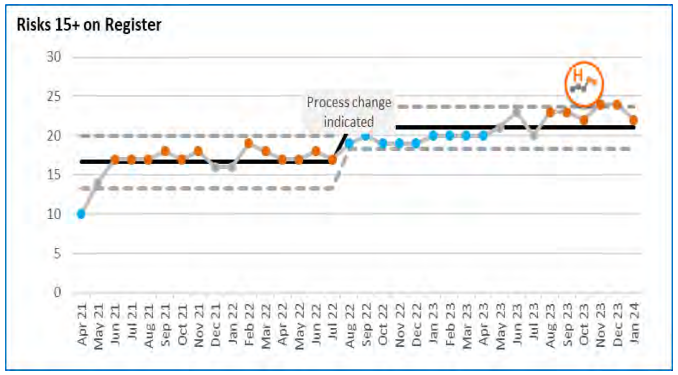
The learning from death process remains without identified admin / IT support and ways to try and resolve this are being explored.

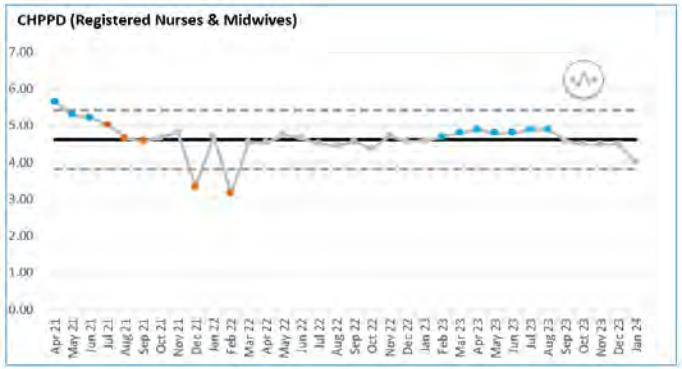
We are reviewing the LeDeR (Learning Disablity Mortaltiy Review data nationally and regionally to triangulate against local findings where the numbers are small.

Quality (5) – Well Led









Performance

- January CHPPD for registered nurses and midwives combined is 4.4. Guidance for organisational level CHPPD for registered nurses and midwives advises this should be >3.
- The Red Flag data for January was 28 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

- Separate Risk Report provided to TMG, Quality Committee and Board.
- Number of risks 12+ reduced slightly. Meetings held with Exec leads in January and February to review all 12+ risks and validate evidence for risk rating and confirm details of controls, assurances and mitigations.
- Board Risk Seminar held 7/2/24 to review Trust risk appetite and risk tolerance statement. Action plan agreed.

Safe Staffing (Rota Fill Rates and CHPPD) - Total (Day & Night Combined) January 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	17711	83756.9	80641.2	96.3%	4.6
Bournemouth & Christchurch	18043	78656.4	76944.4	97.8%	4.3
UHD Total	35754	162413.2	157585.6	97.0%	4.4

Maternity (1)

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

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
Perinatal	Red flags: 1:1 care in labour not provided	0	0	0	0	1	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%
	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%
	Term admissions to NNU	<6%,	5.9%	6.50%	5.50%	4.30%	4.50%	6.10%	6.80%	5.40%	4.90%	6.10%
	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%
	Stillbirth number	Actual	4	2	1	0	0	2	2	1	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
	Dedicated anaesthetic cover on Delivery suite - per week	<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
	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
Feedback	Number of compliments (Smiles via Badgernet)		42	37	41	66	51	32	Moving to new system			40
	Number of concerns (PALS) negative		0	0	4	3	0	2	1	1	1	0
	Complaints	3	2	3	2	2	0	0	3	2	2	1
	FFT Repsonse from November 23		43%	46%	87%	80%	62%	125%	100%	430	276	297
Training	UHD Mandatory training - women's health	90%	82%	84%	86%	88%	88%	88%	86%	86%	85%	87%
	PROMPT/Emergency skills all staff groups	90%	82%	82%	84%	86%	not known	85.2%	74%	79%	82%	86%
	K2/CTG training all staff groups	90%	91.76%	96%%	94%	96%	95%	95%	84%	87%	86%	95%
	CTG competency assessment all staff groups	90%	91.76%	96%%	94%	96%%	95%	95%	84%	87%	86%	
	Core competency framework compliance	90%	84%	87%	89%	86%	84%	85%	93.50%	90.00%	91.00%	moved to ccf2
	Coroner Reg 28 made directly to the Trust	al <6%, Region	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)

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:

- Obstetric Haemorrhage >1.5 litres- action plan in place
- Term admissions to NICU
- Apgar's <7 at 5 minutes

Key Areas of Focus

Obstetric haemorrhage >1.5L: - The performance for this metric has been elevated over the past six months, however improvement was seen in January from previous month. 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- Clinical review showed correlation between tears and obstetric haemorrhage . Quality improvements are being made, and this month showed improvement in 3rd and 4th degree tears.
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 NNU: - term admissions to NICU were elevated this month and learning identified. A detailed action plan and quarter 3 report was shared with safety champions and quality committee for assurance of ongoing actions for improvement..

Apgar's <7 at 5 min- review of cases in January showed accurate assessments and further ongoing training continues

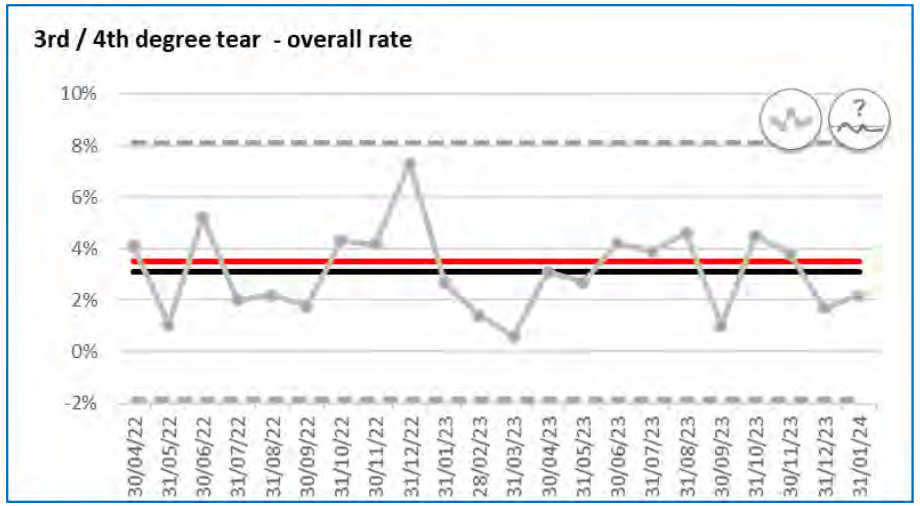
Training: Immediate actions have been taken to improve MDT PROMPT training within the next 12 weeks.(end of March) Overall compliance now 86%.

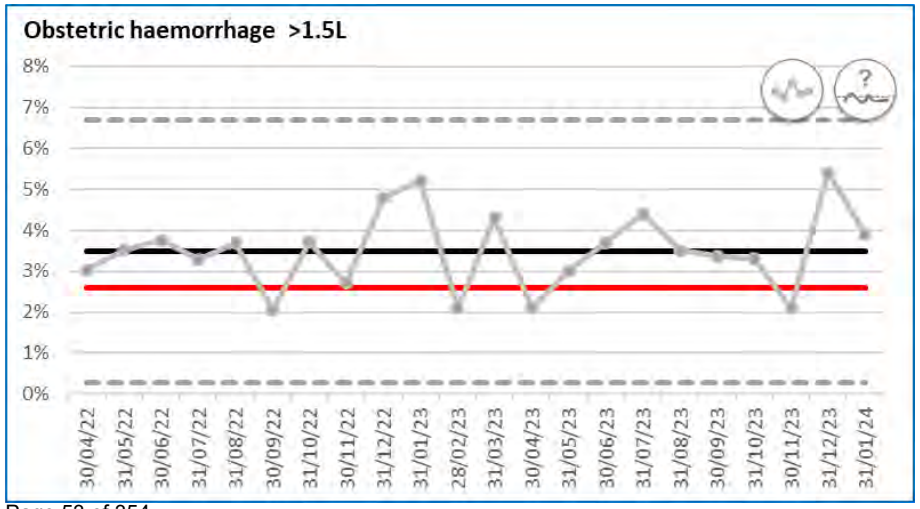
Maternity (SPC)

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

Maternity - Areas of Focus

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
3rd / 4th degree tear - overall rate	Jan 24	2.2%	3.5%			3.1%	-1.9%	8.1%
Obstetric haemorrhage >1.5L	Jan 24	3.9%	2.6%			3.5%	0.3%	6.7%
Term admissions to NNU %	Jan 24	6.1%	6.0%			5.6%	2.6%	8.6%





Maternity (2)

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

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

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 January

PMRT
Two cases were reviewed in January under the PMRT process .
Both cases care were graded as good.

- Shared learning from one case : to ensure appropriate use of interpreters at all points of contact.

MNSI

One case was referred to MNSI for a baby who was born in an unexpected poor condition and went for therapeutic cooling.

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.
3. PPH greater than 1.5 liters initial quality improvement commenced.

Other reports submitted in January through safety champions/people and culture committee.

PMRT quarter 3
ATAIN quarter 3
Maternity workforce six monthly staffing paper

Progress in achievement of Year 5 Maternity incentive scheme

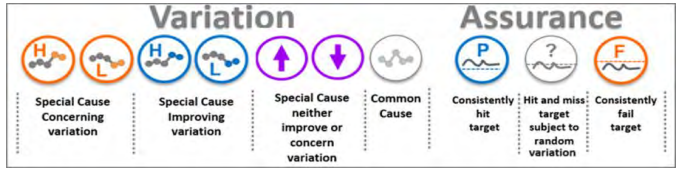
MIS year 5 - All safety standards not met declaration to be submitted by the 1st of February
Work continues on all safety standards with monthly assurance meetings to monitor compliance.
For the standards partially met, there has been further progress n made in January.

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 .
Safety action 6 - Saving Babies Lives Care Bundle 3 – Quarter 2 assessment with ICB showed 79% compliance., however 50% not met in element 4 fetal monitoring therefore standard not met. Quarter 3 assessment in February, further improvements seen, awaiting assessment outcome for reporting.
Safety action 8 - In house training, This remained a challenge in January due to sickness , workforce gaps .The Standard of 90% was not met for all staff groups, however improvement has seen from December 82% to 86% in January . MDT action plan in place.

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 bedd	Jan 24	0.39	-			0.30	-0.01	0.60
Inpatient Falls (Moderate +) per 1,000 beddays	Jan 24	0.09	-			0.13	-0.11	0.38
Medication Incidents (Moderate +) per 1,000 beddays	Jan 24	0.30	-			0.04	-0.05	0.13
Medication Incidents (All) per 1,000 beddays	Jan 24	4.38	-			5.12	3.23	7.00
Patient Safety Incidents (All) per 1,000 beddays	Jan 24	28.84	-			29.06	25.31	32.80
Patient Safety Incidents (Moderate +) per 1,000 bedd	Jan 24	0.21	-			0.35	0.00	0.71
Serious Incidents	Jan 24	5	-			3	-1	8
Never Events	Jan 24	0	-			0	-1	1
Hospital Associated Infections - MRSA	Jan 24	0	-			0	-1	1
Hospital Associated Infections - MSSA	Jan 24	3	-			4	0	8
Hospital Associated Infections - C Diff	Jan 24	7	-			7	-1	15
Hospital Associated Infections - E Coli	Jan 24	17	-			8	-1	17
HSMR In Month - UHD (Source: HED)	Oct 23	114.86	-			110.50	96.45	124.54
Mixed Sex Accommodation Breaches	Jan 24	38	-			5	-12	23
Complaints Received	Jan 24	62	-			60	25	95
Complaint Response Rate (55 Days)	Jan 24	56%	-			34%	3%	65%
Friends & Family Test	Jan 24	94.1%	-			90.3%	87.0%	93.5%
Patient Deaths in Hospital	Jan 24	245	-			230	163	297
Deaths Within 36hrs of Admission	Jan 24	23	-			36	13	58
Deaths Within Readmission Spell (5 day readmission)	Jan 24	18	-			20	5	34
Risks 12+ on Register	Jan 24	43	-			41	34	48
Risks 15+ on Register	Jan 24	22	-			21	18	24
Red Flags Raised	Jan 24	28	-			77	14	141
CHPPD (Registered Nurses & Midwives)	Jan 24	4.00	-			4.63	3.83	5.43
			-					



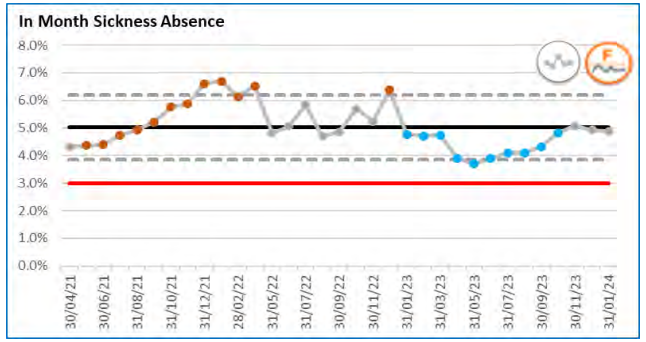
Our People

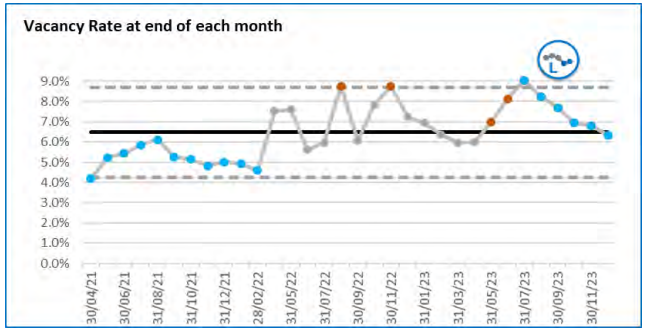
Irene Mardon
Acting Chief People Officer

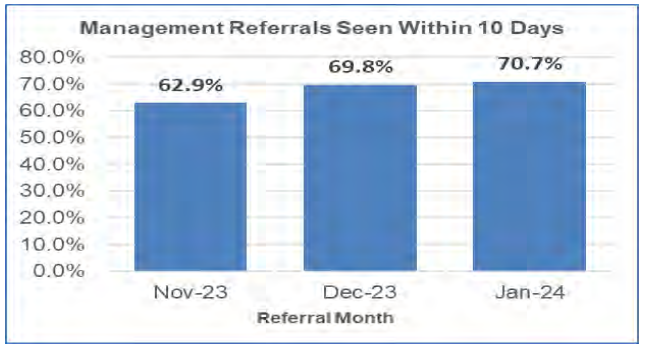
Operational Leads:
Lisa White - Acting Deputy Chief People Officer

Committees:
People and Culture Committee

Well Led - Workforce (1)







Performance

Sickness Absence and Wellbeing

- In month sickness absence for January 2024 was at 4.9%, this is the same as previous month. Latest rolling 12 month rate (as at end of January 2024) is 4.5% which is a slight increase on the previous month.
- Cold, Cough and Flu was the top reason for absence in January, slightly higher than stress/ anxiety/ depression (risk 1493).
- The waiting time from management referral to staff being seen by Occupational Health within the KPI of 10 days of referral has improved slightly from 69.8% in December to 70.7% in January. New starter to support this service commences in June 2024.
- Staff physiotherapist wait times in January for an urgent appointment has increased to 9 days from 4 days in December, and to 26 days from 11 days in December for routine. KPI- 5 days for urgent, 10 days for routine. This is due to reduced staffing within the Physio team – locum cover ceased and now awaiting new starter to commence in the Spring.
- The average waiting time for an appointment with the Staff Psychological service in January increased to 14 days from 7 days in December due to increased referrals following winter wellbeing promotion and sickness absence in the team. The highest presenting problems of high stress and sleep problems remained constant through January from December.

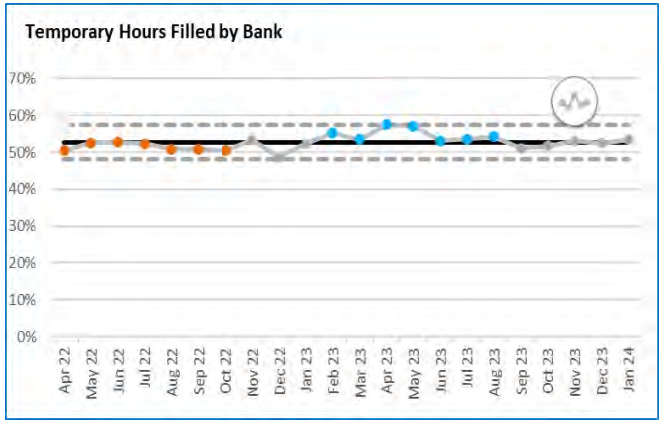
Vacancy Rate

- Vacancy rate is reported a month in arrears to allow for reconciliation with the ledger. Latest vacancy position is 6.3% (as at 31st December 2023), this includes any changes made in arrears.
- In January there were 246 new appointments, which includes 124 internal - a significant increase compared to149 appointments in December. This includes 15 medical starters in January, including 2 internal appointments, compared with a total of 7 in December.
- 239 adverts (agenda for change staff) were posted in January, compared with 230 in December, and a record number of 4034 applications were received, compared to 3604 in December. The number of job offers made in January 2024 was 218, compared with 187 in December.
- The number of starters and offers was almost exactly as it was in January 2023, however over 1000 more applications were received in January 2024 than January 2023.
- 18 medical and dental posts were advertised in January, compared to 23 in December, with the number of applications received over the month being low at 210, compared with 1377 previous month. This level is due to advertised roles either being specialised in nature or Consultant level posts, for which fewer candidates are expected. Offers were made to 13 candidates, compared to 22 in December.

HCSW Recruitment

- HCSW vacancies are currently at 178 WTE compared to 177 WTE vacancies reported last month. For NHS Direct Support reporting, a lower vacancy figure of 128 WTE is recorded due to the Trust identifying that 50 WTE of the overall vacant posts are occupied by Apprentice Nurses, who work clinically as Healthcare Support Workers 60% of their working week.
- January 20th Recruitment day resulted in over 220 applicants, 50% were invited for assessment or interviews. 62 candidates were offered on the day, and our pipeline looks strong through to meet the target set by the NHSE Direct Support Team.

Well Led - Workforce (2)



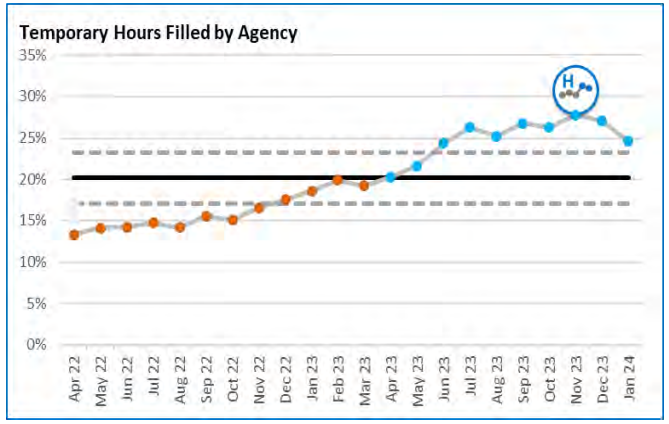
Performance

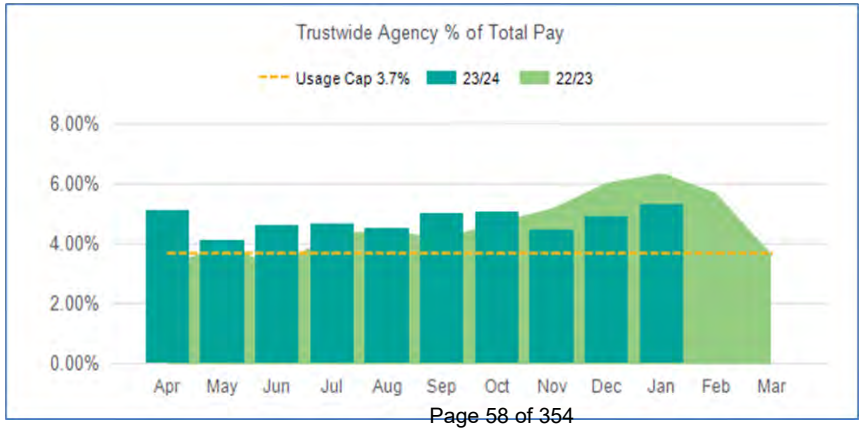
Underlying issues:

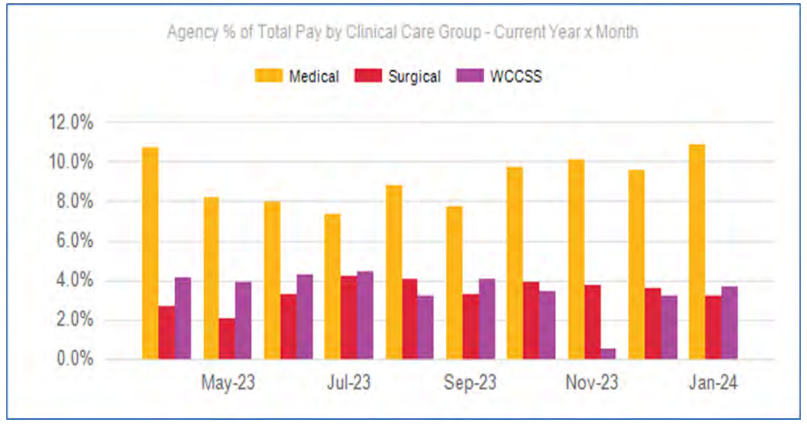
- An increase in agency spend from 4.89% in M09 to 5.31% in M10.
- Agency spend has increased in the Medical Care Group M9 9.55% to 10.86% in M9, The Surgical Care Group was 3.55% in M9 and now 3.21% in M10. Women's, Children, Cancer and Support Services Care Group was 3.20% in M9 and now 3.64% in M10.
- 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

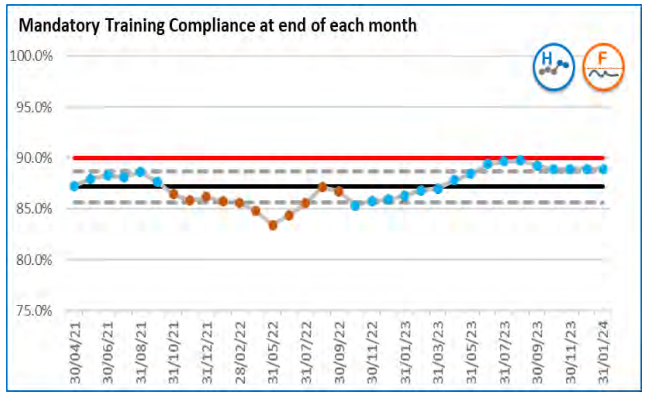
- Risk 1492: A system wide approach to reducing agency rates was agreed from 2nd January 2024. The new rates have been successfully implemented and work is in train for further rate reductions from Q1, together with removal of Tier 4 agency usage.







Well Led - Workforce (3)



Performance

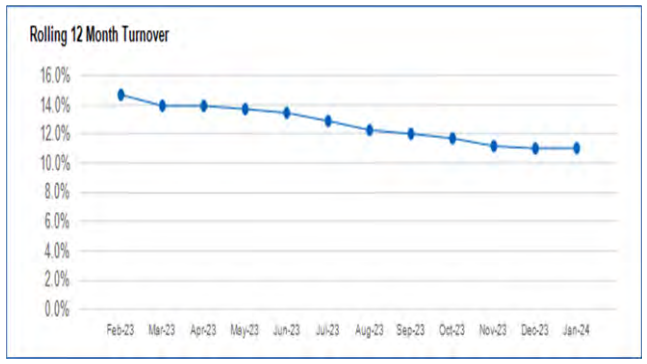
- Mandatory Training compliance has increased slightly to 88.9% as at end of January 2023 and is still under the 90% target across all sites.
- The appraisal season for Values Based restarts in April. Appraisal compliance for values based as at end of January is 64.2%. Values Based compliance at end of last year (March 2023) was 59.5% an improvement on last year. Medical & Dental is at 59.2% and does not restart until April.

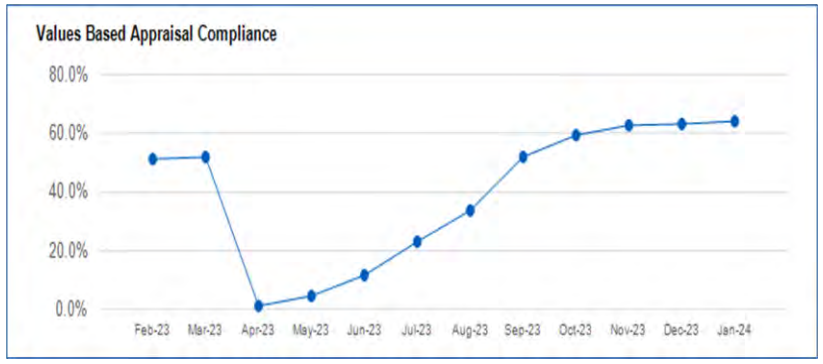
Turnover

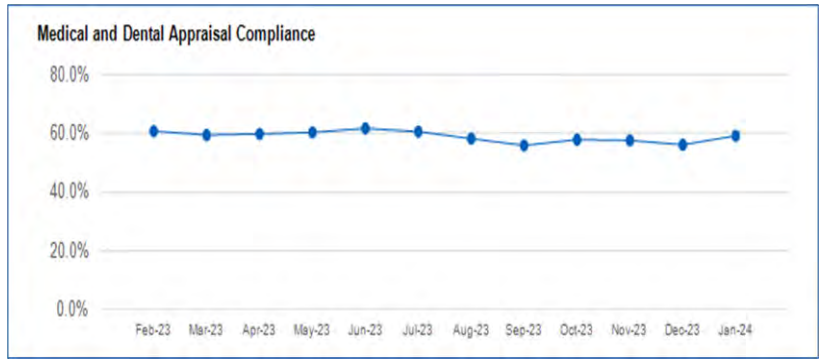
- Rolling 12 month Turnover rate (excluding fixed term temp) is at 11.1% (as at end of January 2023), which is a slight increase on last month; however, the trend remains downward over the year to date.
- The Medical and Dental data cleanse project is complete from a staffing perspective, some establishment 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.

Key Areas of Focus

- Information Governance is currently below the 95% national compliance required – currently it is 88.4%.
- Review of appraisal paperwork and training underway for 2024 appraisal season launch in April.







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	Dec 23	6.3%	-			6.5%	4.3%	8.7%
In Month Sickness Absence	Jan 24	4.9%	3.0%			5.0%	3.9%	6.2%
Mandatory Training Compliance at end of each month	Jan 24	88.9%	90.0%			87.2%	85.7%	88.7%
Temporary Hours Filled by Bank	Jan 24	53.5%	-			53.6%	47.2%	60.0%
Temporary Hours Filled by Agency	Jan 24	24.6%	-			23.2%	19.1%	27.3%
Agency Pay as Proportion of Total Pay	Jan 24	5.3%				4.7%	3.0%	6.3%

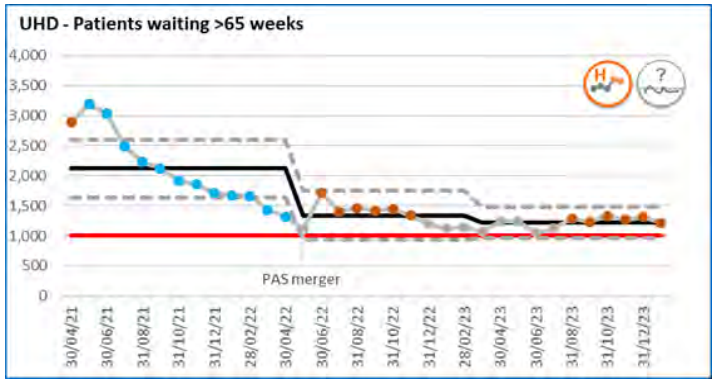
Population Health and System Working

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

Responsive – (Elective) Referral to Treatment)



	Standard	UHD	% of pathways with a DTA
Referral To Treatment			
18 week performance %	92%	60.3%	
Waiting list size (and trajectory)	76,589	67,983	21%
Waiting List size % variance compared to trajectory		-11.2%	
No. patients waiting 26+ weeks		17,786	31%
No. patients waiting 40+ weeks		8,435	32%
No. patients waiting 52+ weeks (and % of waiting list)	5.5%	3,722	34%
No. patients waiting 65+ weeks (and % of waiting list)	1.8%	1,220	36%
No. patients waiting 78+ weeks (and % of waiting list)	0.1%	86	34%
No. patients waiting 104+ weeks (and % of waiting list	0.0%	0	
% of Admitted pathways with a P code		97.97%	

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.

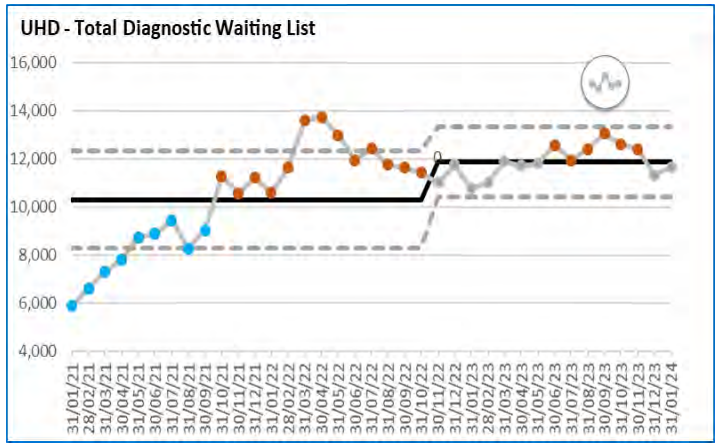
Performance

- The Trust is consistently achieving the target to reduce the total Referral to Treatment (RTT) waiting list. The size of the waiting list fell to 67,983 at the end of January 2024. This is 8,606 below the operational planning trajectory (76,589) and an in-month reduction of 984 (6.8% reduction since March 2023).
- RTT performance improved from 59.80% in December 2023 to 60.3% and remains above the Southwest Regional average.
- Industrial action by Junior Doctors in January 2024 and bed pressures resulted in the loss of the following capacity: 99 ordinary inpatient cases; 209 daycases; and 420 outpatient appointments.
- The operational plan trajectories were developed on the basis of no further industrial action in 2023/24. Consequently, the Trust missed the January trajectory for reducing >78-week waits. 86 patients were waiting >78 week at the end of January 2024, compared to 57 in December 2023 and against a planned trajectory of 37.
- >65-week waits also remained above trajectory however a reduction of 113 waits >65 week was achieved in January 2024.
- A sustained reduction in the cohort of patients who will breach 65-week waits if not seen or treated by March 2024 continues, with the cohort size of 2,522 remaining at the end of January (compared to 3,863 in December). This is a 93.8% reduction in the cohort since 31 March 2023.
- The planned trajectory for March 2024 is 276. Further industrial action by Junior Doctor's at the end of February may impact on the Trust's ability to deliver its reduction plan for longwaiters.

Key Areas of Focus

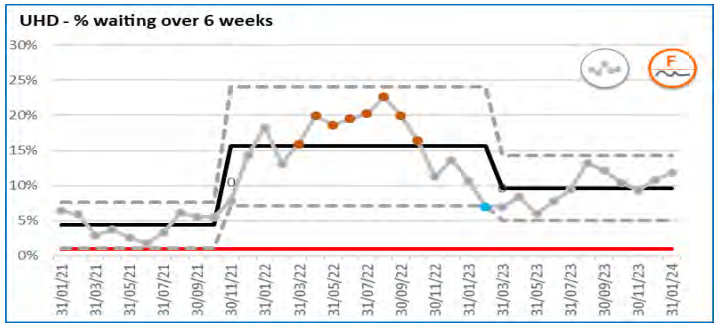
- To implement changes to RTT reporting in line with updated NHS England reporting guidance on Consultant led Referral to Treatment, ensuring all community pathways are reported through Community collections.
- Delivery of capacity plans to reduce 78 week waits to 0 by March 2024 and 65 week waits in line with the trajectory above, including additional capacity in surgery, gynaecology. neurology, dermatology, and respiratory medicine.
- Rebooking of appointments/operations for patients impacted by industrial action in February 2024
- Increasing productivity within core capacity. This includes reducing missed appointments (DNAs) and improving theatre and outpatient session utilisation rates.

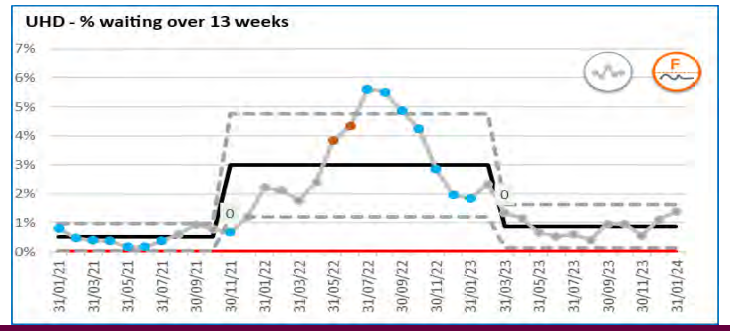
Responsive – (Elective) Diagnostic Waits



Diagnostic Performance (DM01)

% of >6 week performance	(6+ Weeks / Total)	1%	1372/11668	11.8%





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 overall diagnostics performance (DM01) has been delivered, despite pressures resulting from industrial action and bed occupancy. January 2024 performance was 11.8% compared to 10.8% at the end of December 2023. 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 161 patients waiting more than 13 weeks for a diagnostic test.

Endoscopy performance deteriorated to 11.8% at the end of January (10.3% at the end of December), predominately due to the impact of industrial action.

- There is ongoing use of 18weeks insourcing, the InHealth mobile endoscopy unit and waiting list initiatives (WLIs).

Echocardiography performance has slipped to 21.4% in January, from 18.2% in December, predominately due to 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.

Neurophysiology performance deteriorated to 29.3% in January from 22.4% in December.

- 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 slipped to 8.2% in January , from 8.0% in December, predominately due to cardiac imaging capacity.

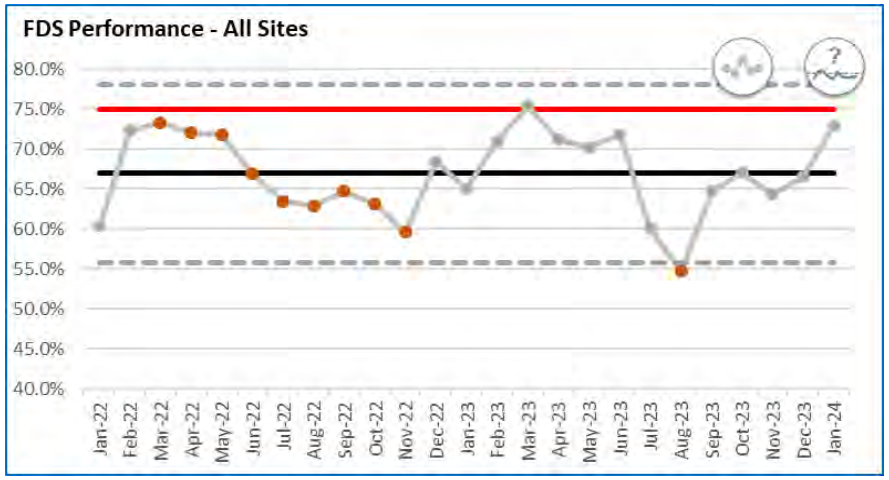
- Imaging – the target is not being achieved due to ongoing reduction in cardiologist CT / MRI sessions and ultrasound performance.

Key Areas of Focus

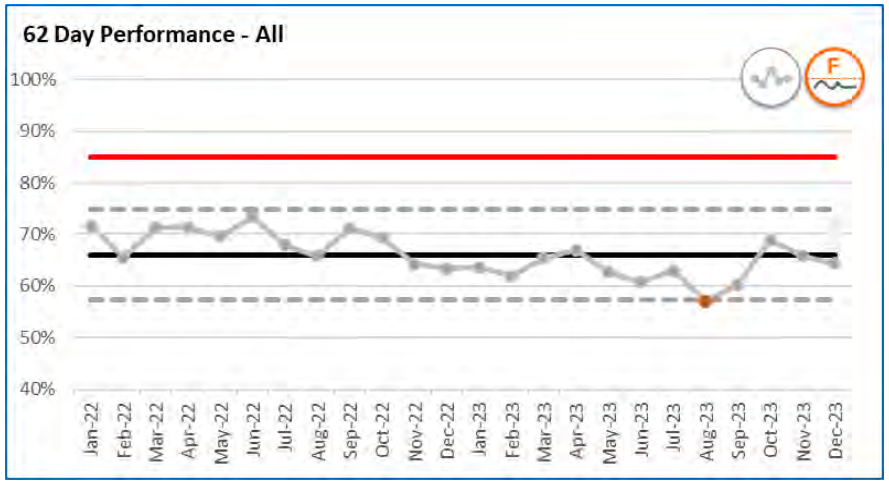
- **Endoscopy:** InHealth mobile unit - notice has been served, scheduled for removal 31/03/24. Plan in place for activity to be re-provided. Dr Doctor is being integrated with e-Camis for Endoscopy for ongoing management of bookings to ensure high utilisation.
- **Echocardiography:** DrDoctor is being integrated with TomCat to access the appointment reminder function for patients. Onboarding of new insourcing agency staff continues.
- **Radiology**: Mobile MRI scanner will remain at AECC full-time until end of March 2024. Agency Sonographers (via Healthshare) commenced Ultrasound services in the Outpatient Assessment Centre (OAC) during December 2023 (280 slots per week).
- A review of cardiac MRI provision for Dorset County Hospital patients (circa 20 slots/month). Maternity leave cover secured for MRI cardiologist. Scoping potential private providers to support in interim.
- Dr Doctor is being integrated with Soliton for Radiology with ongoing management of bookings to ensure high utilisation and low DNAs.

Responsive (Elective)
Cancer FDS & 62 Day Standard

28 Day Faster Diagnosis Standard (Target 75%)
Finalised UHD December Performance (66.6%)



62-Day Standard (Target 85%)
Finalised UHD December Performance (64.4%)



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 December Performance

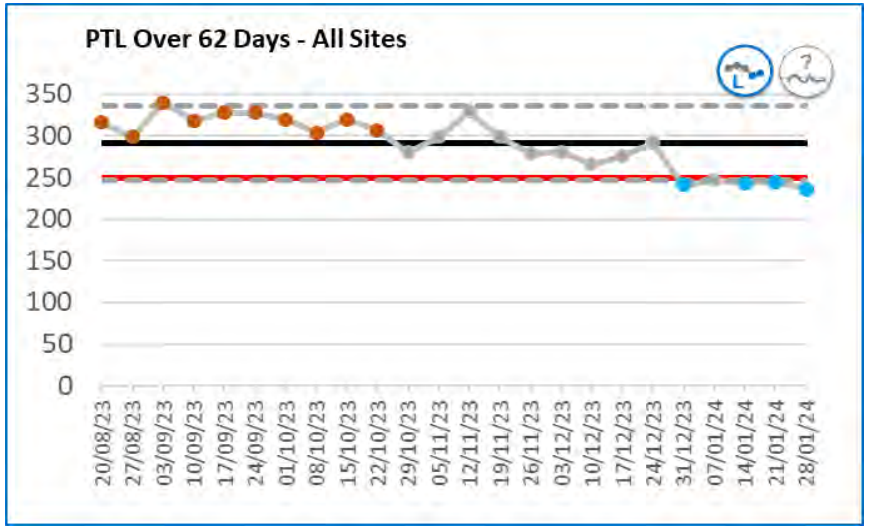
- 28 Day Faster Diagnosis Standard - Performance increased in December by 2.3% to 66.6%. Performance remains within the process control limits, which demonstrate the standard can be met within the current processes. The improved performance is mainly due to a reduction in the Gynae and Skin backlog with more patients being seen within 28 days. 9 out of 14 tumour sites achieved the standard. The main tumour sites affecting the performance in December were Skin and Colorectal.
- 62 Day performance in December 2023 decreased by 1.4% to 64.4% compared to November 2023. Performance demonstrates normal variation within the process control limits. The standard however is above the upper process control and therefore indicates this will not be met unless a process improvement is made. The main breach reasons in December 2023 were due to capacity issues at the front end of the pathway for Colorectal, Gynae and Skin.
- 31 Day performance was achieved in December (96.2%).
- The total number on the UHD Patient Treatment List (PTL) over 62 days decreased to 241 in December (38 less compared with November and 9 below the month's trajectory of 250).

Provisional January Performance (un-finalised)

- 28 Day Faster Diagnosis Standard – A further improvement is predicted in January 2024 with performance currently at 72.9% (meeting the January trajectory of 72.5%).
- 62 Day performance - The provisional performance for January is currently 57.6%, however this is expected to increase as further treatments are reported.
- 31 Day performance - The provisional performance for January is currently 94% (target 96%). This is mainly due to surgical capacity at Christchurch (Skin).
- The total number of patients over 62 days decreased further in January with the reported month end position being 236 against a trajectory of 250. Work is ongoing with the Care Groups to reduce the number of patients over 62 days including weekly clinical reviews of all long waiters to meet the March 24 target of no more than 220 patients.

Responsive (Elective)
Cancer Over 62 Day Breaches

62 Day Breaches (Target December: 250)
Finalised UHD December Performance: 241



High Level Performance Indicators

Cancer Standards	Standard	Final Dec-23	Provisional Jan-24
28 Day Faster Diagnosis Standarc	75%	66.6%	72.9%
31 Day Standard	96%	96.2%	94.0%
62 Day standard	85%	64.4%	57.6%

Key Areas of Focus

An The priority areas of focus for Quarter 4 2023/24 are Colorectal, Gynaecology, Iron Deficiency Anaemia (IDA) and Skin.

Key areas of focus for the 3 most challenged tumour sites include:

Colorectal:
- Cessation of the Faecal Immunochemical Test (FIT) <10 pathway in the Trust, which is moving to Primary Care in Q4 2023/24.
- Service to complete an up-to-date capacity and demand model to enable an improved performance position.

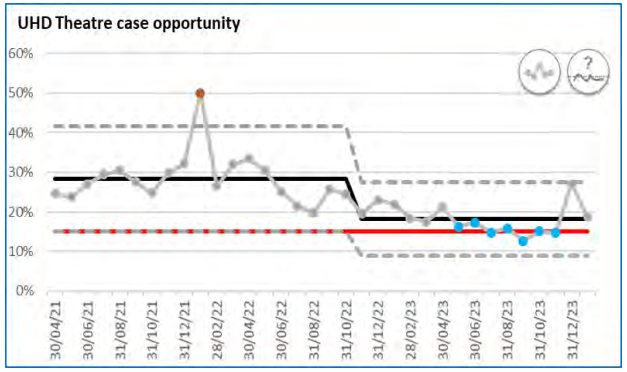
Gynaecology:
- Undertake a post implementation audit of the Post Menopausal Bleeding) post HRT pathway throughout Q4 to evaluate its impact on referrals and patient experience.
- Further communication and engagement with Primary Care to be provided to ensure the new PMB post HRT pathway is maximised as a referral route.
- Additional weekend hysteroscopy sessions planned throughout Q4 to provide additional capacity to improve performance.

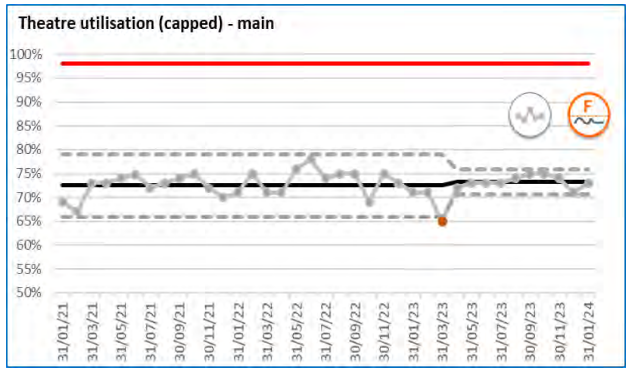
Iron Deficiency Anaemia (IDA):
- Service to complete a deep dive and recovery plan to support the Upper GI position.

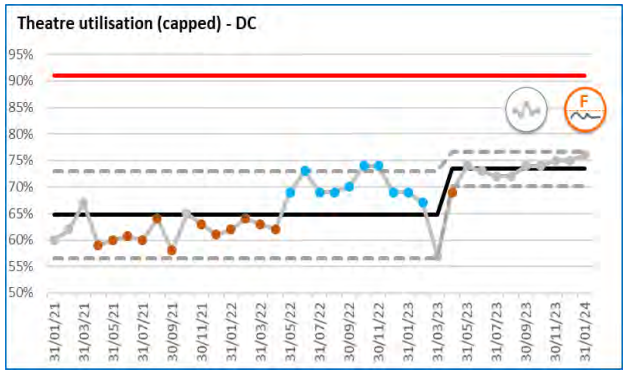
Skin:
- Insourcing solution sourced to provide additional Urgent Suspected Cancer Referral (USCR) capacity throughout Quarter 4 2023/24.
- Ensuring a financial plan is received from NHS Dorset to support the go live of tele-dermatology within the Trust.

Cross tumour sites:
- Potential increase in USCR's expected in light of the recent media relating to the King's diagnosis of a cancer and the Duchess of York. Referral numbers are being monitored daily.
- Promoting excellence in the basics including continuation of weekly clinical reviews of all long waiters to meet the over 62 Day trajectory for 220 patients by March 2024.
- Ensuring standardisation across all tumour sites for clinical triaging to improve efficiencies in outpatient clinic utilisation including breast one stop clinics.

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 current process. December 2023 was disrupted by industrial action and interrupted the improvement journey, the recovery from this alongside bed pressures has been ongoing throughout January 2024.
- 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. Strike action had a significant impact on the December 2023 key metrics however there has been an improvement in the capped utilisation (main theatre) as shown in the chart between Dec 23-Jan 24.
- As of the 28th January the average late start time in minutes sat at 29 minutes (all specialities). To note that since 28th Jan this has begun to fall.
- Orthopaedic improvement work continues to drive improvement across booked and capped utilisation (still below 75%); late starts, number of patients per 4-hour session; number of sessions and inter-case downtime; all triggering special cause variation and work to improve ongoing.
- 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.
- Activity increasing with average cases per session between December and January for specialities including ENT, OMF & Breast.
- For touch time utilisation across all specialties between the 31/12/23 and the 28/01/24, there was an increase from 72.07% to 76.78%.

Underlying issues:

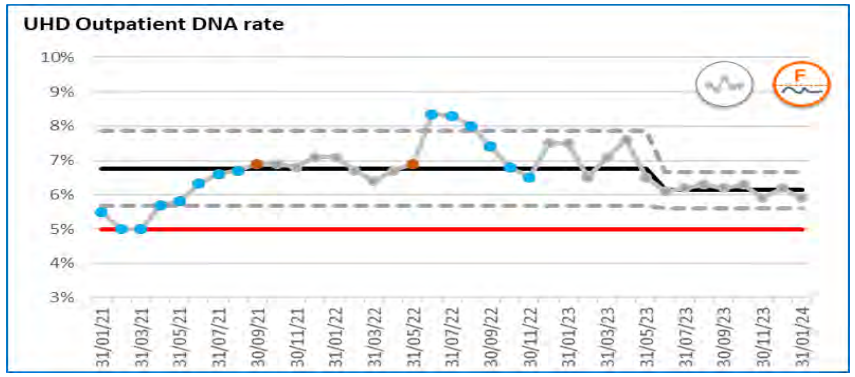
- On the day cancellations have increased throughout January 24, alongside bed occupancy, impacting list utilisation.
- Ongoing staffing shortages across theatres remains a barrier to providing a full template for all surgical specialities, noting improvement as above. Seasonal illnesses have also impacted staffing throughout staffing groups.
- Orthopaedic lists remain challenged impacting wider efficiency markers, noting improvement in several areas outlined above.
- High utilisation variability across Oral Surgical lists whilst the upper process limit is closer to target the performance is variable.

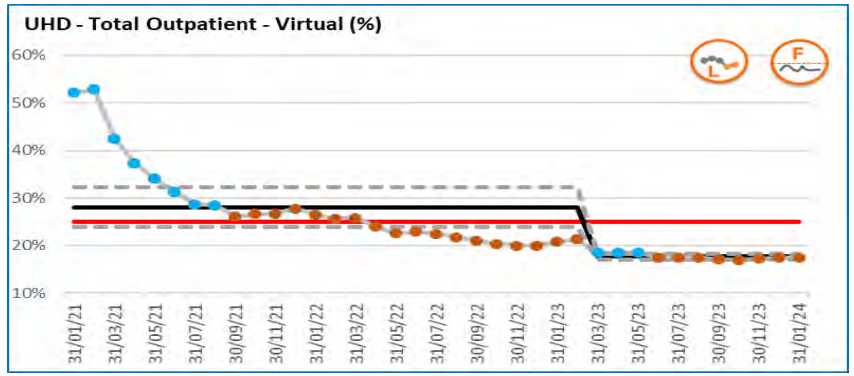
Key Areas of Focus

- Capacity and Demand work is ongoing. Staffing and activity trajectories completed and are now being assimilated into planning.
- Pursuing an opportunity to use 'process mining,' software to more effectively identify areas of opportunity.
- Targeted work underway to focus on orthopaedic and OMF utilisation, including booking habits to improve list utilisation and reduce case opportunity. The Orthopaedic team are also adopting use of the CCS tool, training continues to be rolled out.
- Implementation of MyPreOp and linkage to the CCS tool to support Pre-Op Assessment: integration is now ready for testing and work is ongoing to validate the information which would be seen when the integration is live on the CCS platform.
- Live theatre reporting and performance screens near to going live.
- The awaited output of the NHSE review of theatres will form the foundation of the improvement programme and next steps to delivering sustained improvement in theatre productivity.
- The next round of Junior Doctor IA will run from 24/2/24 to 28/2/24 and will have a direct impact on the metrics as seen previously.

Responsive (Elective) Outpatients

Referral Rates (MRR Return)		Standard	This Year	Trust Perf
GP Referral Rate year on year		-0.5%	102958	-2.0%
Total Referrals Rate year on year		-0.5%	155970	-3.8%
Outpatient metrics				
Overdue Follow Up Appointments (Cons-Led Only)				26506
New Attendances				22016
Follow-Up Attendances				32662
% DNA Rate	*(Total DNAs / New & Flup Atts)*	5%	3418 / 54678	5.9%
Hospital cancellation rate	*(Hospital Canx / Total Booked Appts)*		12641 / 79738	15.9%
Patient cancellation rate	*(Patient Canx / Total Booked Appts)*		9001 / 79738	11.3%
Reduction in face to face attendances (acute only)				
% telemed/video attendances	*(Total Non F-F / Total Atts)*	25%	9595 / 54678	17.5%





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 December continues to represent normal variation. The Trust plans to switch on text reminders across all clinics in February 26th 2024, unless a clinically led opt-out rationale is provided by specialty teams (currently 54% of all clinics have text reminders switched on).

17.5% of attendances were delivered via telemedicine/video. 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. The Trust will be moving to Dr Doctor for video consultations from April 2024. A change programme and communications to support this are being developed. Formal notice has been submitted to decommission the previous provider.

The number of patients overdue their target date for a follow up appointment fell marginally in January 2024. The reduction was less than forecasted due to the impact of industrial action on delaying follow up appointments. A further 'Quick Question' validation exercise is to be undertaken this month.

Key Areas of Focus

- Provide tools to care groups to continue to review clinic utilisation rates and complete template reviews by specialty and monitor progress. Roll out plan with care groups being developed.
- 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.
- Embedding the outpatient performance dashboard (including all Outpatient KPIs) into performance management practices at Care Group and speciality level. Plan to launch Outpatients Care group Forums in mid/late March 2024.
- Continuing to promote telemedicine/video and the benefits for patients.
- E outcomes project -Trial with rheumatology due to commence early/mid March 2024 following resolution of IT data quality issues.
- Manage decommissioning of virtual consultation platform and transfer to DrDoctor – 31 March 2024
- Work has started to scope available Trust capacity on Bookwise with a plan to use this as the single system for capacity management within the Trust. Scoping of additional funding to add additional rooms to existing capacity (on Bookwise) underway.
- Two-way rescheduling kick off meeting held and cardiology to trial approach. Project plan being developed with a plan for implementation by September 2024.

Responsive - (Elective) Screening Programmes

Breast Screening

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

BREAST SCREENING	STANDARD	ACHIEVED
Round Length within 36 months	90.00%	99%
Screening to first offered assessment appointment within 3 weeks	98.00%	93%
Screening to Normal Results within 14 days	95.00%	99%
Longest Wait Time (Months)	36	36
UPTAKE – QTR 2 (July - Sept)*	70%	58%

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

Performance:
- The screening to first offered assessment appointment target has not been met in January 2024
- All other targets have been successfully met.
- The quarterly uptake figure has reduced to 58% which is lower than anticipated.

Underlying issues:
- The screening to first offered assessment metric has been impacted on due to lack of clinical assessment cover reducing the screening throughput. This has also been impacted by long term clinical workforce reduced capacity (long term sickness).
- Quarterly uptake has been impacted on by poor patient attendance, including a cohort who historically have very low uptake rate.

Actions:
- There have been significant issues with the Bournemouth screening site and equipment which has resulted in a loss of screening in that location for the last two months. Efforts are being made to establish a new site with Tesco,Castle Lane.
- Using a combination of DrDoctor and GOV.UK regular non responder and appointment reminder texts are being sent. Further integration project work is underway to enable automated appointment reminder texts.
- The paper-lite working project is going exceptionally well and all Poole clinics are now processed paperless through to film reading. This has improved the turnaround and screening results are being processed far quicker .

Bowel Screening

Bowel Screening Standard	Target	Trust January Performance
SSP Clinic Wait Standard (14 days)	95%	100%
Diagnostic Wait Standard (14 days)	90%	97.30%

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

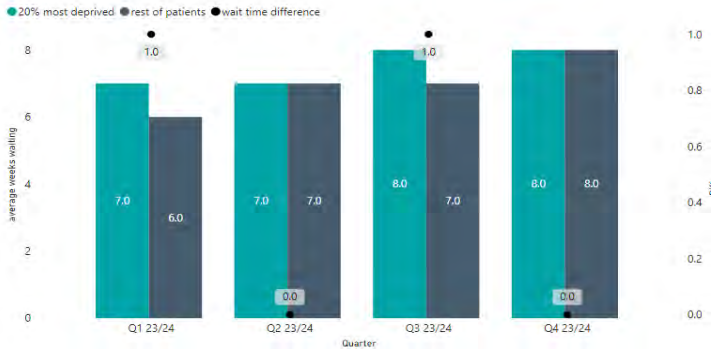
Performance:
- SSP Clinic Wait Standard: This standard continues to be maintained at 100%.
- Diagnostic Wait Standard: This standard was delivered at 97.3% in January 2024.

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.
- Next phase of age extension due April 2024

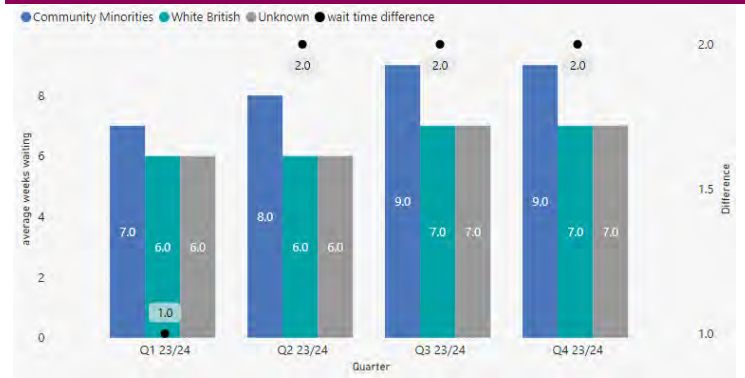
Actions:
- Deliver plans with Dorset County to use additional insourcing capacity in 23/24
- Review insourcing plan for UHD for remainder of 23/24
- Support accreditation process for 2 potential new screeners and identify other endoscopists where possible

Health Inequalities

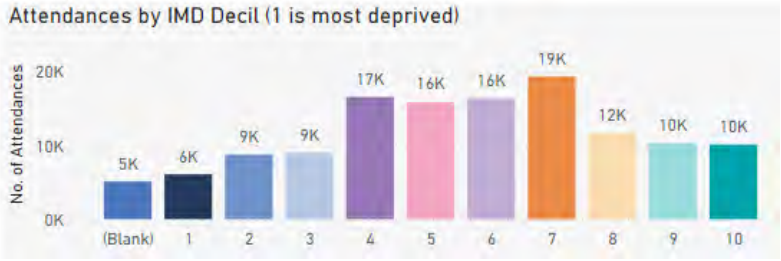
Median Weeks waiting and DNAs by Deprivation Group



Median Weeks 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, 8.4% of patients on the waiting list live in the 20% most deprived areas of Dorset. The median weeks waiting at the point of treatment shows no variation between patients from the 20% most deprived group and the rest of the population treated.

Waiting list by age band: There is variation between age and length of wait on the waiting list with the greatest variation between 0-19yrs and 20+ age bands. The level of variation between 0-19yrs and older age bands has increased from 2 weeks in Quarter 3 2023/24 to 5 week in Q4 to date. Ongoing monitoring during the quarter is in place.

Waiting list by ethnicity: 10.8% of patients on the waiting list are from community minority ethnicity groupings. An analysis of the median weeks waiting by ethnicity grouping identifies a 2 week variation between patients within community minority groups and White British populations in Quarter 4. This is unchanged since Q3 2023/24.

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

Key Areas of Focus

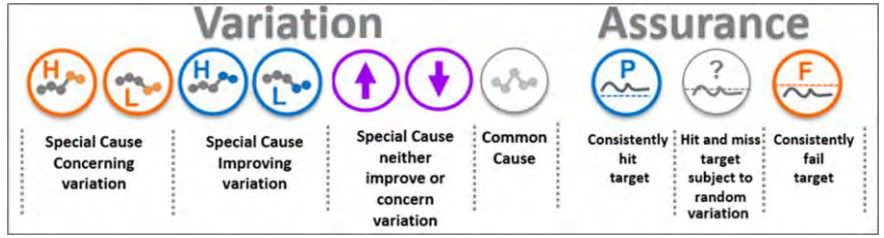
The Trust Health Inequalities group are working to:

- 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.

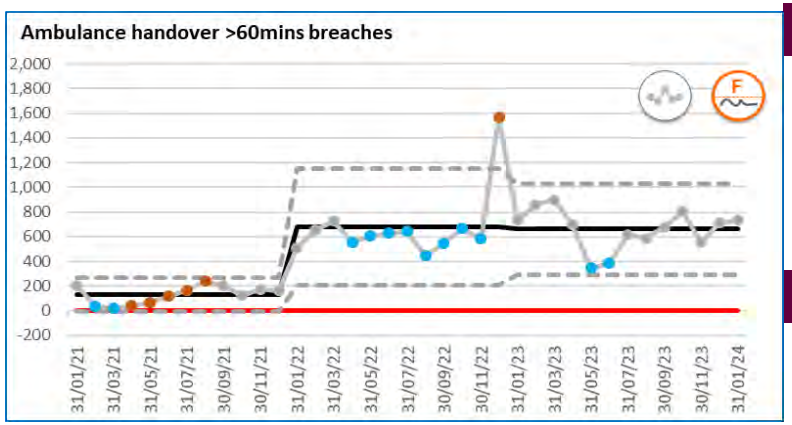
Performance at-a-glance
Responsive (Elective) - Key Performance Indicators Matrix

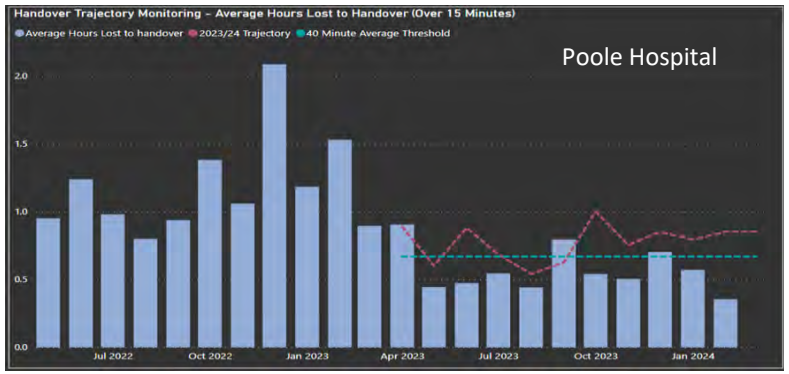
UHD Elective Care

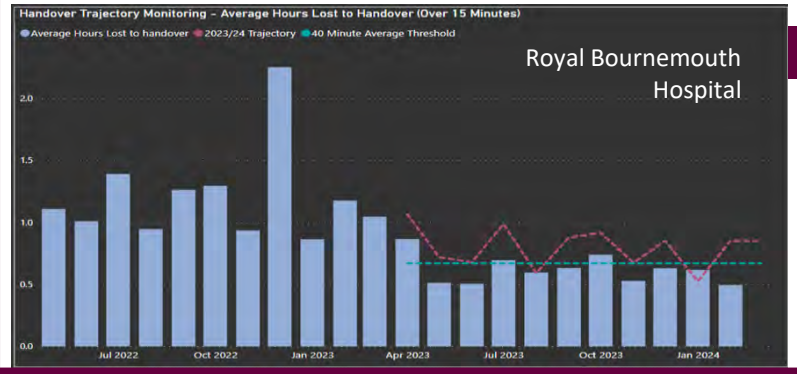
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
UHD - Total Waiting List Size	Jan 24	67983	76589	L	P	72509	69538	75480
UHD - Patients waiting >104 weeks	Jan 24	0	0		P	0	0	0
UHD - Patients waiting >78 weeks	Jan 24	86	-	L		620	382	857
UHD - Patients waiting >65 weeks	Jan 24	1220	1009	H	?	1218	961	1475
UHD - Patients waiting >52 weeks	Jan 24	3722	-	L		3886	3139	4634
UHD - Patients waiting >52 weeks non admitted	Jan 24	2460	0	L	F	3125	2737	3513
UHD - RTT Performance against 18 week standard	Jan 24	60.3%	92.0%		F	59.0%	55.5%	62.4%
UHD - Total Diagnostic Waiting List	Jan 24	11668	-			11872	10406	13339
UHD - % waiting over 6 weeks	Jan 24	11.8%	1.0%		F	9.6%	5.0%	14.3%
UHD - % waiting over 13 weeks	Jan 24	1.4%			F	0.9%	0.1%	1.6%
Cancer 2ww Referrals	Jan 23	3029	-			2982	1533	4430
UHD - Faster Diagnosis Standard (FDS) 28 days	Dec 23	66.6%	75.0%		F	65.7%	59.2%	72.1%
UHD 62 day standard	Dec 23	64.4%			F	63.5%	53.6%	73.3%
Trauma Admissions	Jan 24	366	-			365	303	428
% of NOF patients operated on within 36 hrs of admission	Jan 24	73.0%	85.0%		F	46.6%	13.0%	80.2%
UHD - Total Outpatient - Virtual (%)	Jan 24	17.5%	25.0%	L	F	17.7%	17.0%	18.3%
UHD Outpatient DNA rate	Jan 24	5.9%	5.0%		F	6.1%	5.6%	6.7%
Theatre utilisation (capped) - main	Jan 24	73.0%	98.0%		F	73.3%	70.6%	76.0%
Theatre utilisation (capped) - DC	Jan 24	76.0%	91.0%		F	73.4%	70.1%	76.7%
UHD Theatre case opportunity	Jan 24	18.8%	15.0%		?	18.6%	9.0%	27.5%



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.

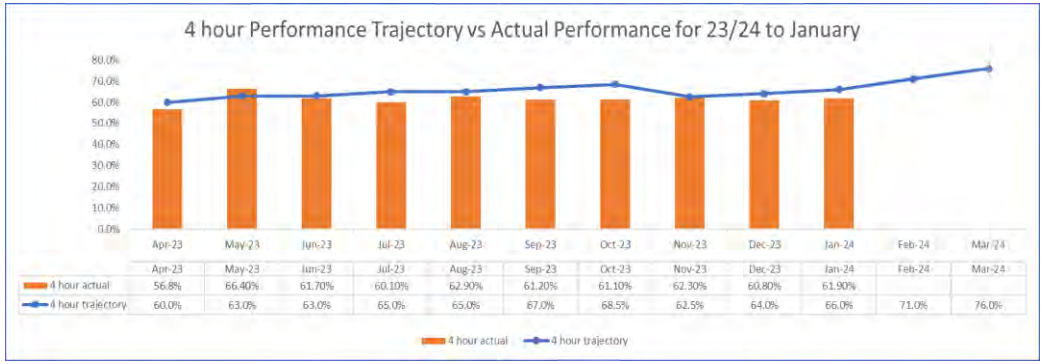
Performance

- January saw slightly fewer Ambulance handovers than December at 4394 vs 4456 in December. However, this was not an equal reduction with RBH ambulance attendances up by c3 a day, and Poole down by c5 per day. Both sites received significantly more Ambulances than in January 2023 by approximately 34 a day cross site.
- There was a slight drop in performance for the number of Ambulances waiting longer than 60 minutes up to 733 vs 711 in December, which is consistent with January 2023.
- The total number of handovers that were over 60 minutes in January was 16.7%, an increase of 3% from last month.
- Based on the 15-minute ambulance handover standard Poole reported a total of 1005 hours lost, and RBH 1188 hours in January.
- In the South-West there was a total of 38,000 hours lost between the 19 Trusts reported by SWAST. 2348 of these hours were lost in Dorset.

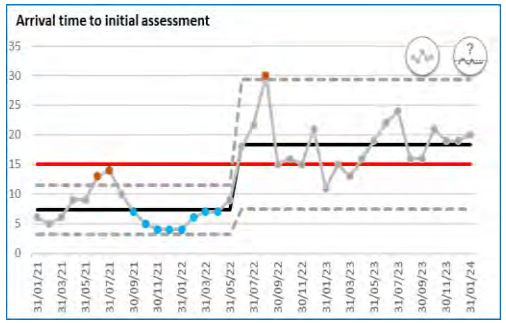
Key Areas of Focus

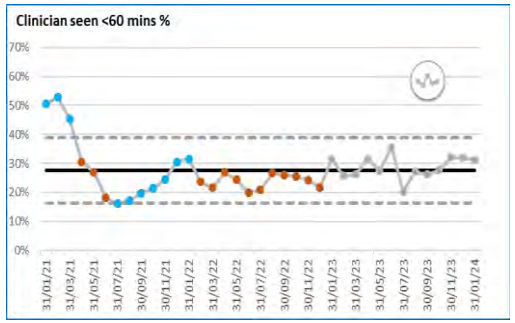
- XCAD (Ambulance reporting system) went live as planned for ED in December 2023, we have started to see an increase in the data accuracy, especially when patients are cohorted by SWAST in the corridor.
- The Trust risk register relating to Ambulance Handover remains at 15 with focus on supporting cohorting of patients with SWAST to enable prompt and safe handover.
- This has been challenging to sustain due to increased numbers of patients presenting with COVID/RSV. Subsequent impact resulting in a delayed handover until appropriate Infection Prevention and Control compliant clinical space can be made available as ED/Ambulance corridors would be unsuitable. This risk has been reducing through January

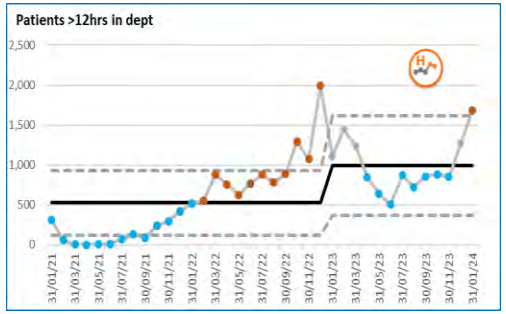
Responsive (Emergency) Care Standards

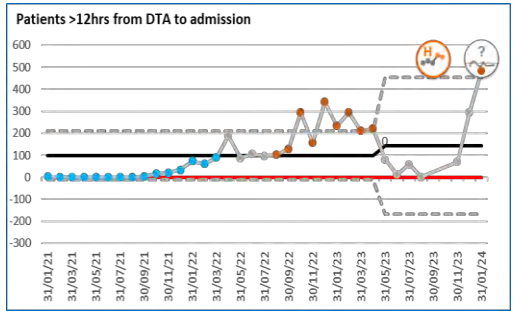


	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
4 hour actual	56.8%	66.40%	61.70%	60.10%	62.90%	61.20%	61.10%	62.30%	60.80%	61.90%		
4 hour trajectory	60.0%	63.0%	63.0%	65.0%	65.0%	67.0%	68.5%	62.5%	64.0%	66.0%	71.0%	76.0%









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 61.9% against the revised trajectory of 66% in January. The run rate for the month remained challenging with severe operational pressures which resulted in reduced access to SDEC as these areas supported the >100 escalation beds opened in January. The department has however seen an improvement in performance since December.

- Total attendances for January were marginally higher than December, but are significantly higher than January 2023.
- Arrival time to initial assessment increased slightly to 20 minutes, and mean time in the department saw an increase by 20 minutes to 349 minutes vs 326 in December.
- Whilst an improvement from this time last year this is largely driven by admitted flow and challenging bed position delaying moves out of the department. Whilst decision to admit remained relatively static at 278 minutes vs 271 in December, total number of patients waiting more than 12 hours from decision to admit saw a significant increase for the second successive month to 482 from 92 in November
- The total number of patients spending more than 12 hours also increased for the second month in a row to 1681 from 843 in November.

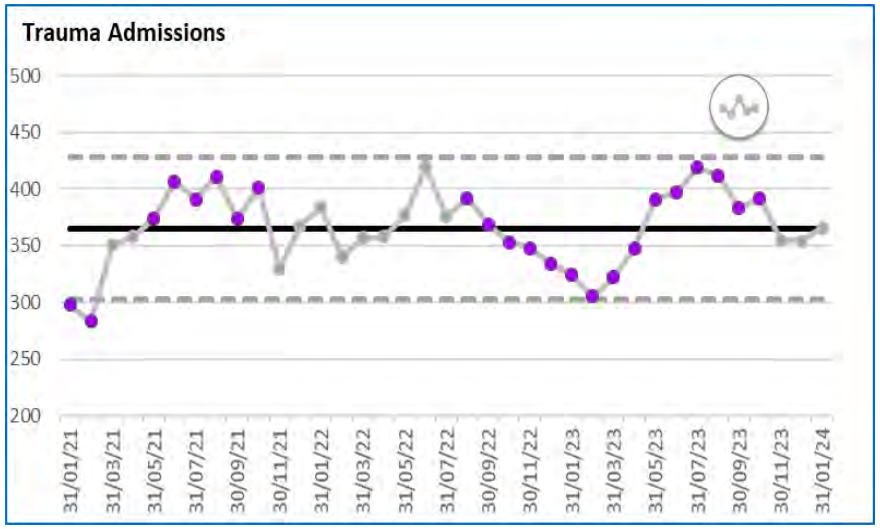
Key Areas of Focus

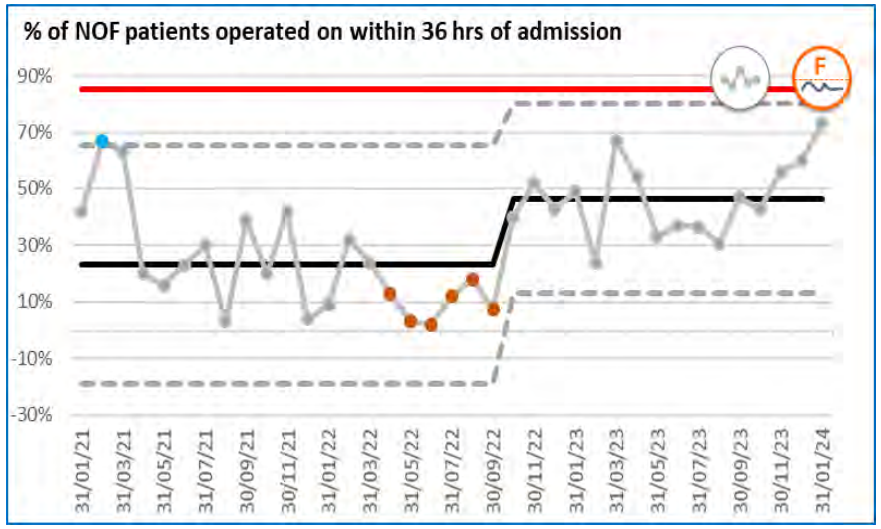
SDEC availability now on a 1:3 basis for Medicine at weekends and 6 days a week for Surgery every weekend.

Actions taken in Q3 focused on supporting and increasing senior decision-making capacity within the non-admitted function of the emergency department. This has supported a small improvement. As a department Non-Admitted performance continues to average 61% with range 52%-70% over the last 4 weeks. Admitted performance has averaged 17.3%, range 9%-33%

Review of UTC service provision cross site is on-going with, with ongoing discussion with commissioners to confirm the contract activity levels by slot allocation. Once agreed we will improve slot utilisation and direct streaming from ED to UTC further.

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

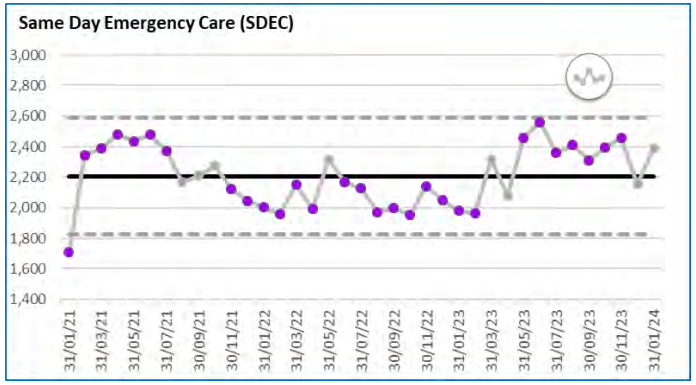
January performance for time to theatre for fractured neck of femur (# NoF) patients: 88% achieving surgery within 36 hours of being fit for surgery and 73% operated on within 36 hours from admission.

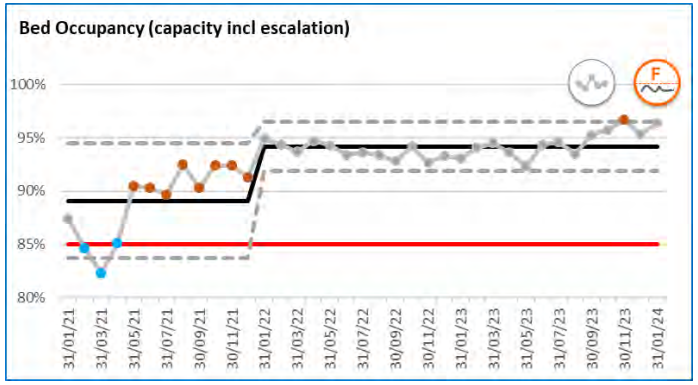
- Overall trauma admissions sustained at high levels with 366 in January including 93 with a fractured neck of femur (NoF).
- 9 of the 93 NoF's were unfit for surgery on admission
- 16 Shaft of femur (SoF) fractures admitted in January with 15 requiring surgery, 8 patients with a # NOF required a THR
- 9 patients required 2 trips to theatre, equating to an additional 11 theatre cases .
- The barn theatres are working well. Ongoing work to review case mix and paediatric capacity.

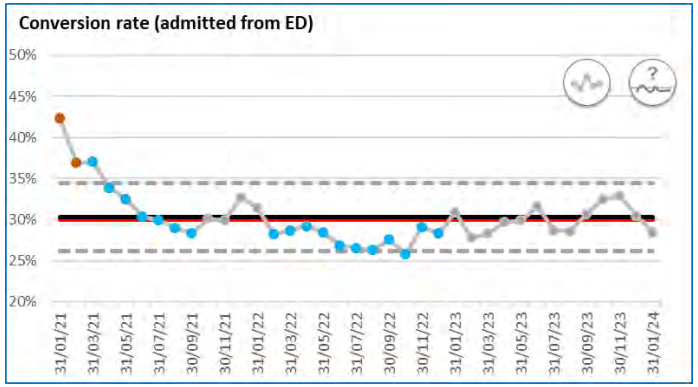
Key Areas of Focus

- e-Trauma , Go live completed 15th January 2024. Digital ED link to Virtual Fracture Clinic (VFC) has ceased due to Agyle implementation, which will delay e-trauma VFC implementation. Risk register updated as increase in delays in fracture clinic reviews is causing capacity issues.
- eTrauma now includes VTE assessment element
- Hand Hub has commenced operating 2 sessions per week with 18 patients through service releasing 9 main theatre sessions
- Trauma outliers continue to remain low.

Responsive – (Emergency) Patient Flow







Data Description and Target

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

Performance

Bed occupancy increased in January. As previously reported the average occupancy for the first 3 weeks of December (to exclude Christmas variation) was 1075, this increased to 1097 for January.

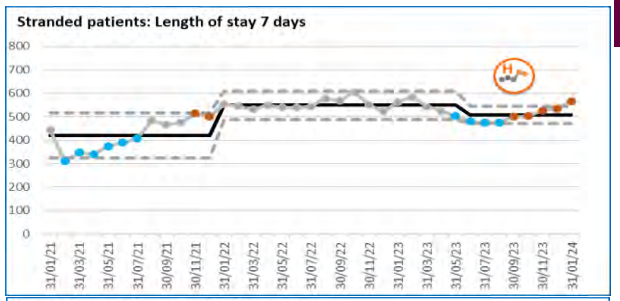
The average number of escalation beds open in January increased by more than 30 to 95 (range 77-107). Despite this there were significant delays with patients waiting for beds.

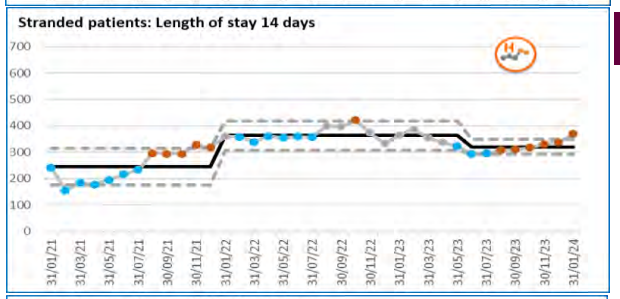
No Criteria to Reside (NCtR) continues to impact occupancy and escalation. NCtR again increased as an average in January, to 235, peaking at 271 in early January. February to date remains consistent with the January average position.

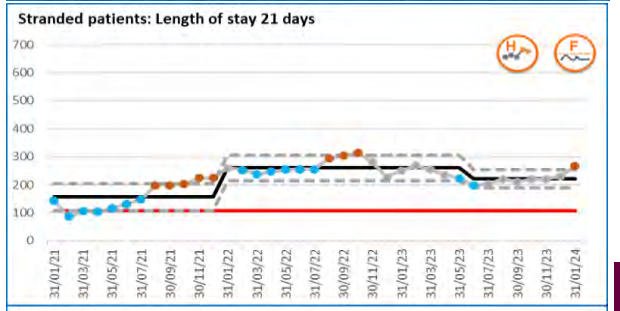
Key Areas of Focus

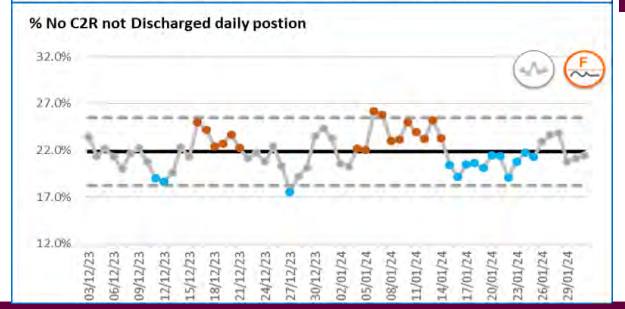
- At ICB level a 5-point plan has been agreed for Q4 and is being monitored through the weekly meeting with system partners, at the time of reporting there has been no impact on Dorset wide NCtR numbers.
- UHD has developed a recovery plan that has been agreed by UHD Executives and shared with system partners. This 3-phase plan drives the closure of escalation over the last 6 weeks of Q4 with prioritisation focused on re-instating services displaced by escalation – SDEC, TIU, Day case areas. UHD will then 'hold the line' on not reopening the escalation capacity, with the ask to system partners to create flow to prevent ED crowding and Ambulance Delays.
- 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.
- Virtual Ward capacity and occupancy continues to grow, with >50 patients occupying a Virtual Ward bed throughout January. On average there were 76 patients per week being admitted, with over 1050 Occupied Bed Days recorded.

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.

Additionally from November Trusts were asked by NHS England to confirm that a Discharge Ready Date metric is published and reviewed by the Trust Board. This is published by UHD and will be reported via this IPR moving forward.

Performance

21+ day length of stay position shows wards are far from the target of a maximum of 108 patients, in January the average number was 266 which is 40 higher than December.

UHD has been consistently showing as an outlier in the South-West with a higher percentage of bed base occupied by patients with NCtR. January continues to see this at c24%, with the number of patients still waiting in beds at UHD consistently >230.

The ICB ambition to achieve a 50% reduction by the end of Q2 has been substantially missed and would require c140 additional discharges to deliver the target of 120.

The challenge of delayed patients in beds remains the key issue both in terms of UHD position in the South West, and operational pressures and ongoing levels of escalation (40 funded plus >50 unfunded beds – with over 100 open on 6 separate days in January and concurrently c40 in our Emergency Departments for long periods waiting for beds).

In terms of the new Discharge Ready Date metric this is currently captured for c70.6% of patients as at 14th February 2023.

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.

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.

Focused work is progressing towards using EDR as discharge planning date for P1/2 patients, with ambition to reduce LoS by 5-8 days for this group of patients

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

UHD Urgent and Emergency Care

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Arrival time to initial assessment	Jan 24	20	15			18	7	29
Clinician seen <60 mins %	Jan 24	31%	-			28%	16%	39%
Patients >12hrs from DTA to admission	Jan 24	483	0			143	-168	455
Patients >12hrs in dept	Jan 24	1681	-			993	371	1616
4 hour safety standard	Jan 24	61.9%	76.0%			61.9%	56.4%	67.5%
Ambulance handovers	Jan 24	4394	-			4266	3858	4673
Ambulance handover 30-60mins breaches	Jan 24	1238	-			866	640	1092
Ambulance handover >60mins breaches	Jan 24	733	0			661	291	1032
Bed Occupancy (capacity incl escalation)	Jan 24	96%	85%			94%	92%	97%
Stranded patients: Length of stay 7 days	Jan 24	566	-			507	470	544
Stranded patients: Length of stay 14 days	Jan 24	370	-			321	292	349
Stranded patients: Length of stay 21 days	Jan 24	266	108			221	188	254
UHD NCTR % - all delays	Jan 24	40.0%	-			47.0%	40.2%	53.9%
Non-elective admissions	Jan 24	6538	-			5982	5130	6833
> 1 day non-elective admissions	Jan 24	3981	-			3756	3187	4325
Same Day Emergency Care (SDEC)	Jan 24	2391	-			2208	1828	2588
Conversion rate (admitted from ED)	Jan 24	28.5%	30.0%			30.3%	26.1%	34.4%

Sustainable Servicers

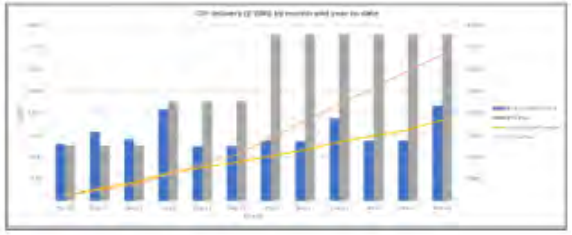
Pete Papworth
Chief Finance Officer

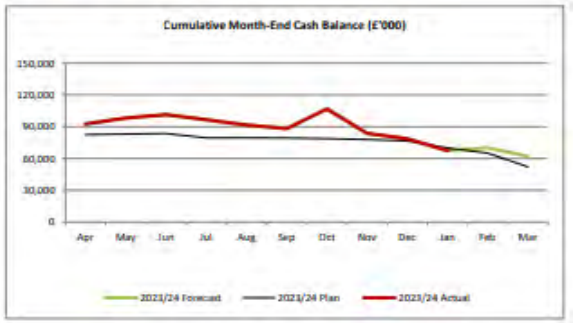
Operational Lead:
Andrew Goodwin, Deputy Chief Finance Officer

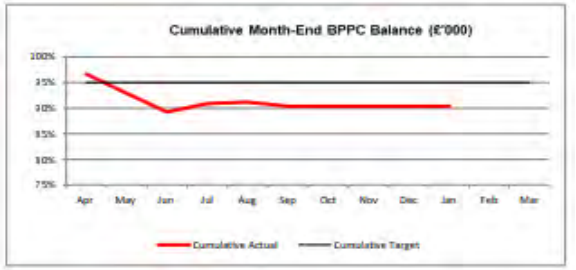
Committees:
Finance and Performance Committee

Finance

FINANCIAL INDICATORS	Year to date Budget £'000	Actual £'000	Variance £'000
Control Total Surplus/ (Deficit)	(2,587)	(15,906)	(13,318)
Capital Programme	105,410	68,086	37,324
Closing Cash Balance	69,873	67,330	(2,543)
Public Sector Payment Policy	95.0%	90.4%	(4.6)%







Commentary

At the end of January 2024 the Trust has reported a deficit of £15.9 million against a planned deficit of £2.6 million representing an adverse variance of £13.3 million. This is mainly due to a reduction in elective income of £1.4 million reflecting lower than planned activity; energy cost inflation of £4.1 million; and unfunded escalation costs of £5 million. Premium cost pay overspends within Care Groups have been partially off-set by additional bank interest and reduced depreciation charges.

Efficiency savings of £14.9 million have been achieved against a target £25.8 million. Current savings plans total £18.3 million representing a shortfall of £15 million and a recurrent shortfall of £21.4 million. In addition to targeting further savings for the current year, increasingly, the focus is shifting to the development of plans for next financial year.

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 £2.8 million cost of the December and January Industrial Action is an allowable variance to this forecast. It should be emphasised that considerable risk remains inherent within this forecast and focused effort is required by all NHS system partners to achieve the revised outturn projection.

A formal request has been submitted to the national capital team to re-profile £19.1 million of capital funding into future years. This reflects the current forecast expenditure profile of the acute Re-configuration (STPW1) programme. Should this request not be supported, the Trust would be a considerable risk as this funding cannot be drawn down in advance of spend and would therefore be lost.

CAPITAL	Year to date Budget £'000	Actual £'000	Variance £'000
Estates	10,174	5,844	4,330
IT	8,460	4,076	4,384
Medical Equipment	3,510	2,904	606
Donated Assets	540	791	(251)
Strategic Capital	82,726	54,471	28,255
Total	**105,410**	**68,086**	**37,324**

As at 31 January 2024 the Trust is holding a consolidated cash balance of £67.3 million which is fully committed against the future Capital Programme. The balance attracts Government Banking Services interest of 5.14% at current rates, together with a PDC offset benefit of 3.5%.

In relation to the Public Sector Payment Performance the Trust is currently delivering performance of 90.5% against the national standard of 95%. Financial Services continue to work closely with relevant teams to identify further mitigating actions.

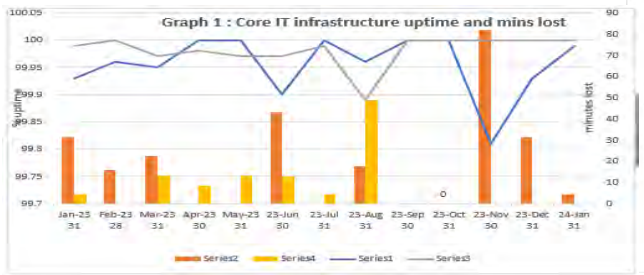
Digital Dorset / Informatics

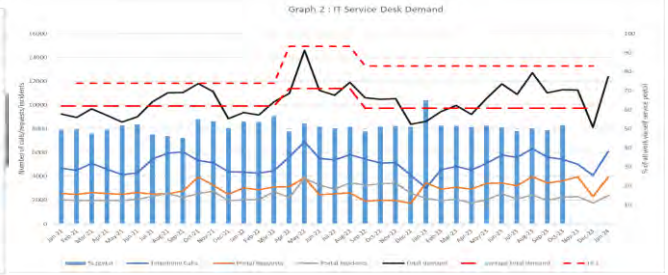
Pete Papworth
Chief Finance Officer

NHS
University Hospitals Dorset
NHS Foundation Trust

Well Led - Informatics (1)

Business as usual / Service Management





Projects / Developments / Security / IG

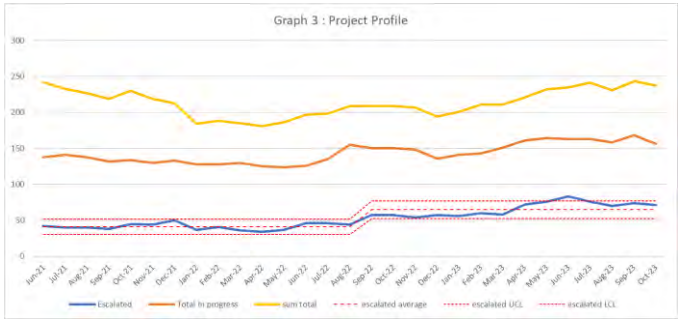


Table 5: Training Statistics

Total Trained in January: 426

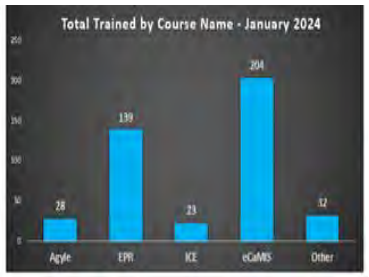


Table 4: Information Asset Compliance

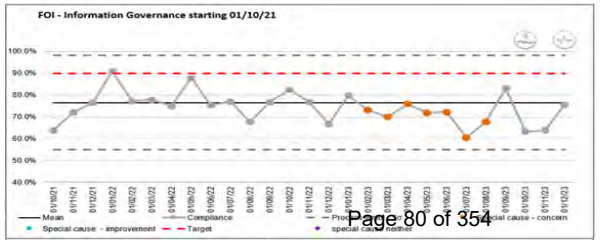
All Active Assets

Status	Total	%
Draft Only (Pending Updates)	19	6.74%
Awaiting IAO Review/Approval	207	73.40%
Awaiting IG Review/Approval	16	5.67%
DSPT Compliant (2023/24)	40	14.18%
Total	282	

Table 6: 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%

Table 7: FOI compliance



Commentary

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

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

Graph 3. Progress continues to be made on the IT projects moving forward with clear governance on all programmes of work.

Table 5 shows the staff trained by system in January.

Table 6 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.

Table 7 shows a 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.

Well Led - Informatics (2)

Table 8 UHD Scanning Bureau Stats January 2024

	Poole	RBH	Total
Hugh Symons Scanned - Notes - Images	112,156	450,100	**562,256**
Hugh Symons Scanned - Loose Paper - Images		32,706	**32,706**
Scanned In House - Notes - Images	478402	176080	**654,482**
Scanned in House - Loose Paper - Images		210	**210**
Case Note Tracking Errors Found	183	66	**249**
Incorrrect Uploaded Notes - Number of Patients		7	**7**
Incorrect Filing in Notes - Number of Patients	109	170	**279**
Number of Blank Outpatient Case Notes Prepared / Delivered / Returned / Shredded	3,033	1431	**4464**

Commentary

Table 8 Shows the scanning stats and record errors found in this process - an image is one side of a piece of paper.

Table 9 Subject Access Requests continue to come into the team with increasing complexity - the current database is calculating breaches incorrectly - none for January 2024

Graph 10 Shows data quality errors continuing to be made

Table 11 Shows key applications system outages. IPR Format and content under review within Informatics.

Table 9 SUBJECT ACCESS REQUESTS

Compliance by Date of Receipt - Stats (Home)			
Month	**Total**	**Compliant**	**Breach**
2023 (11) November	232	227	5
2023 (10) October	260	237	32
2023 (09) September	255	252	3
2023 (08) August	268	263	5

Graph 10:Demographic Data Quality - NHS Numbers, Merges & Deceased Status

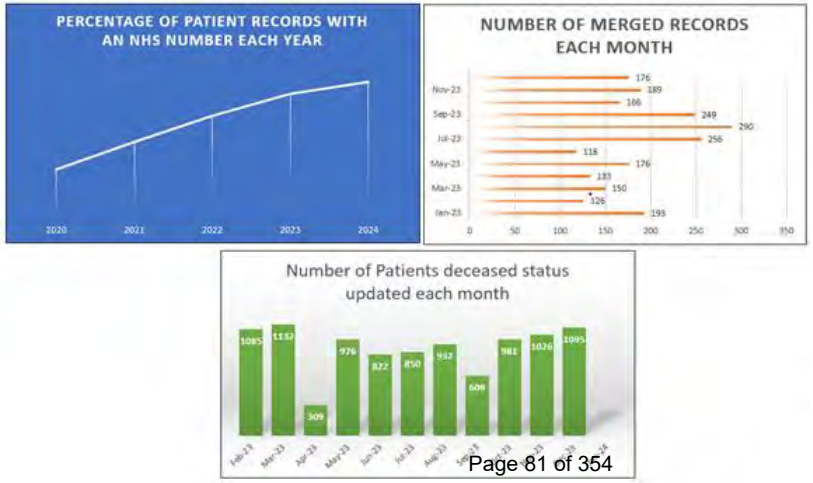


Table 11 Key Application Unplanned Downtime
8th January 1515-1745 EPR Server 3 issue - Server refreshed to resolve
15th Jan 1500 - 16th Jan 1056 Health of the Ward - Patients not Refreshing Scheduled change was made to specialties, but this caused synchronisation issues. Change Reversed

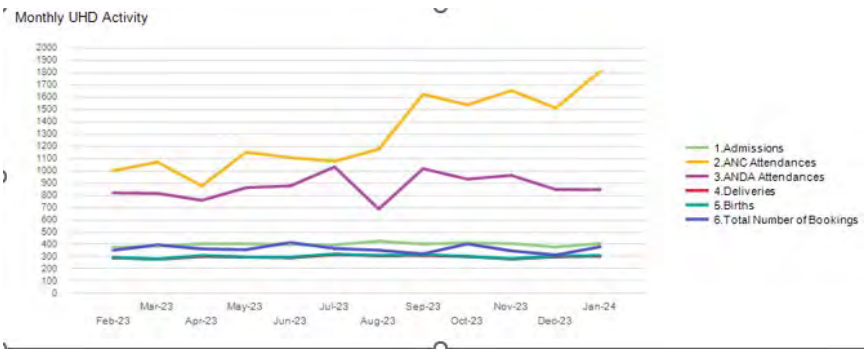
University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 06 March 2024

Agenda item: 6.2.2

Subject:	Maternity quality and safety champions report January and February, (December and January Data)
Prepared by:	Lorraine Tonge Director of Midwifery Head of Midwifery, Kerry Taylor Clinical Director, Alex Taylor
Presented by:	Claire Rogers- Care Group Director of Nursing

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 reports will be used in conjunction with IPR slides attached to give the board a summary of the key areas of focus for maternity. The full reports have been presented to the safety champions, care group board and Quality Committee in January and February The report highlights: **Activity** – 

Advise:
There has been a drop in births, 4062 in 2022 compared to 3629 in 2023. It is expected that there will be a rise again in 2025 due the move of maternity however difficult to quantify as nationally birthrate decreasing.

Advise:
There has been an increase in antenatal clinic attendances. There were 1000 attendances in February 2023 and 1810 attendances in February 2024.
This is partially due to changes in polices/guidance and observations required in pregnancy with the population increased health complexities, however, to understand fully, a review of antenatal pathways is underway.

Perinatal quality surveillance –

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

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

Alert:
There were 2 Maternity Neonatal Safety Investigation cases where both babies unexpectedly went for therapeutic cooling.
Early reviews identified learning for CTG and escalation, which has been disseminated with the teams.

Assure: Overall, all staff groups fetal monitoring training is at 95% and the fetal monitoring team are working daily with the clinicians to improve standards.

Advise:
Serious incident to note - Potential delay in detecting severe jaundice in a global majority baby who required triple phototherapy with a Bili-blanket, plus immunoglobulin therapy to prevent exchange transfusion. A Board report will be provided of the learning.

Assure:
There was no MBBRACE reportable case for December 2023 or January 2024.

Training
Alert**:**
Compliance is currently <90 % for PPROMPT training to meet the maternity incentive scheme, however, there has been improvement - 79% compliance in December and currently 86% compliance in February. The action plan will continue.

Advise:
Introduction of 'Saving Babies Lives training' in line with core competency requirements has commenced. As this is now a requirement that all SBL training is multi disciplinary team (previously midwife training only) overall compliance will not be evident until later in the year.

Assure:
Fetal monitoring training – overall compliance 95%.

Our international lead midwife won a national award as trailblazer in leading IEA team and supporting them in their local training.
Additional training is in place, which includes mental health and ligature training for 2024.

Safe staffing -
Advise:
For board awareness, challenges remain with Obstetric recruiting. Current Obstetric Consultant workforce gap 1.8WTE

Consultant workforce pressures result in challenges to cover the labour ward and elective caesarean lists. Interim locums mitigate these risks. In addition there are changes in the Neonatal consultant workforce in April which is being reviewed as an increased risk.

Advise

Red Flags:
Maternity started to report all maternity clinical red flags via Safe Care in June 23. Antenatal Ward and Labour Ward report this data.

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

Red flags in this reporting period showed there was 24 incidences in December 2023 and 29 incidences in January 2024 with a sustained reduction seen which correlates with the improvement in midwifery staff vacancies.

There was 99% - 1:1 midwifery care provided in labour.
There were 3 occasions of Opel 3 in December and 3 occasions of Opel 3 in January.
1 occasion of Opel 4 in December 2023 no occasions of Opel 4 in January 2024.
There were no adverse outcomes.

Assure:
There have been significant Midwifery workforce improvements, and the six-month midwifery staffing paper (presented to people and culture committee in February 2024) which reflects this. Midwifery Vacancies are at 3.75% in January which is the lowest in the southwest region. Midwifery Support Workers will be fully recruited by end February 2024. Focus is now on retention supporting our staff and preparing for the move in 2025.

Service user voice
Advise:
There are 7 open complaints in February and 1 complaint has been received in January 2024. Themes identified were compassion, consent with examinations, and communication. The Matrons continue to work with clinicians to learn from this feedback.

There were no litigation cases closed in January 2024.

Audits

Alert**:**

An audit for women needing translating services, demonstrated need for further work and actions are in place to address this.

'Saving babies lives audits'

Advise:

Saving babies lives to reduce stillbirths audit quarter 2 was assessed by the ICB in December 2023. 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.

Assure:

Element 4 an audit of peer reviews of CTG fetal monitoring has been an areas of action for matrons to assure consistency of process. In January 2023, 87% of the reviews were completed which meets the 80% target.

Continuous work will continue to achieve a higher standard in all elements. Quarter 3 assessment will be completed in February 2024 and shows continuous improvements made.

Risk

Advise:

Risk 1202 is highest maternity risk at 15 for medical staffing.

Assure:

Risk 1744 inability to provide Midwifery staffing in triage reduced from 12 to 4 as 24-hour midwifery triage service now in place.

CQC action plan

Assure:

Many of our actions have now been identified as sustainable and standards maintained.

Advise Training figures as above reported show that there were overall improvements from December 2023 to January 2024 from 82% to 86% of all staff groups meeting PROMPT training. Further work and priority is being given to the action plan, but overall compliance remains challenging impacted by medical workforce gaps and any further industrial action.

Medical cover in triage 24/7 remains a challenge with gaps in medical workforce. Mitigation with locums continues in covering gaps.

Maternity incentive scheme year 5

Trust	Action 1	Action 2	Action 3	Action 4	Action 5	Action 6	Action 7	Action 8	Action 9	Action 10
	NPMRT	MSDS	TC	Medical Workforce Planning	Midwifery Workforce Planning	SBL Care Bundle	Patient Feedback	In House Training	Safety Champions	ENS
UHD	Y	Y	Y	N	Y	N	Y	N	Y	Y

Alert:
We have been unable to achieve all 10 safety actions in MIS year 5. We are working on the 3 standards that are not met fully.

Action 4 – Medical workforce
Action 6 -Saving babies lives V3.
Action 8 -Training compliance and core competency framework version 2 to implement. Challenge with increase in training days and increase in trainers required.

We are now in year 6 MIS timeframe, so the team will continue to work on all actions however it is expected that the standards will increase in year 6 as maternity safety outcomes and national improvements are not being realized from the scheme.

Ockendon-
Assure:
Remaining actions of the maternity dashboard and updating maternity matters website are being progressed with the support of the ICB and making progress.

Maternity Support Programme
Assure:
Diagnostic report received and an improvement plan is in development and work commenced on the improvements.

Safety champions meeting- full report discussed.
Safety champions focused time was given this month.

- Quarter 3 PMRT
- Quarter 3 Atain and action log
- Six monthly midwifery staffing report (this was presented through people and culture committee in February)

The IPR slides highlights:
The maternity dashboard, which summarizes maternity KPI's perinatal, workforce, feedback, and training. We will be moving to SPC charts This will give a clearer direction and understanding to maternity of areas to focus improvements.

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
Perinatal	Red flags: 1:1 care in labour not provided	0	0	0	0	1	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%	2.7%	2.2%
	Obstetric haemorrhage >1.5L	>2.6 %	2.10%	3.0%%	3.7%	4.4%	3.5%	3.36%	3.3%	3.1%%	5.4%	3.9%
	Term admissions to NNU	<6%,	5.9%	6.50%	5.50%	4.30%	4.50%	6.10%	6.80%	5.40%	4.90%	6.10%
	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%
	Stillbirth number	Actual	4	2	1	0	0	2	2	1	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
	Dedicated anaesthetic cover on Delivery suite - per week	<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
	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
Feedback	Number of compliments (Smiles via Badgernet)		42	37	41	66	51	32	Moving to new system			40
	Number of concerns (PALS) negative		0	0	4	3	0	2	1	1	1	0
	Complaints	3	2	3	2	2	0	0	3	2	2	1
	FFT Repsonse from November 23		43%	46%	87%	80%	62%	125%	100%	430	276	297
Training	UHD Mandatory training - women's health	90%	82%	84%	86%	88%	88%	88%	86%	86%	85%	87%
	PROMPT/Emergency skills all staff groups	90%	82%	82%	84%	86%	not known	85.2%	74%	79%	82%	86%
	K2/CTG training all staff groups	90%	91.76%	96%%	94%	96%	95%	95%	84%	87%	86%	95%
	CTG competency assessment all staff groups	90%	91.76%	96%%	94%	96%%	95%	95%	84%	87%	86%	
	Core competency framework compliance	90%	84%	87%	89%	86%	84%	85%	93.50%	90.00%	91.00%	moved to ccf2
	Coroner Reg 28 made directly to the Trust	al <6%, Region	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)

<u>Advise</u>

- PPH >1.5
- Atain
- Apgar's <7 at 5 minutes

Ongoing QI improvements taking place.

<u>Assure</u>

Improvement in 3rd and 4th

Assurance is provided to the quality committee on action plans for improvements

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 reports Discussion on highlights with Care Group Director of Nursing
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
Maternity quadrumvirate Safety champions meeting Directorate meeting Care group Board	27/02/2024	Noted and approved through Governance processes.
Quality Committee	27/02/2024	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

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 06 March 2024

Agenda item: 6.2.3

Subject:	Mortality Report
Prepared by:	Sean Weaver, Medical Director – Quality & 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
Purpose of paper:	Assurance
Executive Summary:	Hospital Standardised Mortality Ratio (HSMR) August 2023: 101 (Telstra Health); September 102.68 from new data supplier (HED) Summary Hospital-level Mortality Indicator (SHMI) July 2023: 0.86 from NHS Digital. A reduction in our palliative care coding is contributing to two recent alerts. This has been shown from multiple sources and aligns with clinical case review. This is leading to ongoing work to review and improve the whole coding pathway. We have made a positive change in our data supplier from Telstra heath to HED based at University Hospitals Birmingham. There are many advantages to this, and the change is causing us to review which metrics are most consistently accurate. The work to improve the Learning from Deaths is ongoing. There are two rate limiting steps; the first is the actioning of an approved IT request for change and the second is a lack of admin support for the database which covers 2700 deaths per year in our trust and for which alternatives are being sought.
Background:	Routine regular reporting from Mortality Surveillance Group.

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

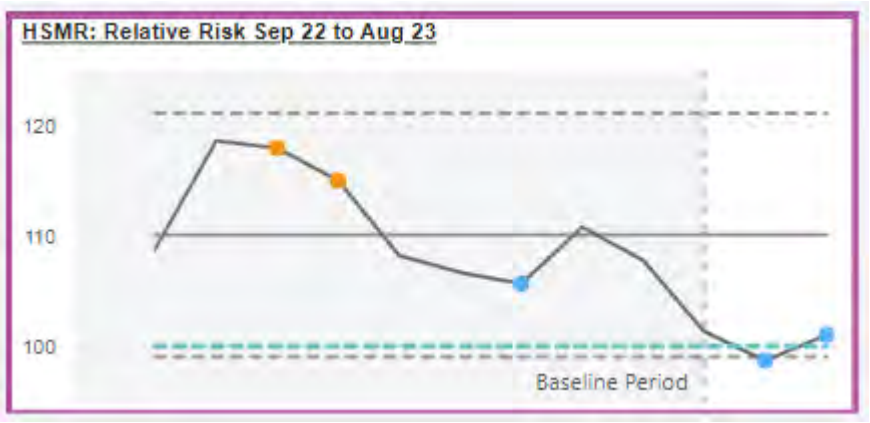
Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Quality Committee	23/01/2024	Noted.

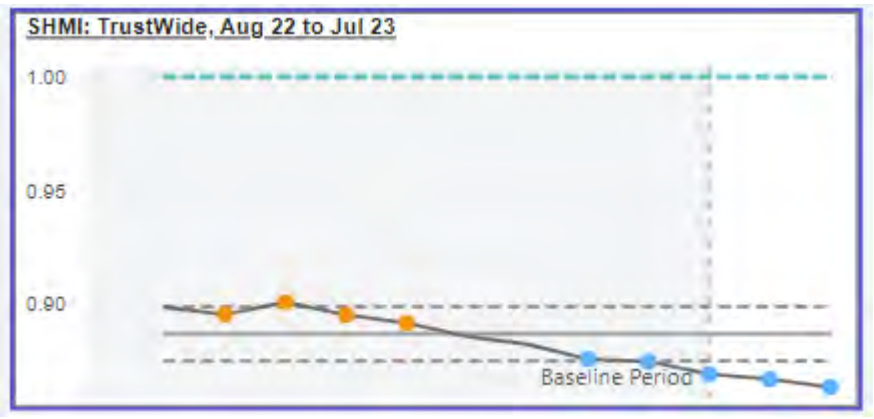
Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality ☐ Patient confidentiality ☐ Staff confidentiality ☐ Other exceptional reason ☐

Headlines

The mortality dashboard is live
QR.PBI111 Mortality Dashboard - Power BI Report Server (uhd.nhs.uk)

HSMR August 2023 101; September 102.68 from new data supplier
SHMI July 2023 0.86 from NHS Digital



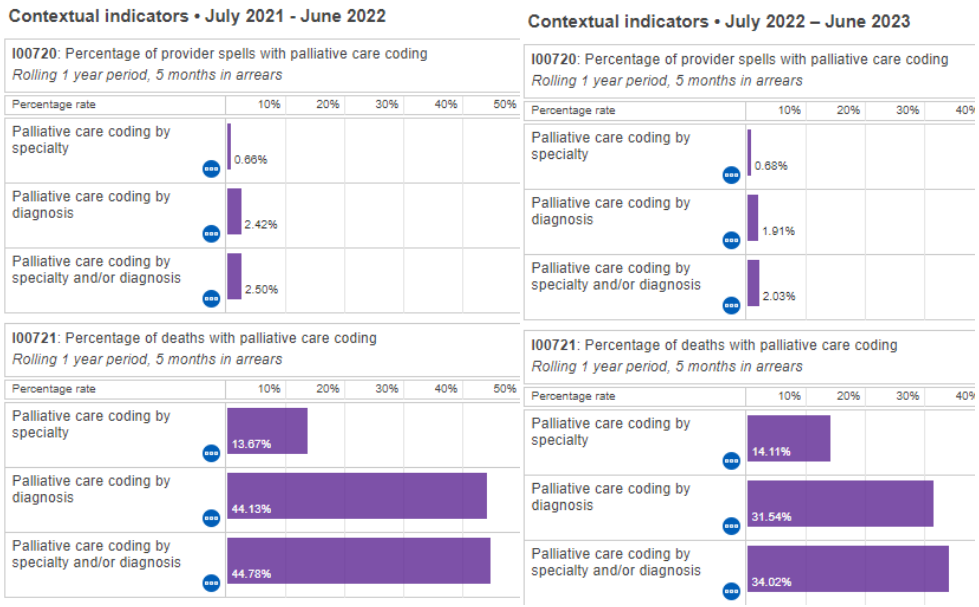


Alerts and Coding

We have had two alerts on acute and unspecified renal failure and septicaemia except in labour. It was the opinion of both our external data supplier and our coders that these were due to a lack of accuracy in the coding, in particular coding palliative or end of life issues. This fits with the sample cases that had been reviewed and were looked at by clinicians.

Coding is clearly key to our mortality metrics. Telstra Health have reported a drop in palliative care coding from 2.6% to 2.15% - almost 20%. This is most seen in the elderly populations.

Telstra Health also presented data to show that our depth of coding has reduced over the last year. This is supported by the NHS Digital data which supports the SHMI – see below



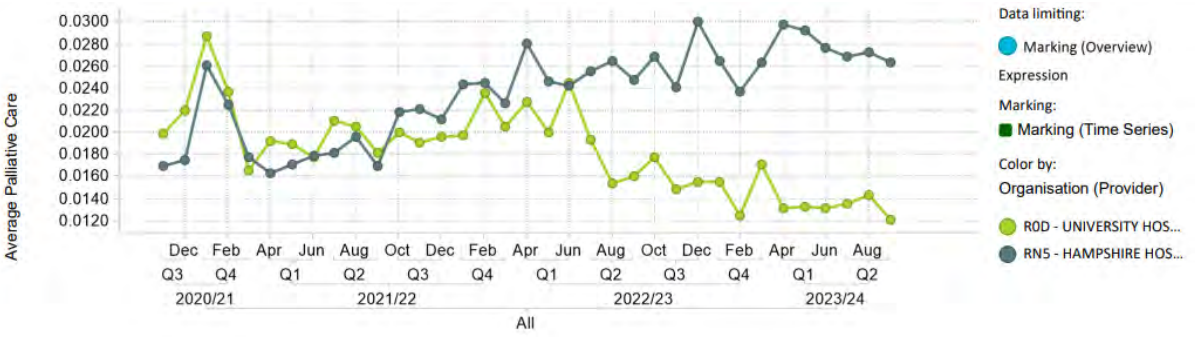
The Medical Director for Quality and Safety has met with the coding team and started a dialogue on the challenges in the whole coding pathway from ward and notes to final coding. This has been very useful and will lead to a body of work to ensure coding is as accurate as possible resulting in accurate data that we can interrogate for clinical reasons.

There are also concerns in the secondary malignancy group of patients of cases where admitted as an emergency by GPs and these cases are being reviewed by the palliative care team.

Change in Data Supplier

Historically we have had data support from Telstra Health. This has been good but was up for review. We have moved to a new supplier called HED based at University Hospitals Birmingham. This has many advantages. It gives us much more ability to analyse our data, covers far more than mortality, gives us immediate access to patient level data to do deep dives, automates much (but not all) of the reporting by the BI team and is also cheaper.

We are establishing this data resource across the trust and it is already giving us some new insights. Looking back on the coding comment above we have been able to look at our palliative care coding over time and also compare it to another trust – in this case Hampshire Hospitals.



It is important to point out that this is reflective of the whole coding path and how the work of UHD is captured– from notes entry to final coding – rather than just the actions of the coders.

It is also making us review our use of the two major mortality metrics used – HSMR and SHMI. Both are statistical models. HED and Telstra Health give us somewhat different HSMRs and

expose the way it can vary on modelling and which patient data is included. SHMI is sent to us by NHS Digital and is more set. Both have advantages and disadvantages and both need to be interpreted as both are heavily influenced in different directions by our hospices. We are unusual in having two hospices in the trust and they increase our HSMR (make it worse) and reduce our SHMI (make it better).

In light of this data change we will be reviewing our metrics and their presentation to ensure they are reliable and consistent.

Patient First Goals

Mortality is a headline measure for Patient First – currently our in month HSMR. Supporting this improvement measure is our wider learning from death strategy. The desire to look at a smaller proportion of deaths to review and learn from has been shared. This will support more thematic learning – especially areas with a high number of deaths such as Older Peoples Services and Oncology – in a way similar to that already in use in Palliative Care.

All consultants have been reminded of their agreed mortality responsibilities and all mortality leads have been contacted about reporting to MSG and in future to care group meetings.

A request for change has been submitted and approved by IT but is yet to be actioned which is one limiting factor for this to happen. A second limiting factor is the current lack of admin/IT support for the mortality work. We have 2700 deaths in the trust each year and the mechanics of managing the database is important and currently not happening which limits the work. We are looking at alternative ways of supporting this work.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 06 March 2024

Agenda item: 6.3.1

Subject:	Safe Staffing Report - Nursing
Prepared by:	Tracy Moran, Lead Nurse Workforce
Presented by:	Paula Shobbrook, Chief Nursing Officer

Strategic Objectives that this item supports/impacts:	Systems working and partnership ☐ Our people ☒ Patient experience ☐ Quality: outcomes and safety ☒ Sustainable services ☐ Patient First programme ☐ One Team: patient ready for reconfiguration ☐
BAF/Corporate Risk Register: (if applicable)	None
Purpose of paper:	Assurance
Executive Summary:	The Trust has sufficient processes and oversight of its staffing arrangements to ensure safe nurse staffing is prioritised as part of its routine activities. The Committee is asked to note: • The positive improvements in relation to vacancies and turnover for Registered Nurses and Healthcare Support Workers. • The work being undertaken to recruit and support progression of internationally educated nurses. The Nursing and Midwifery workforce updates demonstrate the ongoing work to maintain oversight and management of safe staffing. It provides an overall picture of the daily management and levels of staffing; items to note include: • Fill rates for Nursing at or above 99% reflecting the improved vacancy and turnover position; • Red flag reporting showed a stabilisation in Red Flags; • Focus on mental health care support worker demands at care group level.
Background:	The paper is written as part of the Board Assurance structure.

Key Recommendations:	None – for information and assurance only.
Implications associated with this item:	Council of Governors ☐ Equality and Diversity ☐ Financial ☐ Operational Performance ☐ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☒ Regulatory ☐ Strategy/Transformation ☐ System ☐
CQC Reference:	Safe ☒ Effective ☐ Caring ☒ Responsive ☐ Well Led ☒ Use of Resources ☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
People and Culture Committee	14/02/2024	Noted

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

Contents:

	Section	Page Number
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	• Monitoring	3
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	Appendix 1 Nursing Workforce Standards Benchmark	

Introduction

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

Figure 1: Principles of safe staffing

The report (Part one) provides assurance around safe staffing within nursing in the period April – September 2023. Maternity staffing is reported separately to comply with the Maternity Incentive Scheme reporting requirements. Part two of the report covers the period July - December 2023.

This report is written specifically as an assurance report around inpatient area staffing; therefore AHP workforce progress is omitted.

Monitoring

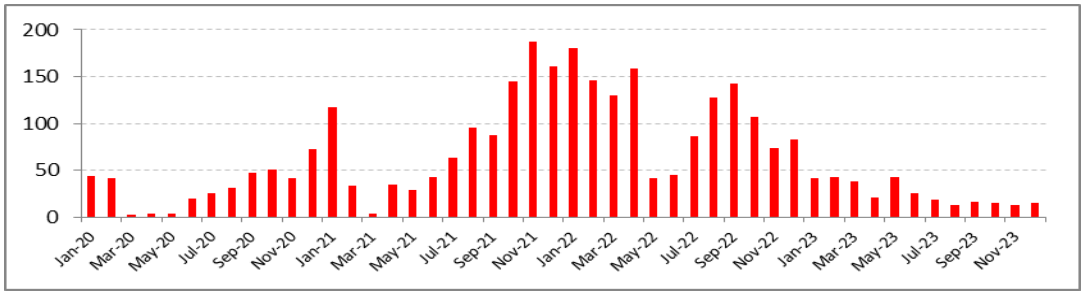
Nursing staffing levels are reviewed twice daily in real time at the safe staffing meetings.The midwifery team manage safe staffing using the OPEL scoring, connecting with the twice daily safe staffing meetings in times of escalation.

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

Red Flags

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

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



Care Hours per Patient Day

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

Our local data for this reporting period is:

	Hospital Site name	Patient Count	Total monthly planned staff hours	Total monthly actual staff hours	Fill Rate %	CHPPD
September 2023	Poole Hospital	15624	122713.3	125799.3	102.5%	8.1
	Bournemouth & Christchurch	15586	119931.9	125191.4	104.4%	8.0
	UHD Total	31210	242645.2	250990.7	103.4%	8.0
August 2023	Poole Hospital	15157	126778.5	131859.0	104.0%	8.7
	Bournemouth & Christchurch	15493	124051.9	128096.6	103.3%	8.3
	UHD Total	30650	250830.3	259955.5	103.6%	8.5
July 2023	Poole Hospital	15483	127009.0	130452.5	102.7%	8.4
	Bournemouth & Christchurch	15770	123893.7	130678.6	105.5%	8.3
	UHD Total	31253	250902.7	261131.1	104.1%	8.4
June 2023	Poole Hospital	15369	123530.1	125663.9	101.7%	8.2
	Bournemouth & Christchurch	15600	121751.4	122081.9	100.3%	7.8
	UHD Total	30969	245281.5	247745.8	101.0%	8.0
May 2023	Poole Hospital	15308	128557.0	128592.9	100.0%	8.4
	Bournemouth & Christchurch	16939	126415.1	125442.3	99.2%	7.4
	UHD Total	32247	254972.0	254035.2	99.6%	7.9
April 2023	Poole Hospital	15529	126602.7	124461.0	98.3%	8.0
	Bournemouth & Christchurch	16222	121851.8	122118.5	100.2%	7.5
	UHD Total	31751	248454.5	246579.5	99.2%	7.8

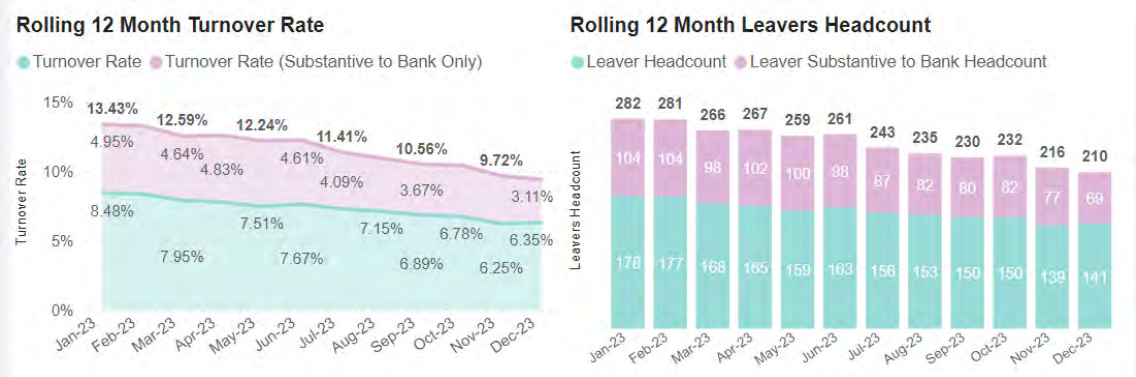
Current position - nursing workforce data

The Cosmos Workforce dashboard provides baseline data for nursing. The below provides an in depth view for the reporting period April – September 2023.

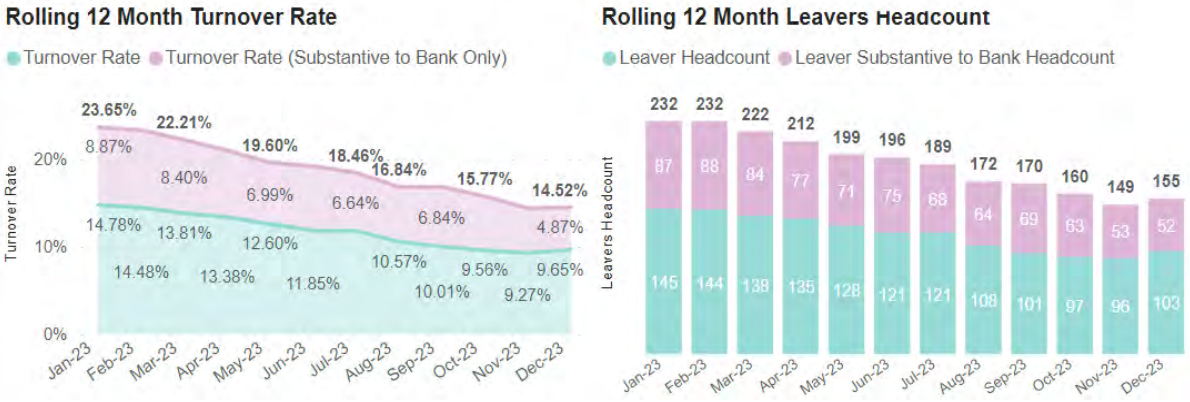
Turnover

RN turnover is currently 9.72%, a 2.83% improvement since March 2023 but above the Trust target of 5%. HCSW turnover has improved by 5%; currently at 14.5% against a Trust target of 10%.

RN turnover



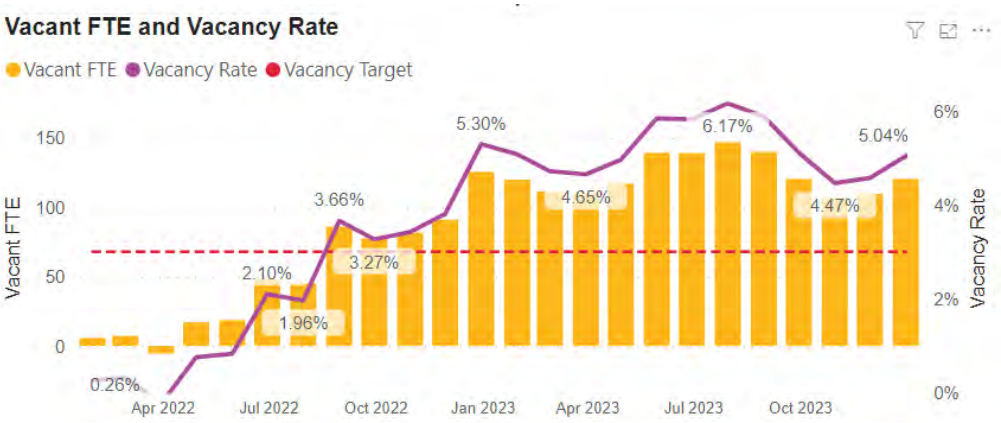
HCSW turnover



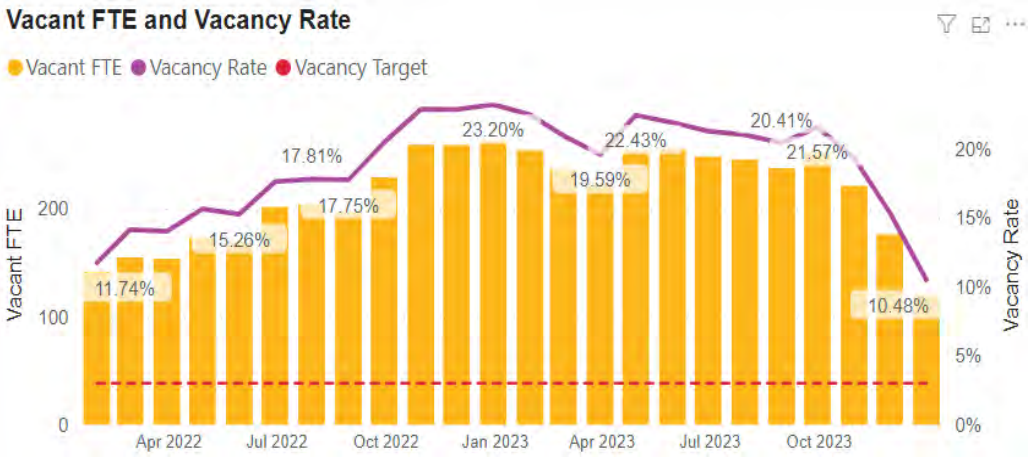
Vacancies

The current RN vacancy rate is 5%; a 0.65% improvement since March 2023 and closer to the Trust target rate of 3%. The HCSW vacancy rate has improved by 9.11%, currently at 10.48%. The Trust target vacancy rate is 3% for RN and HCSW.

RN vacancy



HCSW vacancy



Recruitment activity

Internationally Educated Nurse (IEN)

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

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

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

Health Care Support Workers (HCSW)

NHSE Direct Support Team have worked with the Trust to achieve a 25% reduction in vacancy by November 2023.

A QI Project has led to recruitment checks being started at interview to improve time to hire rates and the introduction of a short questionnaire during Trust Induction, for all newly recruited HCSW to share their experience of the on-boarding process and engagement with recruiting managers.

Template reviews update

Bi-annual Ward Staffing Reviews

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

The first UHD establishment review concluded in July 2023, resulting in changes to rosters that will take effect in February 2024. The next review will commence in January 2024 with a 30 day patient acuity and dependency data collection. This data will be triangulated with quality metrics and professional judgment to reach a recommended staffing requirement for all inpatient areas.

Premium Agency Spend

As at the end of September 2023 a cumulative over-spend of £7,337k for the period April – September 2023 is recorded for nursing. Agency costs, including RMN, accounted for £9,470m.

Premium Spend April 2023 – September 2023

Staff Type	Budget (£000's)	Substantive (£000's)	Pay Underspend(£000's)	Overtime (£000's)	Bank (£000's)	Agency (£000's)	Variance (£000's)
Registered Nurse/Midwife	71,076	61,092	9,985	308	7,534	9,470	(7,337)
HCSW	20,519	16,542	3,977	75	2,540	0	1,362

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

- Consolidated bank approach
- Dorset wide Seasonal Incentive Scheme
- Dorset wide agency pay rate framework
- International recruitment
- Training and apprentice roles
- Progression of the system wide review of bank pay rates and removal of the incentive payments.
- Working across the system to agree an agency payment framework including lead times
- Enhanced care service delivery and review of the requirement for RMN

Staffing risks

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

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

RCN Nursing Workforce Standards Benchmarking update

As part of the Trusts annual review process for safe staffing, benchmarking against the RCN Nursing Workforce standards was completed in 2022 and updated in 2023. (Appendix 1)

Conclusion

The Trust continues to closely monitor staffing levels and comply with the recommendations outlined in the Developing Workforce Safeguards Guidance. However, it must be acknowledged that sustained demand and the HCSW vacancy position presented significant challenges with regards to ensure safe staffing across all areas. Noting the staffing information detailed in this report, alongside the robust escalation and mitigation of short- and long-term staffing shortfalls, it can be concluded that the Trust has in place sufficient processes and oversight of its staffing arrangements to ensure safe staffing is prioritised as part of its routine activities.

Part Two - Care Group Updates

The following updates from the Care Groups demonstrate the activity within the divisions and specialist teams in Q3 and Q4 2023, to maintain safe staffing and support the staff working operationally, on a daily basis.

Medical Care Group

Bed escalation has increased further across the care group alongside increased pressures within the emergency departments. Staff work flexibly across sites to ensure safe staffing levels are maintained; this has seen a small increase in our high cost agency expenditure.

The care group has also been challenged with increased numbers of patients assessed as requiring enhanced care needs of MHSWs/RMNs. The recruitment to temporary staffing of MHSWs remains on-going with a training plan for this cohort of staff being led by our Senior Matron in OPS. There is an intention that these roles will support further reduction of MHSWs with the ability to cohort patients reducing individual 1:1 support.

ED sites are now fully aligned with shift times and all band 7s now working an 80/20 pattern of cross site working increasing overall flexibility to ensure safe staffing within the departments.

Work is currently underway within Stroke services to develop their new template that supports the bringing together of the two wards creating an overall reduction of 12 beds. This work is due to be implemented early Q1.

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

Top 10 Directorates by Turnover Rate

Directorate	Rate
153 Acute & Ambulatory Medicine Directorate	2.65%
153 Cardiology & Renal Directorate	6.08%
153 Medical Specialties Directorate	6.57%
153 Older People Med & Neuro Science Directorate	5.29%
153 Urgent & Emergency Care Directorate	5.96%
Total	**5.60%**

Top 10 Directorates by Joining Rate

Directorate	Rate
153 Acute & Ambulatory Medicine Directorate	7.08%
153 Cardiology & Renal Directorate	6.84%
153 Medical Specialties Directorate	13.49%
153 Older People Med & Neuro Science Directorate	17.77%
153 Urgent & Emergency Care Directorate	15.72%
Total	**13.44%**

Both long term and short term sickness has continued to improve as detailed below


Rolling 12 Month Absence Rate
5%
0%
5.09%
4.99%
4.85%
4.61%
4.48%
4.37%
4.16%
4.05%
4.07%
4.03%
3.99%
3.91%
3.88%
3.80%
3.67%
3.45%
3.37%
3.30%
3.13%
3.09%
3.12%
3.10%
3.07%
2.99%
1.21%
1.19%
1.19%
1.17%
1.11%
1.08%
1.03%
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Long Term
Short Term

Surgical Care Group

Retention, turnover and recruitment

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

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

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

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

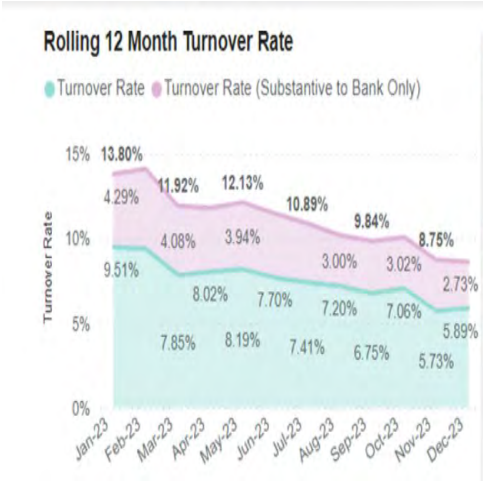
Areas with highest HCSW vacancy rates are:
Anaesthetic directorate: overall theatre vacancy rates have decreased from peak of 25% in May 2023 to 12% in December 2023,
Actions: this forms part of the major project to enhance and recruit to theatre staffing. A Workforce action group is in place with corporate support. Previously unutilised routes of recruitment for THSWs have been used with effect, opening up theatre career and employment pathways.

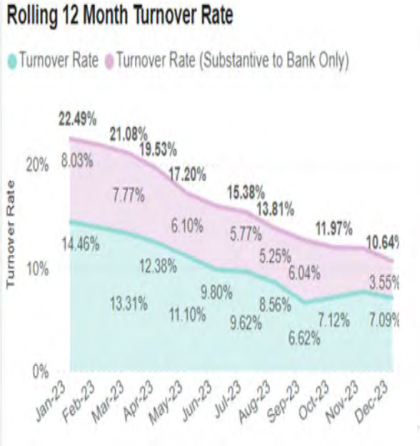
Head & Neck: no concerns

Surgery: across inpatient wards there is a 14% vacancy rate.
Actions: active recruitment has continued up until January 2024 with launch of bed reconfiguration consultation on RBH site.
Trauma & Orthopaedics: Recruitment to vacant posts has been undertaken successfully, with approval to recruit at risk during quarter 3 & 4 due to care quality concerns, pending establishment review and legacy funding deficit. The vacancy rate has decreased from 31% in May 2023 to 5% in December 2023.

Turnover: improvements are demonstrated across all staff groups within the Care Group.

Nursing **HCSW** **Allied Health Care Professionals**





Top 10 Directorates by Turnover Rate

Directorate	Rate
153 Anaesthetics Directorate	7.26%
153 Trauma and Orthopaedics Directorate	6.68%
153 Surgery Directorate	6.17%
153 Head and Neck Directorate	5.09%
Total	**6.58%**

Absence by directorate % range across quarters:

Directorate	Registered Nurse	HCSW	AHPs
Theatres	4-6%	6-11%	3-8%
Critical Care	3-7%		
Head & Neck	10-11%	4-8%	3-9%
Trauma	2%	4-7%	
Elective orthopaedics	3-4%	5-9%	
Surgery wards	4-6%	9-12%	

Agency spend – the YTD December agency spend is 3.36% of total pay spend; this remains below the NHS cap of 3.7%. Controls have been in place to reduce overall and particularly high-cost agency, with a consistent defined sign off process in place and shortened time thresholds for escalation.

Staffing risks Q3/4 live on the risk register:

- **1811 Staff vacancies and skill mix deficit in theatres**: rated as 15. Theatres Workforce Action group established, funded establishment review v scheduled activity underway, enhanced pay rate approved, and substantial recruitment in progress. Risk rating requires review.
- **1809 HCA staffing shortfall in trauma and orthopaedics**: reduced from a moderate to low risk within the last quarter, now 4.
- **1136 Reduction in quality of care to patients across the trauma wards** rated now low risk at 6.

Emerging themes

Service transformation

Approval of nursing workforce models completed in quarter 4, in preparation for first large-scale workforce transformation consultation, on the RBH site, to align for 2025 service changes.

Practitioner workforce

Corporate project underway to align; there is a recognition of need for Advanced Clinical Practitioners at 8a banding across some surgical specialities, however funding undetermined.

Specialties Care Group

- All inpatient areas were part of the Trust establishment review that was signed off at the end of 2023. This process enabled a deep dive into historic decision making around staff in post and allocated budgets. As part of the review Child Health and NICU received significant investment with smaller investment in Haematology and Oncology wards across both sites. Improved supporting staff (housekeepers, ward clerks, and discharge facilitators) was provided for several areas and specifically to CAU (Children's Assessment Unit) who had none of these roles in place. This will enable better support for the service and the patients and families and increase efficiency as the nursing staff will be able to focus on nursing duties. As noted previously child health needed to be broken down into ward areas rather than within one single inpatient cost centre and template reviews where undertaken on this premise. Cost codes for the newly defined areas are now in place and staff have been allocated to wards.
- The Head of Nursing & Professions post commenced full time in post September which has created senior nursing and AHP support across the care group with planned quality initiatives and service improvements now commenced. The post holder is leading on workforce within the care group and providing additional support to Matrons.
- Care Group daily Nursing huddles continue, and care group silvers always attend the meetings. This has facilitated improved communication across all team members and provided opportunities for sharing of urgent messages and information. This remains a useful forum for anyone in the care group leadership to share messages or obtain information. Maternity and other support services are also now in regular attendance.
- The pharmacy full team restructure review has now been completed however a number of posts have still not been recruited into despite advertising widely (which reflects the local and regional challenges in Pharmacist recruitment). A bespoke recruitment and retention initiative to attract and retain junior pharmacists has been approved and put in to place to reduce vacancies and compete with surrounding Ttrusts. This has had some success with 11 wte out of 21 wte posts being filled at band 6 level and only one resignation. This is an improvement of around 20% on the 2022 gaps. The clinical Pharmacy team have developed a service level and priorities document to support decision making when gaps cannot be covered by bank and extra shifts. This is reported daily through the care group.
- The aseptic unit is particularly challenged due to vacancies and the increasingly complex SACT regimes and number of patients requiring treatment. A joint piece of work is underway in collaboration with the Cancer Care Team to understand options for working differently and review of roles and skills. The team are being supported within the Care Group and also the CMO. The staffing risk remains high (16).
- Significant staffing pressures across most CG Services with 54 staffing related risks, 11 new staffing related risks added within the last 6 months. These include new risks for Pharmacy (1), Pathology (2), Women's Health (2), Cancer Care (3), Therapies (2) and Child Health (1). There are 8 high risks, 32 moderate, and 14 low risks. (Total CG risks = 106) across all

directorates and professions. All risks are reviewed monthly and have clear action plans. The impact of these staffing deficits has impacted on provision of service to patients across the Trust as well as the wellbeing of staff.

- Child Health continues to see higher levels of children with Mental Health illness and eating disorders. The cost of RMN within the unit has been significantly reduced however due to the work within the organisation relating to the use of Mental Health Support Workers. The MOU remains in use but is now being reviewed across the system to be completed by March 2024. Child health staffing risks are being supported by long lines of work from Tier 3 agency. This has worked well to increase consistent provision and reduced high cost agency spend. Tier 4 agency has reduced as three nurses from Tier 4 agencies have moved across to Tier 3 in order that they can book shifts on the unit. There are still 5.0 wte vacancies in Registered Nurses (Children's). Recruitment is proactive but there is local competition from bigger centres.
- Formal recognition has been given for the 4 high dependency beds on A1 and funding for this received by the critical care network.
- The OPD nursing structure has not been commenced as the Trust focus is currently on inpatient areas. There is currently no Shelford reference framework or Tool for outpatients nursing structure nationally which makes benchmarking for this area more complex. The newly appointed General Manager is working with the Senior Nursing team to review current nursing/AHP structure now the management structure is in place.
- CNS review project has been challenging due to the complexities of the CNS line management reporting. Budgets have now been aligned which is supporting recruitment into vacant posts.
- Interventional Radiology nurse staffing continues to be challenging despite robust review of options for maintaining a steady workforce going forward. Vacancies reduced in the last two months but there is a junior team. The move of TIU has created bed pressures for the Radiology service with patients temporarily being placed on Sandbourne Suite and not enough space for all patients admitted for day procedures. The team are looking at alternative space within Radiology to see if minimal work can support more recovery space.
- CG continues to support staff through Trust and CG wellbeing initiatives and this work has been triangulated with the staff survey. The care group has a number of PNAs and TRIM practitioners in place and the Care Group has implemented a workforce group.

Table 1: Care Group Vacancy across all staff groups (excepting medical and dental)

The tables document the Care Group summary in terms of funded and vacant positions across all non- medical professional groups. The tables demonstrate a reducing vacancy position from its peak in July 2023 and the 0.36% from the lowest position since February 2023.

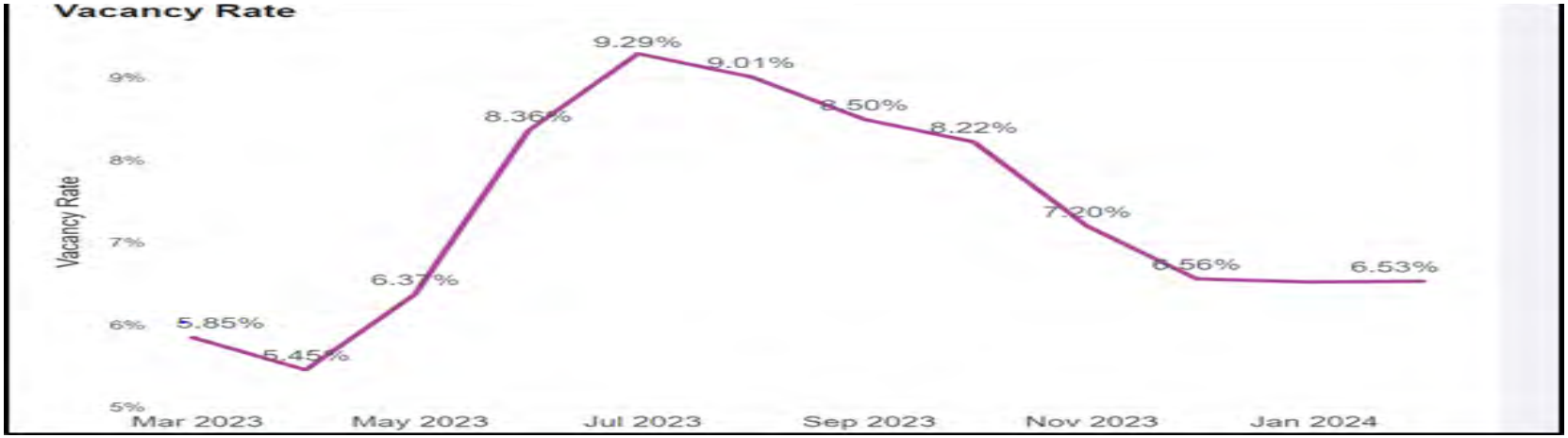


Table 2: Establishment and Vacancy Rates (excepting medical and dental)

	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Funded FTE	8,103.87	8,090.28	8,137.91	8,337.64	8,447.87	8,513.47	8,428.84	8,346.14	8,283.84	8,423.03	8,524.69
Employed FTE	7,594.76	7,612.37	7,583.09	7,618.31	7,658.22	7,681.11	7,709.18	7,636.66	7,650.41	7,849.01	7,983.77
Vacant FTE	509.11	477.91	554.82	719.33	789.65	832.36	719.66	709.48	633.43	574.02	540.92
Vacancy Rate	6.28%	5.91%	6.82%	8.63%	9.35%	9.78%	8.54%	8.50%	7.65%	6.81%	6.35%

The tables below show the short and long-term sickness across all professional groups within the Care Group, except Medical and Dental staff.

Table 3 - levels are quite static and reduced from previous levels. Short term 3.3 % in July reduced to 3.0% December and long term 1.6% in July to 1.5% in December 2023. Total sickness 4.9% to 4.5% - the previous reporting period ranged from 5.81% to 5.29%, therefore, a positive trend.

Table 4 - highest reason for absence is related to anxiety and stress. This is around a 3rd of the total sickness absence reason. This would fit with feedback from staff about workload pressures. Infection (S13) was very low in July 2023 with around 0.1%. This has increased through the colder months and reached a peak in December and is reflective of lived experienced within the teams. Musculosketal/ other and GI problems are fairly static across the six-monthly period and are all under 0.5%

Table 3

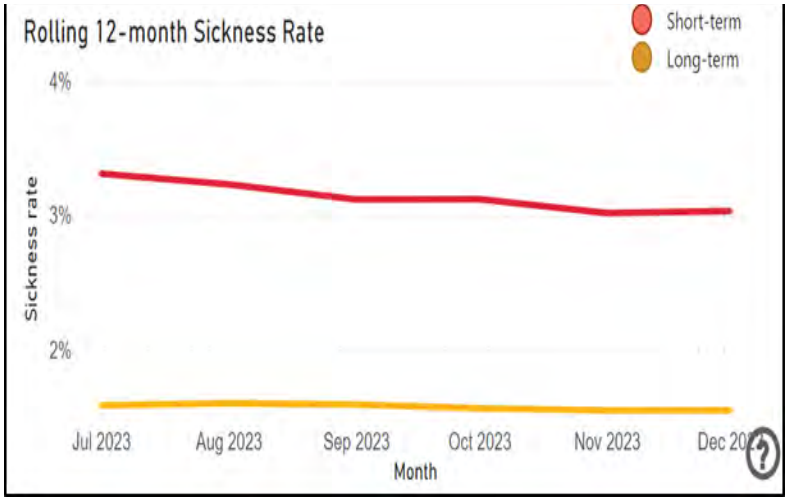
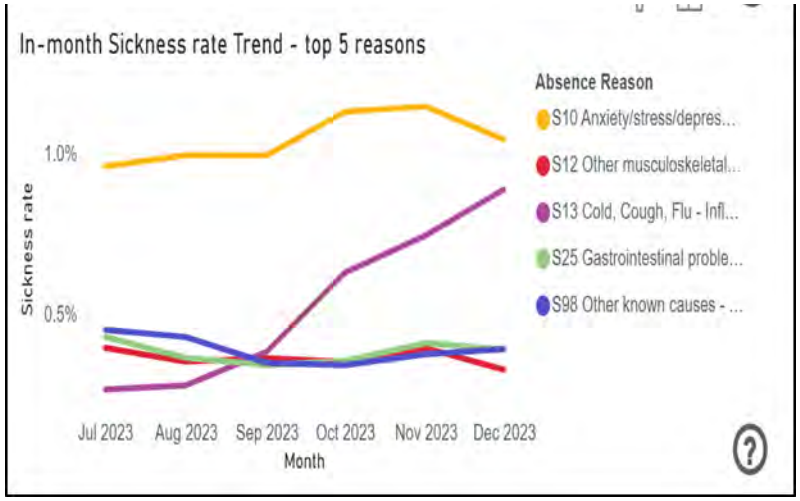


Table 4



Appendix 1
RCN Nursing Workforce Standards Benchmarking 2022

Fully compliant = 6
Partially compliant = 8

Nursing Workforce Standards Benchmarking 2023

Fully compliant = 12
Partially compliant = 2

Nursing Workforce Standard (NWS)		2022 RAG	2023 RAG	Evidence
NWS 1	Senior nurses set nurse staffing and report to Executive Boards. *Executive nurses are responsible for setting nursing workforce establishment and staffing levels. All members of the corporate board of any organisation are accountable for the decisions they make and the action they do or do not take to ensure the safety and effectiveness of service provision.*			**2023 update – compliant** Completion of reviews with reporting to People & Culture Committee expected July 2023
NWS 2	Nurse establishments based on service demand and user need *Registered nurse and nursing support workers establishments should be set based on service demand and the needs of people using services. This should be reviewed and reported regularly and at least annually. This requires corporate board level accountability.*			**2023 update – compliant** Finance approval of CNO approved establishment reviews completed for implementation in Q4.
NWS 3	Business continuity plans enable staffing for safe effective care *Up-to-date business continuity plans must be in place to enable staffing for safe and effective care during critical incidents or events.*			**2023 update compliant** The Red Flag and Safe Staffing Escalation policy sets out the Trusts standard approach to managing staffing challenges from day-to-day to extremis levels.

NWS 4	Nursing workforce is recognised and valued *The nursing workforce should be recognised and valued through fair pay, terms and conditions.*			**2023 update compliant**
NWS 5	Each nursing embedded service has a Registered Nurse Lead *Each clinical team or service that provides nursing care will have a registered nurse lead.*			**2023 compliant** The Trust has a robust nursing leadership structure in place with clear, corporate, care group and directorate level leadership in place.
NWS 6	Nurse leaders receive dedicated workforce planning time *A registered nurse lead must receive sufficient dedicated time and resources to undertake activities to ensure the delivery of safe and effective care.*			**2023 - compliant** Ward Leaders management time standardised for UHD as part of current establishment review.
NWS 7	Practice development time considered when defining workforce *The time needed for all elements of practice development must be taken into consideration when defining the nursing workforce and calculating the nursing requirements and skill mix within the team.*			**2023 – compliant** Uplifts in establishments agreed and implemented, reflecting the need for higher uplift in specialty areas e.g. Critical Care, ED
NWS 8	Apply sufficient uplift when calculating nursing workforce *When calculating the nursing workforce Whole-Time Equivalent (WTE) uplift will be applied that allows for the management of planned and unplanned leave and absence.*			**2023 – compliant** In 2021/2022 the Trust adjusted the uplift to clinical areas as follows: Emergency Department - 27% Critical Care, RACE, AMU, SAU, OPU - 25% All other areas - 22%
NWS 9	Substantive nursing workforce below 80% is exceptional *If the substantive nursing workforce falls below 80% for a department / team this should be an exception and should be escalated and reported to board / senior management.*			**2023 - compliant** Vacancy data available following merger of ESR
NWS 10	Nursing workforce is prepared and works within scope of practice			**2023 – compliant** All nursing staff working as substantive or bank members of

	Registered nurses and nursing support workers must be appropriately prepared and work within their scope of practice for the people who use services, their families and the population they are working with.			staff undergo a robust induction period and undertake mandatory training as required. Each member of staffs training records are accessible to the individual through the Green Brain electronic tool and their line manager on the electronic staff record.
NWS 11	Nursing workforce rostering accounts for safe shift working *Rostering patterns for the nursing workforce will take into account best practice on safe shift working. Rostering patterns should be agreed in consultation with staff and their representatives.*			**2023 update – partial compliant** Policy review completion has been delayed due to operational pressures/HR workforce team staffing challenges/priorities. An e-rostering Group, chaired by the Chief People Officer, was established in April 2023
NWS 12	Nursing workforce is treated with dignity and respect *The nursing workforce should be treated with dignity, respect, and enabled to raise concerns without fear or detriment, and to have these concerns responded to.*			**2023 - partial compliant** IEN Forum established monthly since September 2022 with support of BAME Network; regular attendance of DCNO and escalation of concerns/issues. UHD participating in NHSE sponsored events to develop cultural competence guidance for employing managers. UHD cultural celebration event held in July and See ME First campaign launched. First cohort of IEN Accelerated Development completed; Cohort 2 commenced September 2023. Proposal to recognise IEN prior experience presented for discussion with Executive Team – further information requested to assist with decision
NWS 13	Nursing workforce supported in healthy safe environments *The nursing workforce is entitled to work in healthy*			**2023 - Compliant** Access to break spaces available to staff.

	and safe environments.			
NWS 14	Nursing workforce is supported to practice self-care *The nursing workforce is supported to practice self-care and given opportunities at work to look after themselves.*			**2023 - Compliant** The Trust is committed to enabling our workforce to make healthy lifestyle choices. The Trust provides wellbeing and employee assistance services, providing information on health, wealth and welfare. A total of 21 Nurses have completed the Professional Nurse Advocate course that equips Nurses to provide restorative clinical supervision to Nursing staff and their teams. A further 7 Nurses are enrolled for programmes commencing November 2023 and February 2024.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 06 March 2024

Agenda item: 6.3.2

Subject:	Midwifery Six-Monthly Safe Staffing Report
Prepared by:	Lorraine Tonge, Director of Midwifery
Presented by:	Paula Shobbrook, Chief Nursing Officer

Strategic themes that this item supports/impacts:	Systems working and partnership ☒ Our people ☒ Patient experience ☐ Quality: outcomes and safety ☒ Sustainable services ☒ Patient First programme ☒ One Team: patient ready for reconfiguration ☒
BAF/Corporate Risk Register: (if applicable)	Previous Risk rating 12: 1642 Midwifery staffing – Risk closed in January due to much improved position.
Purpose of paper:	Assurance
Executive Summary:	This report gives a summary of all measures in place to ensure safe midwifery staffing. • We have a fully funded workforce planning in line with birth-rate plus; • The midwife to birth ratio is within expected range; • Vacancies at 3.75 % with further improvement in January; • Turnover 6.08%; • Sickness rates stable at 4.97%; • Specialist hours; • Fully compliant with supernumerary labour ward coordinator; • 100% one to one care in labour; • Red flag incidents and impact are analyzed and learning shared. We will continually recruit to ensure safe staffing and our focus is now on retention and supporting our teams.
Background:	A staffing report for midwifery was included previously within nursing staffing papers. It is now a requirement of Maternity Incentive scheme year 5 for safety that this is now presented to the Board as a separate paper.

Key Recommendations:	It is requested for the Board to note 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**
People and Culture Committee	14/02/2024	Noted.

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

University Hospitals Dorset
NHS Foundation Trust

MIDWIFERY STAFFING REPORT

Author: Lorraine Tonge

Director of Midwifery

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Background

It is a requirement that as NHS providers we continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (NQB) requirements.

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings.

Previously midwifery staffing data has been included in the nurse staffing paper, however, to provide evidence for NHS Resolutions Maternity CNST Incentive Scheme, (See appendix 1) a separate paper is now provided.

1.0 Executive Summary

This report gives a summary of all measures in place to ensure safe midwifery staffing, including fully funded workforce planning is in line with birth-rate plus, the midwife to birth ratio, vacancies, turnover and sickness rates, specialist hours, compliance with supernumerary labour ward coordinator, one to one care in labour and red flag incidents is analysed and recommendations given.

2.0 Birthrate Plus Workforce Planning

Birth-rate Plus is a clinical workload exercise which calculates the need for clinical midwives in each clinical setting with recommendations of specialist's midwives to support care. It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one to one midwifery care throughout established labour. It also takes local factors into consideration.

To calculate the required whole time equivalent (WTE) midwives the Birth-rate plus reports adds an uplift of 23% for annual leave, sickness, and training.

A formal Birth Rate Plus assessment was completed at UHD in June 2021 (See appendix 2) which reviewed the acuity of women who used maternity services, at UHD Trust.

3.0 The Birth to Midwife Ratio

The birth to midwife ratio is calculated monthly using Birth Rate Plus methodology and the actual monthly delivery rate. This is reported monthly on the maternity dashboard so that it can be monitored alongside clinical data.

The table outlines the real time monthly birth to midwife ratio.

Month	July	August	September	October	November	December
Birthrate Plus Ratio	1:25	1:22	1:22	1:23	1:26	1:22

Birthrate plus assessment recommended 1:23.5 midwives per birth for UHD. This ratio shows an increase from the recommended ratio in July and November which correlates with the vacancies and increased births in these two months.

There was no increase in safety concerns in these two months and daily safety huddles monitored occurred.

4.0 Vacancies

Area	Funded FTE	Employed FTE	Vacant FTE	Vacancy Rate
153 WCCSS Care Group	**204.82**	**197.14**	**7.68**	**3.75%**
153 Womens Health Directorate	**204.82**	**197.14**	**7.68**	**3.75%**
428 Post Natal & TCU 20482	29.40	20.58	8.82	30.00%
428 Midwifery Management Team 20485	8.00	9.50	-1.50	-18.75%
428 Labour Ward 20479	45.87	53.68	-7.81	-17.03%
428 Haven 20509	11.08	10.05	1.03	9.27%
428 Ante Natal Ward 20481	15.82	7.95	7.87	49.77%
153 Specialist Midwives 20511	7.19	15.25	-8.06	-112.15%
153 Outpatient Antenatal 20478	17.55	15.73	1.82	10.35%
153 Oasis - Safeguarding support 20489	9.15	12.40	-3.25	-35.52%
153 Labour Line Triage 20487	11.68	11.36	0.32	2.74%
153 IT Midwives 20488	2.40	2.41	-0.01	-0.28%
153 Community Midwifery - West 20496	46.68	38.23	8.45	18.11%
Total	**204.82**	**197.14**	**7.68**	**3.75%**

On cosmos on the 30th of January, it shows our current vacancy of 3.75 % which is a significant improvement from previous report period Jan-June 2023 when the rate was 16.1%. The success is due to several actions taken and monitoring through our workforce action plan.

- We now have appointed a lead midwife for recruitment and retention. This post has been essential in developing our recruitment drive but both locally and nationally. The role also includes supporting and understanding why midwives are leaving UHD. The recruitment and retention midwife will work closely with the Director of Midwifery and Head of midwifery to deliver the workforce action plan and our retention program.

- Additional wellbeing support is also given to midwives by the Professional advocate midwives (PMA).

- We employed 17 newly qualified midwives in this reporting period who joined us in October. To continually support them in their new career we have a dedicated midwife to deliver a preceptorship programme and offer them additional training and support.

- We plan to continue to recruit newly qualified midwives to support our long-term workforce planning.

- We have a continual rolling advert for band 6 midwives which gives us approximately one post per month.

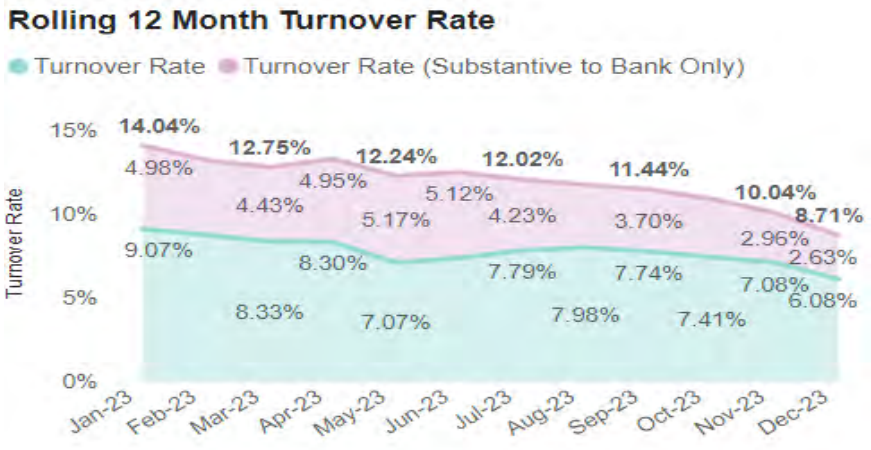
- We have a lead midwife for international recruitment and are part of the international recruitment of midwives' programme. 10 midwives have started with further 2 expected. This has been a great success to our workforce.

- We have joined the apprentice programme for midwives and training which has commence in January 2024.
- We have provided development opportunities for band 6 midwives with deputy clinical leaders programmes and are working towards development from band 7 to band 8 roles.

Due to the reduction in vacancy, there has been a reduction in bank shifts. Whilst Maternity bank midwives provide stability to our workforce, and we have a committed bank workforce at UHD. These midwives tend to want to choose their working pattern that is very flexible. For instance, they will work more hours in the winter months and then have a period of limited or no work during summer holiday periods. The school holidays can be the most challenging to manage.

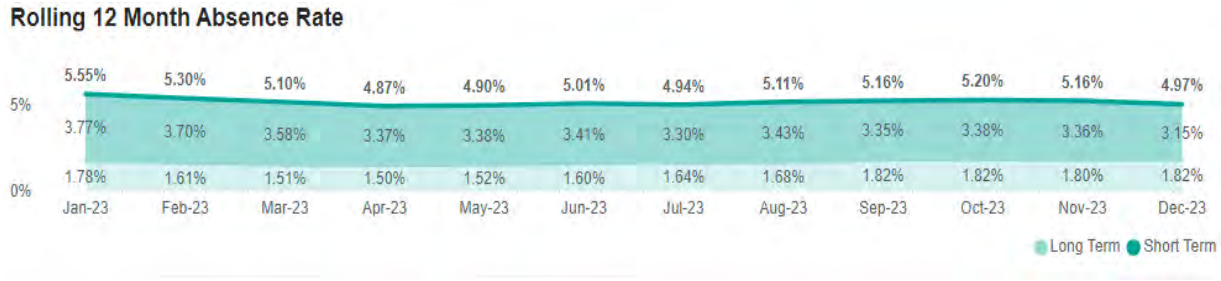
Our long-term strategy must be to reduce retain our staff and reduce the reliance on bank midwives and work towards more flexible contracts.

5 .0 Turnover



We can see from our data that our turnover has decreased over the last 12 months from 9.07 % to 6.08% of our substantive staff. It is predicted to remain at the same rate for the next six months. Our turnover of our bank staff has also decreased showing a more favourable position.

6.0 Sickness



From our data we can see a slight reduction in sickness from January to December. Overall sickness 5.55% to 4.7 % in December with a slight improvement in long term sickness from 3.77% to 3.15%.

A workforce review and strategy are underway for the transfer to the new build and this review will provide the Trust Board with assurance of midwifery staffing planning over the next 3 years.

7.0 Systematic reviews of implementing birth rate plus staffing allocations aligned with safety.

7.1 Staffing templates

There is a systematic review Band 5-7 clinical midwives staffing templates which are completed monthly by the Head midwifery with PWR team and allocate, and finance team in which provided assurances to the board that staff were allocated accordingly to provide safe care.

In addition to this the rosters are robustly reviewed by the senior matrons each month and unfilled shifts are spread evenly and we identify any variances.

The Director of Midwifery is therefore able to provide assurance to the board of the implementation of birth rate plus staffing allocations in clinical roles is monitored and meets birthrate plus standards of safe staffing.

7.2 The review can confirm that **all posts are fully funded to birthrate plus recommendations.**

	Band 5-7 Clinical WTE	Band 3 providing postnatal care 10%	Band 7 to 8 Additional Specialist and management WTE	Total includes all clinical specialists and management roles
Birth- rate plus recommendations WTE (June 2021)	174.61	19.40	21.34	215.35
Current Funded WTE (June 2023)	179.80	20.96 (Postnatal ward)	21.97 band 7-8 4.69 band 6 Total 26.66	227.42

7.3 Improvements from July to December

Band 7 midwives -overnight safety

The template review In June identified the safety need for an additional supernumerary midwife on maternity unit overnight. The overall senior presence relies on one clinical lead

midwife to manage safety on the labour ward, triage, antenatal ward and postnatal as there is only one senior midwife present overnight within the unit. A request was made through the Care Group to address this concern converting 5 funded posts at band 6 to band 7 clinical leaders. This was agreed and the posts have now been filled with staff currently being trained for their new role.

This change enables the maternity service to develop a specialist training programme for future coordinators of the delivery suite, in line with Ockenden 2 recommendations and immediate senior presence.

The additional clinical leaders also provide additional support to the delivery suite coordinators who manage escalation throughout the maternity service out of hours (night duty) which has been reported as a very challenging responsibility, taking them away from their core work, supporting staff working on the delivery suite and obstetric theatres.

This change was made within the current funded posts and provides assurances of midwifery clinical leadership in the maternity unit overnight.

7.4 Band 3 maternity support workers

There have been national changes since birth-rate plus was undertaken in 2021 with upskilling of all maternity band 2 support workers giving any clinical work will be upgraded to band 3 in line with national recommendations.

The Trust is working through this process however our current birth-rate plus will not represent this adjustment. Maternity support workers will however support midwifery staff in providing care within their remit and competency levels but must not be seen as a substitute midwifery care.

Vacancies for MSW were raised to 19% in this period but with a further recruitment drive our current vacancy rate is 14% Ongoing recruitment and retention will continue and posts have been offered in January and when in commenced role we a 0% vacancy rate.

7.5 Specialist's midwives' roles

The calculations and review of midwifery management and specialist roles of 11% allowance in our birth-rate plus assessment in 2021 would not be considered sufficient in December 2023 to provide all the specialist trained midwives recommended in recent safety reports. Ockenden, East Kent and 3-year delivery plan.

Additional roles requirements have been recommended by the Ockenden report and our current funded establishment accounts for these recommendations. Roles such as audit midwife, policy, and guidelines midwife, increase quality and risk midwives, increase with Professional midwifery advocate (PMA) support for midwives, fetal monitoring midwife and patient experience midwife are now in place.

It also accounts for maternity transformation roles such as digital, perinatal mental health (part funded by perinatal mental health service)

In addition to our current funded roles and the maternity incentive safety actions, it is expected that trusts are planning for future roles which were being funded by the ICB and transformation. These roles include Breastfeeding initiative lead (BFI), continuity of care,

preterm birth midwife, and additional digital midwife time pelvic health lead midwife. Continual funding is at risk, and we are awaiting national funding allocation to the ICB for maternity transformation 2024 to understand any risks in service provision.

The current Birthrate plus model did not take these extra requirements into consideration and is undergoing a national model review.

A business case for these additional posts will be presented at the trust budget setting for consideration if required. (Following national allocation of maternity funding from the ICB.)

7.6 Training requirements

Although Birth-rate plus allocates an uplift of 23%, this is now considered inadequate for the number of professional training hours midwives require as they care for both mothers and babies. This is represented in an increase in training requirements set out by the maternity incentive scheme year 5, Core competency framework 2. To achieve this standard, it is likely that the uplift for midwives will need to be increased to between 25% and 27% (as in line with UHD's A and E department). Currently our dedicated bank staff fill the vacant shifts due this additional training however as our vacancies are filled throughout the year funded shifts will not be available and a deficit will be evident. (This training is also multidisciplinary) As staff vacancies are now filled a business case will be presented to outline the increase which will be needed and to identify a funding stream.

8.0 Safety

To monitor safety there are several systems and polices in place to provide consistence assessments of the maternity unit. The frequency of the assessment is dependent on our opal status which can be changeable in maternity over the 24-hour period due to the nature of our work which is predominately unpredictable and changeable.

MDT Safety huddles occur each day with a standard meeting each morning at 9:30 and additional meetings within the day according to opal status and change in activity.

To determine the need for additional assessments, we monitor change of activity in a variety of ways.

8.1 Birth Rate Plus Live Acuity Tool

The Birth Rate Plus Live Acuity Tool was introduced in the intrapartum areas in April 2023 and further role out to other areas is required once intrapartum is established.

It is a tool for midwives to assess their 'real time' workload arising from the number of women needing care, and their condition on admission and during the processes of labour, delivery and postnatally. It is a measure of 'acuity', and the system is based upon an adaption of the same clinical indicators used in the well-established workforce planning system Birth Rate Plus.

The Birth Rate Plus classification system is a predictive/prospective tool rather than the retrospective assessment of process and outcome of labour used previously. The tool is completed four- hourly, by the labour ward co-ordinator. An assessment is produced on the number of midwives needed in each area to meet the needs of the women based on the minimum standard of one-to-one care in labour for all women and increased ratios of midwife time for women in the higher need categories. This provides an assessment on admission of where a woman fits within the identified Birth Rate Plus categories and alerts

midwives when events during labour move her into a higher category and increased need of midwife support.

This safe staffing tool kit supports most of the components in the NICE Guidance (and is endorsed by NICE) on safe midwifery staffing for maternity settings necessary for the determination of maternity staffing requirements for establishment settings. It provides evidence of what actions are taken at times of higher acuity and use of the escalation policy when required.

The Birthrate Plus acuity tool is now implemented on the labour ward. This provides 4-hourly reports on the safety of the staffing and workload, which informs quality and risk reporting. It was expected to be implemented in January however a digital assessment needed to be carried out to ensure the software was compatible with UHD systems. Training of the team was also required. The system has now been in place since April 2023 Staff are now consistently implementing 85% data and the matron from labour ward monitors this monthly and working with the team on improving data input.

The labour ward matron provides monthly reports in the safety champions report to the care group and safety champions for assurance and alerting to any concerns.

8.2 Supernumerary Labour Ward Co-ordinator

Availability of a supernumerary labour ward co-ordinator is recommended as best practice to oversee safety on the labour ward. This is an experienced midwife available to provide advice, support, and guidance to clinical staff and able to manage activity and workload through the labour ward.

The following table outlines the compliance by month: data source birthrate plus acuity tool.

	Number of days per month	Number of shifts per month	Compliance
July	31	62	98%
August	31	62	100%
September	30	60	98%
October	31	62	97%
November	30	60	100%
December	31	62	100%

In July and September there was one occasion whereby a coordinator was not supernumerary for a short period waiting for a second senior midwife to attend from home.

In October we had two occasions where we were unable to keep the coordinator supernumerary whilst break cover was provided, however the helicopter view was maintained, and the midwife was available to respond to any emergency.

With the introduction of second band 7 on every shift from January 2024 this should no longer occur and 100% is expected. There were no safety or adverse incidences during this time relating to the above occasions.

8.3 One to One in Established Labour

Women in established labour are required to have one to one care and support from an assigned midwife. One to one care will increase the likelihood of the woman having a ‘normal’ vaginal birth without interventions and will contribute to reducing both the length of

labour and the number of operative deliveries. Care will not necessarily be given by the same midwife for the whole labour.

If there is an occasion where one to one care cannot be achieved, then this will prompt the labour ward co-ordinator to follow the course of actions within the acuity tool. These may be clinical, or management actions taken.

The following table outlines compliance by Month (data source birthrate plus acuity tool)

	Birth Centre	Labour ward
July	100%	100%
August	100%	100%
September	100%	100%
October	100%	100%
November	100%	100%
December	100%	100%

From the data we have received, we are providing 1:1 care in labour.

In addition to this monitoring tool staff complete a Datix/Learn should the 1:1 standard not be met. There has been no Datix/LERNS submitted from July to December.

The additional reporting to Datix/LERNS will stay in place as we transition to birthrate plus acuity tool for full assurance of data reliability.

The plan is to introduce the acuity tool to other areas such as postnatal ward and this should be done once assurances that it is embedded into the delivery suite.

8.4 Red Flags- Impact on care

NICE recommend the use of red flags. A midwifery red flag event is a warning sign that midwifery staffing is limited which requires review, escalation, and support. If a midwifery red flag event occurs, the midwife in charge of the service should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed.

During the period July to December there was a transition from Datix/LERN reporting to safe staffing trust system in recording data. Therefore birthrate plus acuity tool, Datix and safe staffing tool have been used to provide data of red flag incidences to demonstrate the impact of staffing.

	July	August	September	October	November	December
Home birth suspension	18	17	8	7	9	1
Haven low risk birth centre closure	1	0	1	10	3	1
Women unable to have birthplace of choice.	1	0	0	2	1	2

Delay in cases going to theatre	4	1 for planned LSCS	0	0	1 (for suturing)	5
Delay in pain relief	2	1	1	0	2 Epidural	2
IOL red flags	55	48	61	46	27	24

This data shows us that low risk births were centralised to provide safe care but therefore limiting choice for women. During this period 6 women were impacted and delivered in the high-risk labour ward safely.

The matrons follow up with the women and from feedback, 1 woman was dissatisfied that her care was not delivered at home. Apologies were given that they did not have their birth experience of choice.

The risk of suspending the home birth service is that women may choose to stay at home without medical assistance.

Delays in cases going to theatre and delays in pain relief are reviewed and learning shared.

Delays in induction of labour are reviewed and individualised plans are made for care by the consultant obstetrician during the delay period, according to their risks and needs. Mutal aid is requested, from neighbouring trusts and transfers occur if clinically needed.

Opel status - data source birthrate plus acuity tool

Status	**Jul 23**	**Aug 23**	**Sept 23**	**Oct 23**	**Nov 23**	**Dec 23**
OPEL 1	(84%)	(86%)	(82%)	(82%)	(80%)	(85%)
OPEL 2	24 (12%)	15 (14%)	18 (15%)	15 (13%)	5 (20%)	21 (12%)
OPEL 3	7 (4%)	0	4 (3%)	6 (5%)	0	3 (2%)
OPEL 4	0	0	0	0	0	1 (1%)

There was 1 occasion of opal 4 in the six-month period and 1 patient was redirected to DCH during this time with no adverse outcomes to her care.

This table shows the percentage of women triaged within 15 minutes of arrival in triage by a midwife and the number triaged after 30 minutes.

Month	Percentage Triaged within 15 minutes. *n*=(percentage triaged within 15 minutes/number of days in month)	Number triaged after 30 minutes. *n*=(number of women)	Longest time taken to Triage after 30 minutes. *n*=(time)

June 2023	96.7%	0	0
July 2023	97.4%	1	39 minutes
August 2023	94.8%	5	36 minutes
September 2023	95.6%	3	34 minutes
October 2023	96.3%	2	39 minutes
November 2023	95.3%	2	36 minutes
December 2023	95.8%	3	42 minutes

Audits show that 95% of women were seen by 15 minutes and that this standard is above the national standard of 85%.

Those above 30 minutes are reviewed to ensure escalation occurred and learning is shared with the team.

8.3 Planned versus actual staffing.

	Jul		Aug		Sept		Oct		Nov		Dec	
Actual vs Planned	Day %	Night %	Day %	Night %	Day %	Night %	Day %	Night %	Day %	Night %	Day %	Night %
Midwife Inpatients	88	83	86	84.5	86	83	84	84	94	93	86	89
Maternity Care Assistants Inpatients	87	90	86	91	83	84.5	89	88	91	90	85	89
Midwife Labour Ward	91	92	90	93	92	93	91	91	103	100	93	92
Maternity Care Assistants Labour Ward	90	97	93	92	86	99	95	98	99	95	87	96

When staffing is less than optimum, the following measures are taken in line with the escalation policy:

- Request midwifery staff undertaking specialist roles to work clinically.
- Elective workload prioritised to maximise available staffing.
- Managers at Band 7 level and above work clinically
- Overstaffing of maternity support workers to assist with basic care needs.
- Relocate staffing to ensure one to one care in labour and dedicated supernumerary. labour ward co-ordinator roles are maintained.
- Activate the on-call midwives from the community to support labour ward.
- Request additional support from the on-call midwifery manager.
- Request additional support from Trust nursing colleagues.
- Liaise closely with maternity services at regional sites to manage and move capacity. as required.

All the above actions are designed to maximise staffing into critical functions to maintain safe care for the women and their babies.

In addition, a significant number of bank hours have been used across the service to cover maternity leave and long and short-term sickness.

Overall strategy will be to continue with recruitment and retention.

9.0 Next steps

From this report there are actions which will be taken to continue to maintain safe midwifery staffing and to provide assurances to the Trust Board.

1. NICE (2017) recommend that a birth rate plus assessment is carried out every three years. It is therefore recommended to carry out a birth rate plus assessment in June 2024. The assessment in June 2024 should be in line with the current maternity service we provide but also to assess for the delivery of the service in the new build. (The new build has different layouts so services will be delivered differently.)

2. We will continue to improve recruitment and retention, reducing the reliance on bank staff, understanding, and supporting staff with work stress improving staff wellbeing.

3. As training requirements have been increased for midwives in year 5 MIS a business case for increase uplift will be presented for consideration to the care group.

4. The plan is to introduce this birthrate plus acuity tool to other areas such as postnatal ward and this should be done once assurances that it is embedded into the delivery suite.

5. To work with the ICB on transformation posts for improvement and the bring a business case to the Trust budget setting for continuing with these improvements' posts if funding not established through the ICB.

10.0 Conclusion

This report provides assurances of systematic reviews of our workforce and our current position. It is continuous process and will be reported six monthly to the board as per MIS year 5 safety standards.

It also provides assurances of safety measures in place to address midwifery safe staffing and provision of care.

It is requested for the Board to note the contents of the report and formally record to the Trust Board minutes.

References

RCM leadership manifesto https://www.rcm.org.uk/media/3527/strengthening-midwifery-leadership-a4-12pp_7-online-3.pdf

NICE midwifery staffing guideline https://www.nice.org.uk/guidance/ng4

Ockenden report : emerging findings and recommendations https://www.pslhub.org/learn/investigations-risk-management-and-legal-issues/investigations-and-complaints/investigation-reports/trust-investigations/ockenden-report-emerging-findings-and-recommendations-from-the-independent-review-of-maternity-services-at-the-shrewsbury-and-telford-hospital-nhs-trust-10-december-2020-r3742/

The safety of maternity services in England: Health Select Committee https://publications.parliament.uk/pa/cm5802/cmselect/cmhealth/19/1902.htm#

Appendix

Appendix 1: MIS year 5 standards

MIS-Year-5-Guidance-July-2023.docx

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 06 March 2024

Agenda item: 6.3.3

Subject:	Guardian of Safe Working Hours Report
Prepared by:	Julie Mantell, Medical Education Manager Michael Vassallo, Guardian of Safe Working Hours Paul Froggatt, Guardian of Safe Working Hours
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)	Medical Staffing Risk 1692
Purpose of paper:	Assurance
Executive Summary:	Significant vacancies in doctor in training rotas. Large numbers of locum shifts unfilled. Majority of exception reporting remains working overtime. Majority resolved. No safety concerns raised- 4 reports across site investigated by directorate.
Background:	Guardian of Safe Works is an exceptionally important mechanism to ensure the concerns of doctors in training are heard, collated and addressed.
Key Recommendations:	For information: Ongoing concerns around significant gaps in rotas. Work being undertaken to address recruitment and retention. Concerns around safety described. Increased mechanisms of ensuring feedback to directorates and ensuring addressed. All safety concerns investigated. No safety incidents noted.
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 Improvement of staff satisfaction for doctors in training. Addressing doctors in training concerns re safety	☐ ☐
CQC Reference:	Safe Effective Caring Responsive Well Led Use of Resources	☒ ☒ ☐ ☐ ☒ ☒

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
People and Culture Committee	14/02/2024	Noted.
Trust Management Group	6/02/2024	For information.
Joint Local Negotiating Committee	15/01/2024	For information.

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

University Hospitals Dorset
NHS Foundation Trust

GUARDIAN OF SAFE WORKING REPORT

1st October 2023 – 31st December 2023

UNIVERSITY HOSPITALS DORSET

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POOLE HOSPITAL OVERVIEW (see page 5 for detail)

There has a been a steady increase in the exception reports on the Poole site. As can be seen from the data this is largely driven by reporting from with OPS & general medicine and is consistently more common amongst foundation trainees, F1 more than F2.

There have also been 3 ISCs from F1 doctors which have all occurred within December and with general medicine. I have reviewed these ISCs with the OPS consultant who has undertaken a key role in trying to improve the junior general medical rota. This is an area which I am keeping under review and the clinical director for general medicine and foundation programme director are also apprised of the situation.

ROYAL BOURNEMOUTH HOSPITAL OVERVIEW (see page 11 for detail)

Exception reporting at RBCH has remained stable. There was a total of 62 exception reports for the quarter 1st October to 31st December 2023, a decrease of 3 from the previous quarter. There has been ongoing industrial action during this period, and this is likely to have affected the numbers of exceptions submitted. The main reason for exceptions being raised during this quarter is for doctors working over their contracted hours, a theme which has follows the pattern of the previous quarter. The causes were for this were often poor staffing compared to workload and having to deal with unexpected emergencies. The GOSW will continue monitoring and encouraging exception reporting

There was one patient safety concerns raised during this quarter arising in surgery. This was immediately raised and addressed by directorate.

There were two joint Junior Doctor Fora held during this quarter. Dates for future meeting have the agreed.

Junior Doctors Forum Meetings

During the last quarter there were 2 Junior Doctor Forum Meetings (9th October and 5th December). Discussions around:

9th October:
-It was encouraged that future Forums should be joint rather than being separate.
-Too tired to drive home: following an incident whereby a paediatric doctor could not secure a room, JM confirmed that in addition to information given at medical induction an email was also sent to all doctors advising and confirming process on each site.
-It was reported that OOH hot food availability as not available on the RBH site. JM investigated and confirmed that the hot food machine at RBH has now been fixed and that the Café West was still available.
-JM confirmed that monies for Wellbeing from NHS England should now be with the Doctors Mess accounts.

5th December

Exception reporting: Reduced exception reporting for the last quarter. It was advised best to exception report there and then so if any problems they can be addressed in a more timely manner. Toil vs payment: Doctors can request either toil or payment, if any problems in getting your preferred outcome please raise with the GSW. Quarterly and annual reports are provided to the board of exceptions and their reasons for being raised. No one should be dictating to the doctor whether they can have toil or payment.

Physician Associates: Following document on PAs by the BMA the consultant lead for PAs at RBH gave an overview of the job role of the PA and the support that they provide to our trust and answered questions raised by the junior doctors. Also informed the forum of the governance policy that the trust has in place. The feedback from departments and other doctors working with our PAs is positive and doctors find them very helpful. This is a new workforce and doctors were reminded to think about forming their opinions form working with them. PAs are a complement to the MDT and a support to our medical workforce.

Locum Rates: Questions were answered on locum rates and strike pay deductions.

Strike pay deductions: Any issue by strike pay deductions to let BMA rep know. BMA rep confirmed the strike dates for December and January. Any pressure to come into work if striking please let BMA rep know.

Surgical rota concerns: RBH site - open letter to directorate regarding experience of rotas – is now resolved. GSW and governance lead for surgery requested a copy of the letter. GSW advised doctors to exception report so that these matters can be addressed at a higher level.

University Hospitals Dorset: Poole Hospital

High level data

Number of doctors / dentists in training (total): 204.4

Number of doctors / dentists in training on 2016 TCS (total): 204.4

Amount of time available in job plan for guardian to do the role: 1 PAs/4hrs per week

Admin support provided to the guardian (if any): 0.13 WTE

Exception reports

Speciality	Exceptions raised 1st Oct – 31st Dec 23	Exceptions raised outside of 14 days from event	Outcome agreed (*not closed*)	Number of exceptions closed	Number of exceptions outstanding
Acute Medicine	2 ↑	0	0	2	0
Cardiology	0 ↓	N/A	N/A	N/A	N/A
Emergency	1 ↑	0	1	0	0
ENT	0 ↓	N/A	N/A	N/A	N/A
Gastroenterology	4 ↑	0	0	3	1
General Medicine	67 ↑	4	20	41	6
General Surgery	4 ↓	1	2	0	2
Geriatrics	44 ↑	0	12	32	0
Haematology	0 ↓	N/A	N/A	N/A	N/A
O&G	0 -	N/A	N/A	N/A	N/A
Oncology	0 ↓	N/A	N/A	N/A	N/A
Orthopaedics	2 ↑	0	0	0	2
Paediatrics	2 ↑	0	0	2	0
Respiratory	1 ↑	0	1	0	0
Total	**127 ↑**	**5**	**36**	**80**	**11**

(Source: Allocate)

Brief Overview of Exception Reports Raised

There was a total of 127 exception reports for the quarter 1st October to 31st December 2023, this is an increase of 37 from the previous quarter. The number of reports raised has raised by 29% since the last quarter.

There were three patient safety concerns raised during this quarter. All were managed within directorate with no escalation.

Reasons for Exceptions Raised

Over 86% (110 reports) were in relation to staff working over their contracted hours. These were raised by 34 doctors during this period.

Working over contracted hours	Access to Education	Shift Pattern	Service Support	Natural Breaks/Rest
110	9	2	2	4

(Source: Allocate)

Reporting Grades for this Period

FY1	FY2	GP/ST1/2	Trust SHO	IMT1	IMT2/CT2	IMT3/ST3	ST4+
91	10	11	0	0	11	2	2

(Source: Allocate)

Outcome Types Agreed

Overtime payment	Time off in lieu	No further action	Created in error	Request for more info	Work Schedule Review/Pattern	Outcome Still Awaited
55	54	8	0	1	0	9

(Source: Allocate)

Fines

There were no fines this quarter.

Vacancies

Department	Number of vacancies
Anaesthetics	0
ENT	0
Histopathology	1
O & G	1
OPM	2
OMF	6
Radiology	N/A

(Source: Medical Staffing)

Locum Bookings via Bank

Locum bookings (Bank) by department				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Anaesthetics	1 -	1 -	3 ↓	3 ↓

Emergency Medicine	978 ↓	474 ↓	9319 ↓	4496 ↓
ENT	118 ↓	90 ↓	1187 ↓	892 ↓
General Surgery	56 ↑	30 ↑	630 ↑	346 ↑
Intensive Therapy Unit	0 ↓	0 ↓	0 ↓	0 ↓
Maxillo-facial Surgery	31 ↓	31 ↓	255 ↓	255 ↓
Medicine	832 ↑	468 ↓	7301 ↑	4183 ↓
Obstetrics and Gynaecology	110 ↑	81 ↑	962 ↑	780 ↑
Oncology	71 ↓	45 ↓	672 ↓	408 ↓
Orthopaedic Surgery	503 ↓	422 ↓	4586 ↓	3873 ↓
Paediatrics	90 ↓	46 ↓	912 ↓	487 ↓
Psychiatry	0 -	0 -	0 -	0 -
Urology	0 ↓	0 ↓	0 ↓	0 ↓
TOTAL	**2,790 ↓**	**1,688 ↓**	**25,826 ↓**	**15,723 ↓**

(Source Temp Staffing Office)

During this quarter there was a significant decrease of 18.5% in the overall number of locum shifts requested. Following the trend of the last quarter, where there were a large number of unfilled shifts within Emergency Medicine, Medicine and Paediatrics department.

Of note, just under half of the Emergency Medicine hours requested went unfilled. This is the first time Dental Core Trainees have been on the locum bookings report, which can either be attributed to either a change in the grade reporting or increased data availability.

Locum bookings (Bank) by Grade				
Grade	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
F1	34 ↑	20 ↑	311 ↑	141 ↑
F2	63 ↑	34 ↑	354 ↑	193 ↑
ST/CMT1/2	1,950 ↓	1,225 ↓	18,361 ↓	11,705 ↓
ST3+	714 ↓	380 ↓	6575 ↓	3459 ↓
Dental Core Trainee 1	1 ↑	1 ↑	4 ↑	4 ↑
Dental Core Trainee 2	2 ↑	2 ↑	13 ↑	13 ↑
Dental Core Trainee 3	23 ↑	23 ↑	180.5 ↑	180.5 ↑
Junior Clinical Fellow	3 ↑	3 ↑	27.5 ↑	27.5 ↑
TOTAL	**2,790 ↓**	**1,688 ↓**	**25,826 ↓**	**15,723 ↓**

(Source Temp Staffing Office)

Of note, 725 of the ST/CMT1/2 shifts and 334 registrar shifts requested went unfilled.

Locum Bookings (Bank) by Reason				
Reason	**Number of shifts Requested**	**Number of shifts worked**	**Number of hours Requested**	**Number of hours Worked**
7 day Pilot	0 ↓	0 ↓	0 ↓	0 ↓

Adhoc	237 ↓	237 ↓	1909 ↓	1909 ↓
Annual Leave	180 ↑	161 ↑	1451 ↑	1292 ↑
Coronavirus	1 ↑	0 -	12 ↑	0 -
Civil Duty	2 ↑	0 -	24 ↑	0 -
Deanery Vacancy	219 ↑	143 ↑	2169 ↑	1481 ↑
Escalations	3 ↓	2 ↓	38 ↓	25 ↓
LTFT Cover	240 ↑	155 ↑	2197 ↑	1393 ↑
Maternity/Paternity Leave	67 ↑	38 ↑	583 ↑	328 ↑
Service Demand (e.g winter pressures)	256 ↓	203 ↓	2616 ↓	2153 ↓
Sickness	208 ↑	86 ↓	1955 ↑	856 ↓
Study Leave	109 ↑	49 ↑	936 ↑	427 ↑
Trust vacancy	1065 ↓	529 ↓	10006 ↓	5013 ↓
Urgent Clinical Need	203 ↑	85 ↓	1930 ↑	846 ↓
Waiting List Initiative	0 ↓	0 ↓	0 ↓	0 ↓
TOTAL	**2,790 ↓**	**1,688 ↓**	**25,826 ↓**	**15,723 ↓**

(Source Temp Staffing Office)

The biggest increase this quarter has been for shifts requested due to study leave; this is nearly five times higher than in the previous quarter but over half of the hours requested were not worked.

The most significant decrease was for escalations, with 306 shifts requested in the last quarter compared to only 3 during this quarter. In addition, and of note is the reduction in locum bookings connected to trust vacancies which have decreased by approximate 450 shifts in comparison to the previous quarter – it is likely this is due to the recent activity in trust medical recruitment drive.

The usual pattern of LTFT, annual leave, deanery vacancies and sickness continue to increase.

Locum Bookings via Agency

Locum bookings by Grade		
Grade	**Number of shifts requested**	**Number of shifts worked**
Foundation Year 1	0 -	0 -
Foundation Year 2	37 ↓	19 ↓
ST1/2 - CT1/2	1 ↓	1 ↓
ST3+	168 ↓	137 ↓
Totals	**206 ↓**	**157 ↓**

(Source Temp Staffing Office)

The number of locum shifts requested via agency have more than halved since the last quarter.

University Hospitals Dorset: Royal Bournemouth Hospital

High level data

Number of doctors / dentists in training (total): 173

Number of doctors / dentists in training on 2016 TCS (total): 173

Amount of time available in job plan for guardian to do the role: 1 PAs/4hrs per week

Admin support provided to the guardian (if any): 0.13 WTE

Exception reports

Speciality	Exceptions raised 1st Oct – 31st Dec 2023	Exceptions raised outside of 14 days from event	Outcome agreed (*not closed*)	Number of exceptions closed	Number of exceptions outstanding
Acute Medicine	0 ↓	N/A	N/A	N/A	N/A
A&E	3 ↑	0	1	0	2
Cardiology	2 -	0	1	0	1
Dermatology	1 ↑	0	1	0	0
General Medicine	27 -	6	1	25	1
General Surgery	4 ↓	0	0	4	0
Geriatrics	16 ↑	1	0	9	7
O&G	0 -	N/A	N/A	N/A	N/A
Ophthalmology	0 ↓	N/A	N/A	N/A	N/A
Respiratory	8 ↑	3	2	5	1
Urology	1 -	0	1	0	0
Vascular	0 ↓	N/A	N/A	N/A	N/A
Total	**62 ↓**	**10**	**7**	**43**	**12**

(Source: Allocate)

Brief Overview of Exception Reports Raised

There was a total of 62 exception reports for the quarter 1st October to 31st December 2023, a decrease of 3 from the previous quarter.

There was one patient safety concerns raised during this quarter. This was managed within the directorate. No escalation required.

Reasons for Exceptions Raised

The main reason for exceptions being raised during this quarter is for doctors working over their contracted hours, a theme which has follows the pattern of the previous quarter.

Working over contracted hours	Access to Education	Shift Pattern	Service Support	Natural Breaks/Rest
56	3	1	0	2

(Source: Allocate)

Reporting Grades for this Period

FY1	FY2	GP/ST1/2	Trust SHO	IMT1/ST1	IMT2/ST2	IMT3/ST3	ST4+
21	20	0	0	16	0	4	1

(Source: Allocate)

Outcome Types Agreed

Overtime payment	Time off in lieu	No further action	Created in error	Request for more info	Work Schedule Review/Pattern	Outcome Still Awaited
48	0	3	1	0	0	10

(Source: Allocate)

Vacancies

Department	Number of vacancies
Anaesthetics	1
Cancer Care	3
ED	0
Gastro	1
GP	N/A
O & G	1
OPM	4
Orthodontics	1
Radiology	N/A

(Source: Medical Staffing)

Fines

There were no fines this quarter.

Locum Bookings Via Bank

Locum bookings (Bank) by department				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Anaesthetics	25 ↑	21 ↑	229 ↑	194 ↑

Emergency Medicine	746 ↓	600 ↓	6835 ↓	5453 ↓
Surgery	195 ↓	144 ↓	2060 ↓	1531 ↑
Medicine	990 ↓	637 ↓	10823 ↓	6397 ↓
Oncology	1 ↑	0 -	10 ↑	0 -
Ophthalmic	13 ↓	13 ↓	259 ↓	259 ↓
Orthodontic	0 -	0 -	0 -	0 -
Orthopaedic	207 ↑	174 ↑	1417 ↑	1441 ↑
TOTAL	**2,177 ↓**	**1,589 ↓**	**21,633 ↓**	**15,276 ↓**

(Source Temp Staffing Office)

There was a significant reduction in the number of shifts and hours requested during this quarter a decrease of 657 and 6757 respectively.

Locum bookings (Bank) by Grade

Grade	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
F1	43 ↑	20 ↑	426 ↑	153 ↑
F2	14 ↓	10 ↓	148 ↓	101 ↓
ST/CMT1/2	1,716 ↓	1,295 ↑	15,641 ↓	11,872 ↑
ST3+	455 ↓	311 ↓	5886 ↓	3332 ↓
TOTAL	**2,228 ↓**	**1,636 ↓**	**22,100 ↓**	**15,457 ↓**

(Source Temp Staffing Office)

Of note, over 400 of the ST/CMT1/2 shifts requested were unfilled.

Locum Bookings (Bank) by Reason

Reason	Number of shifts Requested	Number of shifts worked	Number of hours Requested	Number of hours Worked
7 day Pilot	134 ↑	52 ↑	1369 ↑	574 ↑
Adhoc	301 ↓	301 ↓	2960 ↓	2960 ↓
Annual Leave	57 ↓	53 ↓	467 ↓	439 ↓
Coronavirus	1 ↑	0 -	3 ↑	0 -
Deanery Vacancy	1 ↓	1 ↓	10 ↓	10 ↓
Escalations	42 ↓	25 ↓	354 ↓	188 ↓
Leave - Emergency	0 -	0 -	0 -	0 -
LTFT Cover	116 ↑	32 ↑	2402 ↑	431 ↑
Service Demand	273 ↓	179 ↓	2664 ↓	1799 ↓
Sickness	227 ↑	144 ↑	2,023 ↑	1,316 ↑

Study Leave	38 ↑	26 ↑	368 ↑	253 ↑
Trust vacancy	979 ↓	783 ↑	8,959 ↓	7,133 ↓
Urgent Clinical Needs	54 ↓	35↑	513 ↓	326 ↑
WLI - Waiting List Initiative	5 ↑	5 ↑	26 ↑	26 ↑
TOTAL	**2,228 ↓**	**1,636 ↓**	**22,117 ↓**	**15,453 ↓**

(Source Temp Staffing Office)

Locum Bookings via Agency

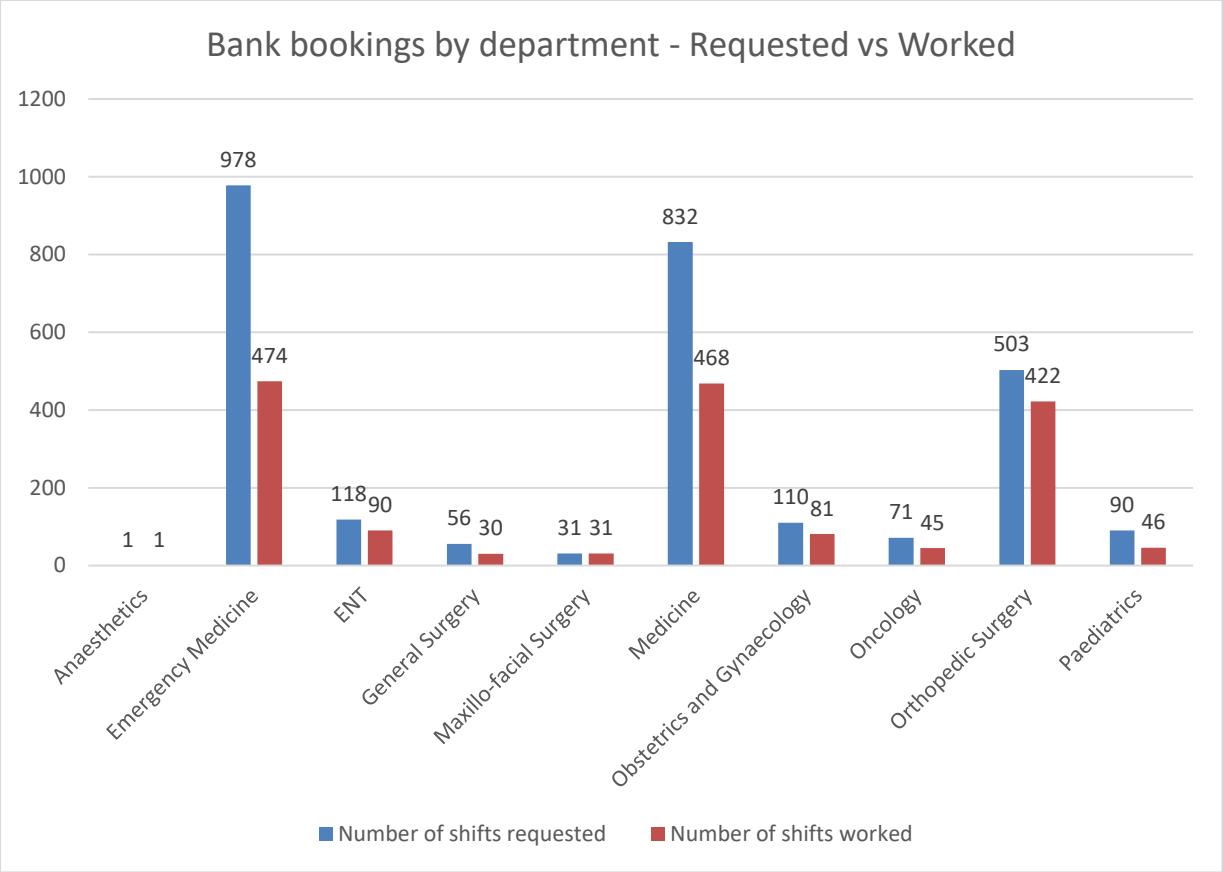
Grade	Number of shifts requested	Number of shifts worked
Foundation Year 1	0 ↓	0 ↓
Foundation Year 2	40 ↓	40 ↓
ST1/2 - CT1/2	3 ↑	3 ↑
ST3+	486 ↑	61 ↑
Total	**529 ↑**	**104 ↑**

(Source Temp Staffing Office)

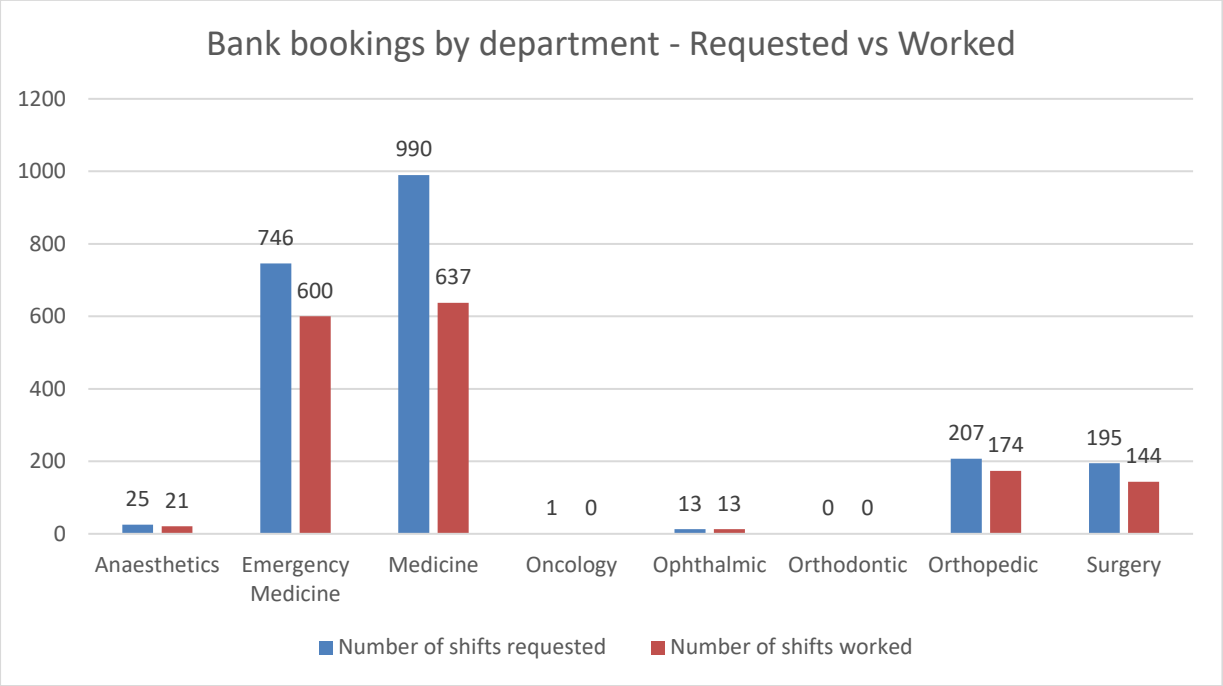
The number of locum shifts requested via agency has increased by 22% from 410 to 529 compared to the previous quarter. The percentage of requested shifts which were worked during this quarter has risen in line with the request increase.

Visual data representations

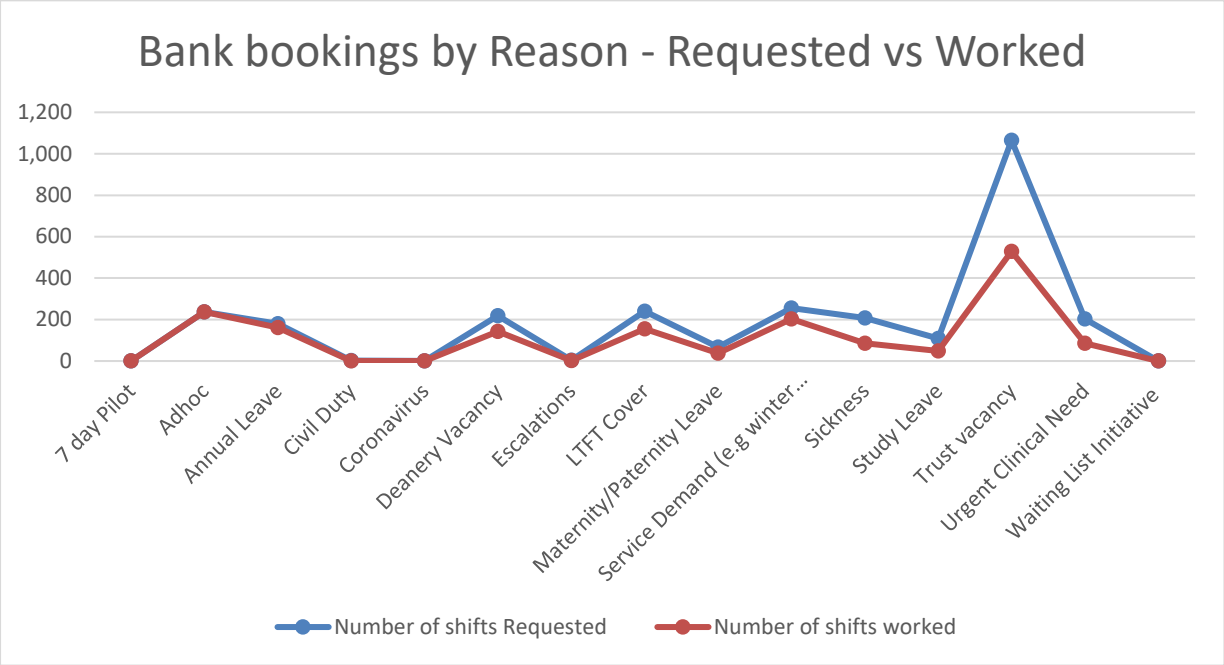
Pooe



Bournemouth

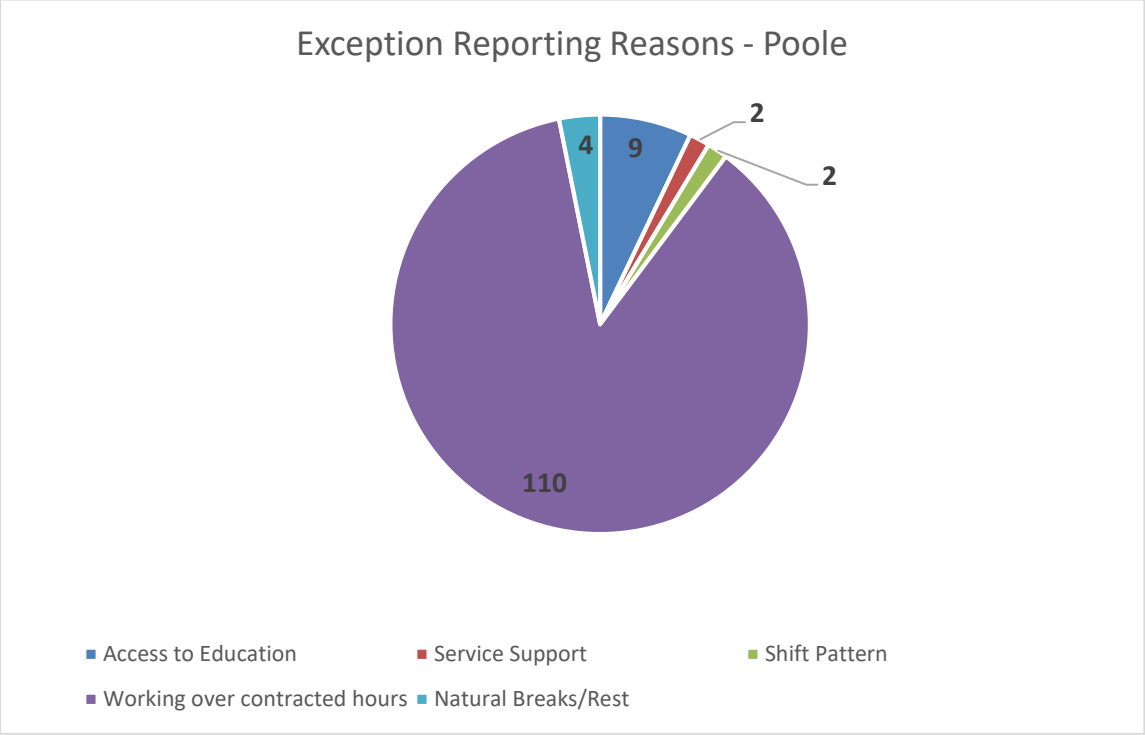


Poole

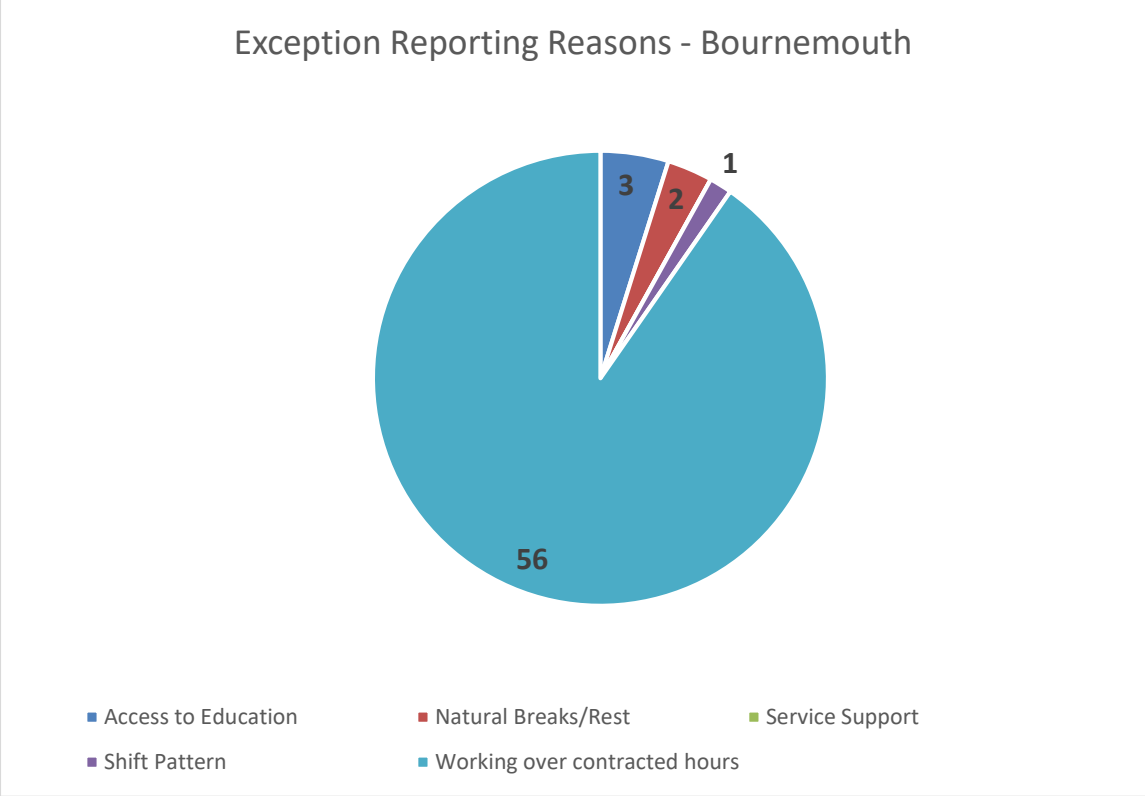


Bournemouth

Poole



Bournemouth



University Hospitals Dorset
NHS Foundation Trust

UHD Car Parking 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.

Out of date policy documents must not be relied upon.

Title: UHD Parking Policy
Author: Elliot Prescott
Version: 3
Date of approval: June 2023
Date of review: June 2026

A) EXECUTIVE SUMMARY POINTS
• This policy is created to harmonise the car parking processes across UHD sites
• The policy aims to manage the limited parking spaces allowed on the sites in a fair manner
• A scale of staff eligibility criteria is defined together and an appeals process
• Charges and concessions for staff and the public are identified
B) ASSOCIATED DOCUMENTS
• Car Parking Guidance - Department of Health and Social Care
• UHD Car Parking Standard Operating Procedure

C) DOCUMENT DETAILS	
Author:	Elliot Prescott
Job title:	Travel and Transport Manager
Directorate:	Strategy and Transformation
Version number:	V3.0
Equality impact assessment date:	6 December 2023
Target audience:	All staff and visitors
Approving committee/group:	Board of Directors
Chairperson:	Rob Whiteman
Review date:	December 2025

D) VERSION CONTROL

Date of Issue	Version No.	Date of Review	Nature of Change – (include section reference)	Approval Date	Approval Committee	Author
Jan 2022	1.0	Jan 2023	Initial document for comment		SPF	
March 2022	1.1		Edited following SPF comments		SPF	
Dec 2023	2	Dec 2025	Updated to new UHD template		SPF	Martin Nash
Jan 2024	3	Dec 2025	Updated to add concessionary car parking form and updated criteria		Board of Directors	Elliot Prescott

E) CONSULTATION PROCESS

Version No.	Review Date	Author	Level of Consultation
2	Dec 2025	Elliot Prescott	People & Culture Committee Staff Partnership Forum Staff Travel Group

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1 Introduction

This policy sets out how University Hospitals Dorset NHS Foundation Trust (the Trust) aims to balance staff, visitor, and patient parking demand with the available parking supply and support alternative modes of travel, in a way that is measured, fair and transparent.

The Trust has a limited amount of parking available. BCP Council allows the Trust to have a fixed number of parking spaces as set out through planning permissions and controls.

This policy considers the following key factors:

- It is important the limited staff parking spaces the Trust has are allocated fairly and transparently.
- In addition, the costs of transport and parking are fair – not taking resources from patient care and any charges we have in place cover all costs, including promoting offers and incentives to meet our travel objectives.
- The Trust is working to reduce congestion around the sites and promote cleaner air and sustainable solutions in line with the UHD Green Plan and the NHS Zero Carbon pledge
- The Trust will offer staff travel options that make getting to/from work as hassle free as it can – and healthy and even enjoyable with initiatives to support and encourage those, who can do so to use alternative modes of travel, to single occupancy car use.

2 Purpose/Policy Statement

The Trust aims to deliver an efficient and effective parking service to visitors and staff. Infrastructure and equipment will be provided in suitable locations, maintained and repaired to ensure a satisfactory level of service, such that users are not unduly inconvenienced when parking or attempting to pay.

Parking space is a finite resource, limited by both physical space and the conditions imposed as part of the Planning Process. More parking on site equals more highway congestion, this leads to increased pollution and in time poorer health for our communities. Breaking this cycle is beneficial for community and individual health.

The Trust takes the international requirement for action to prevent future climate change seriously. It recognises it has a social responsibility to reduce its environmental impact and associated carbon emissions. One of the key areas for action is travel and transport.

This policy aims to be fair to staff and patients alike, to promote healthy travel and to provide parking using a needs and options-based hierarchy.

The Trust retains all rights to parking on Trust owned sites and there is no right or assurance for anyone to be able to park on Trust owned sites. All parking is under agreement and subject to the terms and conditions of use as set out by the Trust.

Land used for parking, and the infrastructure provided, presents a cost to the Trust. It remains a core policy to ensure the allocation of resources to serve parking is kept under review and considered in the context of other potential uses of land, finance, and other resources.

The Trust will ordinarily apply a charge for parking on Trust owned sites, although the Trust will apply concessions including those set out in government guidance.

Definitions

UHD – University Hospitals Dorset

CSS – Criteria Scoring System

BCP – Bournemouth, Christchurch and Poole Council

PPG – Policies and Procedures Group

3 Consultation

Prior to ratification with the Staff Travel Group the following persons/teams will be consulted:

- Director of Estates and Capital Estates
- Associate Director of Estates
- Car Parking and Security staff

4 Procedures/Document Content

5.1 Eligibility

Parking for patients and visitors will be made available at appropriately signed car parks across UHD.

All parking by staff at any site will be managed by the Trust or its agents.

Staff parking will be subject to a permit or similar consent. A permit to park will be available only to staff who are eligible:

- those who are directly employed by the Trust or who are on a long-term contract or via a tendered service e.g., partner organisations and contractors.
- meet the requirements to be allocated a permit.

5.2 Permit Requirements

The Trust will provide permits to park based on appropriate need. It will operate a defined process for determining the minimum requirements for allocation of a parking permit. The process will use a Criteria Scoring System (CSS) to:

- provide an objective and fair assessment of applicants' needs against the threshold for allocation of a permit to park on UHD property.
- determine any allocation or conditions of use, including parking locations to be used, restrictions on time of entry, durations of stay, frequency of use or permissible days.

The Trust will provide an appeal process for staff who do not meet the threshold for their requested permit.

5.3 Space Allocation

The Trust operates several car parks for staff use. Blue Badge, Occupational Health-verified health issues, permanent nights, community nurses, and Liftshare users will be prioritised for parking closest to the hospital. Staff who fall outside of these criteria may be offered parking off-site, so the limited car parking spaces on-site across UHD (particularly Bournemouth and Poole) are allocated to those with the greatest need.

5.4 Public Parking

The Trust requires users of the public car parks to comply with the terms and conditions of use. These will be displayed clearly and prominently in line with the requirements of the British Parking Association guidelines.

5.5 Charges and Payment

The Trust will apply charges at all its public car parks. It will be set to:

- Be at least sufficient to ensure costs associated with the provision of parking by the Trust, including equipment, renewal and maintenance and parking operational costs, are fully recovered by the users.
- Discourage occupation by non-hospital users. The unvalidated charge will be at least equivalent to the cost of parking for an equivalent time in any public parking facility within 600 metres of a hospital site.

5.6 Pick-Up/Drop-Off

Pick-up/Drop-off spaces may be made available close to the main entrances to the hospitals. These areas will be designated for a 20 or 30-minute maximum stay. They are for use by patients and visitors only for the purposes of delivering or collecting passengers.

5.7 Concessionary Parking

The Trust will provide specific concessions to some users to reduce or waive parking charges. These concessions include those within the guidance issued by the Department of Health and Social Care. The Application for Concessionary Parking form can be found in Appendix H of this document.

5.8 Blue Badge Holder Parking

The Trust is committed to providing dedicated parking spaces for Blue Badge holders, whether visitors or staff.

Blue Badge holder parking will be provided near each hospital entrance. Vehicles may park in the designated parking spaces subject to:

- The driver or occupant being an eligible Blue Badge holder.
- The badge being displayed in the windscreen.
- Any stay beyond the maximum duration being notified and agreed with the Trust's on-site Car Parking team.

Hospital staff holding a Blue Badge will be provided with a D-Permit. Vehicles displaying a D-Permit will be eligible to use the parking spaces reserved for Blue

Badge holders in the staff parking areas.

5.9 Maternity and Long-Term Sickness

The Trust is committed to supporting staff throughout periods of maternity leave or long-term sickness. For staff going on maternity leave, the parking permit is suspended but retained for the period of absence. For long-term sickness absence (a period greater than four months), it remains the responsibility of the member of staff to inform the Car Parking team when they started their long-term sickness absence, and when they return. If the member of staff does not inform the Car Parking team, charges continue as normal. If they did not tell the Car Parking team of when they returned and are therefore parking for free, the Car Parking team can organise for charges in arrears.

5.10 Volunteers and Non-Staff Governors

The Trust welcomes and appreciates the considerable value provided by its volunteers and non-staff Governors. Volunteers or non-staff Governors who choose to drive to any hospital site will be:

- Provided public access to parking areas and be able to claim a full refund for expenses accrued following a voluntary shift or governor activity.
- Entitled to a D permit if they are a Blue Badge holder (allowing use of staff disabled spaces).

5.11 Residents

All on-site residents holding a tenancy agreement will be able to apply for a parking permit issued subject to availability. There is limited parking space close to the residential accommodation and these permits are limited. The permit will be subject to charge based on the Charging Rate Table. Residents living with young dependents or with mobility needs will be offered permits for parking near their accommodation, as and when they become available. Disabled staff in residences will be addressed in line with the wider disabled staff policy.

5.12 Occasional Users

Staff who require parking 12 times per month or less can apply for an Occasional permit in place of a full permit. This permit allows the member of staff to park within any permitted staff car park on 12 occasions per calendar month. The criteria governing the allocation of these permits remains the same as other permits, despite the limited usage in comparison to other permits.

These permits will be monitored by on-site car parking teams. In future, Automated Number Plate Recognition (ANPR) systems may be employed to ensure the 12 occasions per calendar month are not exceeded. There is a daily charge for occasional use as defined in the charges table, published in the UHD Car Parking Standard Operating Procedure and the Trust Intranet.

5.13 Inappropriate Parking

Vehicles obstructing essential Trust services or otherwise presenting a danger, hazard or nuisance will be removed without the owner's consent. The Trust will not compensate and will defend its actions against any damage that occurs to vehicles or

their contents when moved.

5.14 Abandoned Vehicles

The Trust has a Vehicle Abandonment Process and will apply this to any vehicles that are potentially abandoned.

6 Roles and Responsibilities

6.1 Chief Executive

The Chief Executive, as part of their overall remit for environmental issues, holds responsibility for the Car Parking Policy.

6.2 Director of Estates and Capital Development

Ensure the Car Parking Policy is enforced, to provide staff, patients, and visitors an effective parking service.

Ensure costs associated with the provision of parking by the Trust, are fully recovered.

6.3 Associate Director of Estates

Responsible for operational implementation of Car Parking Policy.

Ensure the requirements of car parking are aligned to the UHD Green Plan.

6.4 Car Parking/Security Supervisors/Staff

Provide help and advice on all matters relating to car parking that affects users daily.

Ensure car parking services are fully functional and request maintenance if required.

Undertake the day-to-day monitoring of car parking facilities and issue notices to vehicles contravening this policy.

7 Training

No specific training can be identified from the policy. Relevant staff will be updated with latest policy information.

8 Monitoring Compliance and Effectiveness of the Document

Monitoring will be achieved using the Trusts internal LERNS system which allows for issues to be reported.

9 Supporting Documents and References

UHD Parking Standard Operating Procedure

10 Dissemination

This policy will be given to all relevant staff as part of their training and familiarization

and will be made available via the Estates section of the UHD intranet.

11 Approval and Ratification

Following consultation and Equality Impact Assessment Screening this policy will be approved at Board of Directors level. Consultation includes the People & Culture Committee and Staff Partnership Forum/Staff Travel Group.

12 Review

Three yearly updates, unless car parking requirements change prompting earlier review. Changes will be subject to Trust approval.

Equality Impact Assessment

1. Title of document	**UHD Parking Policy**
2. Date of EIA	December 2023
3. Date for review	December 2025
4. Directorate/Specialty	Strategy & Transformation

5. Does the document/service affect one group less or more favourably 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.	Yes	It offers them preferential parking
• 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 unfavourably 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?	No	
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.		Government guidance stipulates that this group are provided free parking at hospitals. Parking is

		provided near entrances to assist with mobility limitations.
Adjust the policy to remove disadvantage identified or better promote equality.		

Appendix A: Staff Parking Permits

For staff set to pay charges for their permit, these will be:

- Applied for the full calendar month.
- Deducted from their monthly salary, unless otherwise specified.
- Set at a rate as determined by the Charging Rate Table for staff.
- Apply to any member of staff who works on Trust premises regardless of their employer or employment status.
- Applied for the duration of the period that parking permission is granted irrespective of actual use. There will be no rebate for periods of annual leave, sickness or absence resulting in unused parking.

The Charging Rate Table will be published annually following review of this policy. It will establish the monthly charge to be paid based on a combination of the permit type granted and user's banding. Staff holding permits will be provided with a minimum two full calendar months' advance notification of any change to the permit rates using:

- the Trust's global email system and,
- notifications within staff publications.

Staff who may be subject to a change in charge liability because of transfer, promotion or other change in employment conditions will be subject to revised deductions based on the date of transfer.

The Trust considers it is the permit holder's responsibility to check the correct deductions are being made. The Trust reserves the right to claim back any unpaid costs from staff who have failed to pay either the full tariff or a lower tariff to that defined by the charging policy and will reimburse to any agreed overpayments to staff.

Appendix B: Public Parking Charges

The charge will be set to:

- Be at least sufficient to ensure all costs associated with the provision of parking by the Trust, including land opportunity costs, capital, renewal, maintenance and operations, are fully recovered by the users.
- Deliver a reduction in private car travel to the hospital.
- Discourage occupation by non-hospital users. The unvalidated charge will be at least equivalent to the cost of parking for an equivalent time in any public parking facility within 600 metres of a hospital site.

Weekly Tickets

Discount tickets for one week's parking are available for patients and visitors able to demonstrate cause for use of the hospital car park (thus not open to use for non-hospital users/visitors). These are only available from the car park offices.

Appendix C: Blue Badge Parking

The Trust are committed to providing specific parking spaces for disabled users and staff parking facilities for disabled staff.

Blue Badge holders are NOT permitted to park in any of the following locations:

- Places where a ban on loading or unloading is in force, as indicated above by kerb markings.
- Parking places reserved for specific users such as resident's bays or loading bays.
- Pedestrian crossings (zebra, pelican, toucan and puffin crossings), including areas marked by zig-zag lines.
- Clearways (no stopping).
- Where temporary parking restrictions are in force, as shown for example by no-waiting cones.
- Any other areas as defined as dangerous or obstructive parking, including:
    - where it would hold up traffic, such as in narrow stretches of road or blocking vehicle entrances.
    - where emergency vehicles stop or go in and out, such as hospital entrances.
    - where the kerb has been lowered or the road raised to help wheelchair users.
    - on a pavement, unless signs permit it.

Holders of Blue Badges are requested to adhere to the time limits if using the pick-up/drop-off areas andensure their holder's parking clock is clearly visible.

Appendix D: Concessions

Parking at no cost

The Trust will not charge the following to use the public car parks:

- Blue Badge holder for the duration of their attendance at, or visit to, the hospital.
- Blue Badge holding employees for purposes relating to their employment.
- Outpatients who attend hospital for an appointment at least three times within a calendar month and for an overall period of at least three months. A 'month' is defined as a period of 30 days.
- The parents/guardians of a child (under 18) who is admitted as an inpatient at hospital overnight between the hours of 19:30 and 08:00 while visiting the child. (Applicable to a maximum of two vehicles).
- Bereavement or Family of Patient receiving End of Life Care (Immediate family only)

Minimum Tariff Rate Applied

- Parent of pre-term baby on Neo Natal Unit.
- Patients receiving a regular course of therapy or treatment (more than three per week).

Weekly Rate Applied

- The Patient admitted for more than 24hours, (rate applied for each seven-day period).
- Visitor with requirement for regular attendance.

Capped with Four Hourly Rate Applied

- Patient requiring treatment in excess of a four-hour visit.
- The Patient was detained in excess of four hours for treatment or test.

Staff Attending Training at Another Hospital Site

Staff who hold a full salary deducted staff parking permit at one of the hospitals within the Trust may apply to for free parking when attending training at a different hospital within the Trust.

Staff who do not hold a full salary deducted staff parking permit may reclaim parking as a legitimate expense through the Trust expenses policy.

Roles requiring essential vehicle use

Staff whose roles involve essential vehicle usage to perform their duties (i.e, Community Nurses visiting patients across the conurbation) may be entitled to receive parking permits at no cost, for the purposes of drop off / pick up only.

Process of Application

All applications for concessions are to be made to the Transport and Travel Team. All concessions for relatives are limited to two vehicle registrations per patient.

The issuing of concessionary parking is subject to change. The Trust has the right to refuse the issue of concessions or to validate parking tickets.

Appendix E: Concessions - Government Guidance

Governing the Trust's concessions policy is the following decree, issued by the Department of Health and Social Care:

https://www.gov.uk/government/publications/nhs-patient-visitor-and-staff-car-parking-principles/nhs-patient-visitor-and-staff-car-parking-principles

Appendix F: Parking Infringements

Parking Infringements

The Trust will pursue a corrective rather than punitive approach to parking infringements. Staff and users will be presented with a warning for the first and second occurrence infringements that present no inconvenience or danger to other users.

More significant actions that cause obstruction, are deliberate, selfish, or dangerous will be subject to penalties. Repetition of minor infringements will also be subject to penalties. Drop-off/pick-up spaces provide an important facility and serve a particular need. Inappropriate use can cause substantial inconvenience for other users and will be subject to a penalty charge.

When issuing a Penalty Charge Notice (PCN), the Trust will do so in accordance with the government's guidance published on 07 February 2022, found here: https://www.gov.uk/government/publications/private-parking-code-of-practice/private-parking-code- of-practice

Removal

Vehicles obstructing essential Trust services or otherwise presenting a danger, hazard or nuisance will be removed without the owner's consent.

Penalty Charge Process

Parking Charge Notices will be issued and will incur a charge to be paid within the time specified.

Appeals

Any appeal against a fixed penalty notice should be in writing to the address provided on the PCN.

Staff

An unreasonable number of Penalty Charges will be interpreted to be three within a rolling twelve- month period.

Staff who accrue unresolved Parking Charge Notices may be found to be in breach of the Trust's disciplinary procedures.

Staff permits may be cancelled and eligibility for parking withdrawn as part of any sanction imposed by the Trust. This may be applied for users found to be:

- contravening the Car Parking Policy,
- accruing an unreasonable number of Penalty Charges,
- failing to pay Penalty Charge Notices within the timescale permitted,
- driving on the site in a dangerous or otherwise careless manner including at excessive speed or
- for any other action considered inconsistent with the privilege of using a vehicle and parking on-site.

The Trust may require any member of staff to prove that any vehicle being parked on Trust premises has insurance, excise duty and where applicable a valid MOT.

The Trust reserves the right to cancel any parking permit without notice.

Appendix G: Vehicle Abandonment Process

Vehicles considered or reported to be abandoned will logged in the Security Occurrence Book. After three days a 'Vehicle Abandonment Notice' will be affixed to the windscreen. This notice will require the owner to remove the vehicle within a defined period (currently 10 days). After the notice period has elapsed the Trust may remove the vehicle and place a charge on the vehicle or its keeper for the removal and disposal costs. The Trust reserves the right to check vehicle status and ownership with the DVLA.

Appendix H: Application for Concessionary Parking

Appendix A – Application Form for Concessionary Parking

Please return to the Car Park Office

Car Park Telephone No: 0300 019 ext: 5894 (Bournemouth and Christchurch), 8040 (Poole)

Patient/Visitor - Surname: _____

Issuing Ward/Department: _____ Phone Extension: _____

***Authorisers Name**:_____ **Authorisers Signature**:_____

*** Authoriser please note – Only the following can be accepted as being eligible for Concessionary Parking – Please do not add anything else as this can cause distress or embarrassment to the Patient/Visitor when rejected.**

Capped 4 hourly (£4.40) Rate Applied

☐ Patient requiring treatment more than 4 hours visit.

Minimum Tariff Rate Applied (7- day treatment ticket available for the cost of 3 x 2 hr rate = £6.60)

☐ Parent of pre-term baby on Neo Natal Unit

☐ Patients receiving a regular course of therapy or treatment **(more than 3 per week)**

Start Date of Treatment _____ **End Date of Treatment** _____

This form must be kept by the patient for the duration of their treatment and can be used to purchase future 7-day treatment tickets for the duration term entered above.

Free Parking

☐ Patients receiving a regular course of therapy or treatment **(at least 3 appointments within a month for an overall period of at least 3 months)**

Start Date of Treatment _____ **End Date of Treatment** _____

(The end date must be 3 months from the start date)

This form must be kept by the patient for the duration of their treatment and can be used to obtain future 7-day treatment tickets for the duration term entered above.

☐ A parent staying overnight with a child (under 18)

☐ Bereavement or Family of Patient receiving End of Life Care (Immediate family only)

University Hospitals Dorset
NHS Foundation Trust

Standard Operating Procedure

UHD Car Parking

When using this document please ensure that the version you are using is the most up to date either by checking on the Trust intranet or if the review date has passed, please contact the author.

'Out of date policy documents must not be relied upon'.

SOP Number: 1

SOP Title: UHD Car Parking Standard Operating Procedure

Approval Committee	Version	Issue Date	Review Date	Document Author
Board of Directors	1	January 2024	Every 6 months or significant change	Elliot Prescott

1. Definitions/Glossary of Terms

ERIC: Estates Returns Information Collection
'Trust owned sites': Locations owned and leased to University Hospitals Dorset NHS Foundation Trust
UHD: University Hospitals Dorset
SPF: Staff Partnership Forum

2. Purpose

Description of the standard procedures related to staff car parking across UHD. Our aim is to allocate parking permits according to the UHD Car Parking policy.

The Trust intends to progressively reduce the proportion of staff that travels to work by single occupancy private car use, by supporting attractive alternatives that will drive forward our green objectives in cutting pollution and congestion around the Trust's sites.

3. Scope

Procedures used in the allocation of parking permits for parking spaces on Trust owned sites.

Revenue transparency – the Trust publishes details of the revenue generated from car parking via the NHS ERIC report, which is available online from NHS Digital.

4. Responsibilities

Who is responsible?	Responsibility
Car Park Manager	Sufficiently staffed and trained personnel to follow this procedure to ensure that parking charges, appeals and the permit process is accurately followed. Car Parking charges annually reviewed in line with Car Parking Policy.
Travel & Transport Manager	Establish and maintain effective communication links with external providers, council partners, colleagues and

	collaborators in regards to strategic travel plans, promotions and operations

Caution required:
Data Protection/Security of personal information in the handling of permit applications.

5. Procedure

Public Car Parking

Charges and payment

The Trust will apply a charge for car parking at any of its sites. The charge levied will be set to:

- Be at least sufficient to ensure operational costs associated with the provision of parking by the Trust are covered.
- Be always more than a typical day return bus fare.
- Deliver a reduction in private single occupant car travel to the hospital sites, by creating and funding incentives for those with viable alternative travel options.
- Avoid need for subsidy from healthcare services.

Irrespective of the charge or payment, a period of 15 minutes grace will be given for the car park user to get to their car and out of the car park.

Charges for visitors and patient parking

As at date of this document, charges for visitors to Trust owned sites are below:

Duration of Stay	Price
Up to 30 minutes (in designated short-stay bays only)	Free
Up to 2 hours	£2.20
Up to 3 hours	£3.30
Up to 4 hours	£4.40
Up to 6 hours	£6.60
Up to 14 hours	£10.00
24 hours	£12.00
Overnight (18:00-07:00)	£2.00

Concessions

Concession applications are to be made to the Car Parking team. The issuing of concessionary parking is subject to change and the Trust has the right to refuse the issue of concessions or to validate parking tickets. All concessions for relatives are limited to two vehicle registrations per patient.

See Appendix A for an example of an 'Application Form for Concessionary Parking'.

Parking at no cost

The Trust will not charge the following groups to use the Trust owned car parks; in line with government policy.

- Blue Badge Holders

- Outpatients who attend hospital for an appointment at least three times within a calendar month and for an overall period of at least three months. A 'month' is defined as a period of 30 days.
- The parents/guardians of a child who is admitted as an inpatient at hospital overnight between the hours of 19:30 and 08:00 while visiting the child. Applicable to a maximum of two vehicles.
- Patients undergoing treatment for cancer at the Trust when they are attending appointments as part of on-going treatment. This will include a course of radiotherapy or chemotherapy, regular reviews, daily or weekly infusions. Concessions do not apply to ad hoc visits once treatment has ceased nor for attendance for blood tests at any time.
- Relatives of patients who help with the daily day-to-day care of an inpatient, subject to confirmation by the ward sister.
- Relatives of patients who are receiving end of life care, over two or more days.
- Relatives of patients on the Critical Care Unit/High Dependency Unit where long-term repeat visits are undertaken, for a stay over three days.
- Patients and staff parking motorcycles

Staff Car Parking

Staff attending training at another hospital site

Staff who hold a parking permit at one of the Trust's sites may apply for free parking when attending training at a different Trust site.

Staff who do not hold a parking permit may reclaim parking costs as a legitimate expense.

Charges for staff parking

Staff parking charges will be reviewed annually by the Trust as per the Car Parking policy. Appendix B details charges for the different groups

.

- Students
- Staff on lower earnings (less than HMRC personal tax allowance)
- Bands 1-5
- Bands 6-8b
- Consultant/senior management band 8c and above
- Overnight and weekends only (shift workers)
- Community workers
- Occasional uses (max 12 per month)
- Residents

Parking Permits

All UHD employees, substantive or bank, may apply for a parking permit. Additionally, other groups not directly employed by the Trust may apply.
An application for a permit can be made at any point in the year. Each application will be assessed against set criteria and a decision on allocation made by the Car Parking team. See Appendix C for permit eligibility criteria.

The Car Parking team will identify applications that qualify for a permit and those that don't. Applicants will be notified of the outcome as soon as possible either way.

Staff members are required to update information on any change of circumstances, this may include

new home or work address, changes in personal circumstances and those of dependants, and car registration.

Once granted, a parking permit lasts for a maximum of two years. One month before the expiry date, the staff member will receive an email from the Trust asking them to reapply and update any of their information if required. At the point of reapplication, eligibility for a permit will be reassessed in line with the prevailing criteria. All staff must park in their designated parking location. Staff with a Littledown parking allocation must remove their car by 22:00.

There is a minimum of a 6 month period between previous and new applications where the original application was declined.

If the applicant does not agree with the permit allocation decision, they have the right to appeal. See section 'Making an appeal'.

Types of permits

- UHD Employee
- UHD Bank Contract
- UHD Community Staff
- UHD Blue Badge
- UHD Nights Only
- UHD Resident
- Occasional
- Student
- Non-UHD Cash

Allocation of a parking permit

The criteria behind the allocation of parking permits can be found in Appendix C.

Making an appeal

Staff who do not qualify for a parking permit or feel their application has been incorrectly assessed may appeal.

- An appeal must be submitted by email to CarParks.Admin@uhd.nhs.uk stating in detail the grounds for the appeal.
- The appeal must be supported by the applicant's line manager.
- The appeal will then be reviewed by an independent panel of Trust staff.
- The result will be sent to the appellant via email within seven days of the panel's decision.

If after this, the appellant still disagrees; a final appeal can be made to the Trust's Strategy and Transformation Officer by forwarding the correspondence so far with a justification for their appeal.

Sustainable Travel Options

The Trust will encourage staff to travel for work sustainably. The Trust will provide facilities and incentives to support cyclists, walkers, and users of public transport.

The Trust will:

- Encourage its managers to be flexible with working arrangements to make sustainable travel easier for staff.
- Provide discounted bus travel, facilitate car shares, and operation of the cycle to

work scheme. Secure cycle facilities, lockers and showers will be available for staff at each location.
- Work with the local bus service provider and the local authority to promote and provide suitable information for public and staff who choose to travel by bus.
- Further information on local bus service Morebus can be found in Appendix D.

6. Training

No formal training has been identified to ensure the on-going adherence of this procedure.
Internal team training will be delivered through local induction process.

7. Monitoring

The Travel and Transport teams will monitor the performance of this Operating Procedure, reporting regularly car park usage, permit applications and Liftshare usage, as well as reporting progress against sustainable travel targets as issued by the local authority.

8. References

1. BPA Approved Operator Code of Practice
2. Government guidelines for NHS Trusts
3. BCP planning requirements

9. Version Control and Change History

The document will be scrutinised on a three yearly basis and updated accordingly. However, where there are changes in evidence-based practice these changes will be added as they occur before this date if necessary.

Version	Date	Author	Section	Principle Amendment Changes
1	December 2022	George Atkinson		UHD Parking Policy & SOP separated.
2	December 2023	Elliot Prescott		SOP fully revised and updated.
3	January 2024	Norman Gillespie	4.	Responsibilities updated and overall document formatting changes.

10. Consultation

Version	Date	Author	Level of Consultation
1	December 2022	George Atkinson	
2	December 2023	Elliot Prescott	Staff Partnership Forum/Staff Travel Group
3	January	Norman	Staff Partnership Forum/Staff Travel Group

	2024	Gillespie	

Appendices

Any appendices must be clearly complementary to the main document, sequentially numbered and with a clear indication of the date and source of material included.

Appendix	Name
A	Application Form for Concessionary Parking
B	Staff Parking Charges
C	Permit Eligibility Criteria
D	Useful Links

Appendix A – Application Form for Concessionary Parking

Please return to the Car Park Office

Car Park Telephone No: 0300 019 ext: 5894 (Bournemouth and Christchurch), 8040 (Poole)

Patient/Visitor - Surname: _____

Issuing Ward/Department: _____ Phone Extension: _____

***Authorisers Name**:_____ **Authorisers Signature**:_____

*** Authoriser please note – Only the following can be accepted as being eligible for Concessionary Parking – Please do not add anything else as this can cause distress or embarrassment to the Patient/Visitor when rejected.**

Capped 4 hourly (£4.40) Rate Applied

☐ Patient requiring treatment more than 4 hours visit.

Minimum Tariff Rate Applied (7- day treatment ticket available for the cost of 3 x 2 hr rate = £6.60)

☐ Parent of pre-term baby on Neo Natal Unit

☐ Patients receiving a regular course of therapy or treatment **(more than 3 per week)**

Start Date of Treatment _____ **End Date of Treatment** _____

This form must be kept by the patient for the duration of their treatment and can be used to purchase future 7-day treatment tickets for the duration term entered above.

Free Parking

☐ Patients receiving a regular course of therapy or treatment **(at least 3 appointments within a month for an overall period of at least 3 months)**

Start Date of Treatment _____ **End Date of Treatment** _____

(The end date must be 3 months from the start date)

This form must be kept by the patient for the duration of their treatment and can be used to obtain future 7-day treatment tickets for the duration term entered above.

☐ A parent staying overnight with a child (under 18)

☐ Bereavement or Family of Patient receiving End of Life Care (Immediate family only)

❑ Appendix B - Staff Parking Charges

Staff Parking Permits (incl. Locum and Agency) Price Per Month	
Classification Equivalent Earnings	**2023**
Students (4 weeks)	£14.70
Lower Earnings Charge*	£14.70
Bands 2 to 5	£29.40
Bands 6 to 8b	£35.70
Consultant/Senior Management Band 8C – Invoices and above	£52.50

*The Lower Earnings Charge applies to staff earning less than the HMRC Personal Tax Allowance.

Other charges for staff parking are as follows:

Parking Type	**Period**	**Charge**
Overnight and Weekends only(shift workers)	Month	Free
Community worker*	Month	*Free
Occasional: max 12 uses per month	Daily	£3.15
Residents	Month	£52.50
Parking Charge Notice	Per PCN	£85 with 40% reduction if paid within 14 days

* Staff whose roles involve essential vehicle usage to perform their duties (i.e., Community Nurses)

Appendix C - Permit Eligibility Criteria

Group	Criteria	Permit Type(s)	Comments
Day worker	Applicant only works during the days (07:00 – 19:30)	UHD Employee Non-UHD Cash UHD Bank Contract Student	
Night worker	Applicant only works night shifts (19:30–07:00).	UHD Nights Only Non-UHD Cash UHD Bank Contract Student	No charge.
Shift worker	Applicant works rotation shifts, with rotation over a 24-hour period – some shifts between the hours of 07:00 – 19:30, and other shifts 19:30 – 07:00.	UHD Employee Non-UHD Cash UHD Bank Contract Student	Permit issued at half the price of what they would pay for a day permit (as per their AfC banding) to reflect free parking at nights (19:30–07:00) but paid for during 'in hours' (07:00–19:30).
Day worker	Applicant requires or chooses parking less than 12 times per month.	Occasional	Valid for a maximum of 12 uses per calendar month.
Day worker	No viable alternatives to single occupant car journey.		Those living within 2 miles or less from their main work site are automatically expected to be

			able to walk, bike, bus or car share. This is assessed through personalised travel planning. Beyond this distance other applicants are assessed by travel distance, graduated to reflect the greater the distance the higher the points.
Essential car use	Applicant is required to use a vehicle daily as part of their normal work duties, as outlined in their Job Description (i.e., community nurses), when no other alternative transport is suitable including lease vehicles.	Community permit	This is not commuting to/from work at start and finish of the day.
Commitments outside of work	The applicant is a parent or guardian for a child in school (aged 4 – 16) years at the time of application.	UHD Employee Non-UHD Cash UHD Bank Contract	Providing parking permits to staff who may need to be with their children in the event of an emergency should not be standard procedure as staff can make use of taxi services instead. However, some consideration needs to be given for staff who may need to drop off/pick up children from/to school, which would be difficult without car usage. This will be considered on a case-by-case basis.
	The applicant is a sole provider of regular physical and emotional support, to someone with a recognised learning disability or long-term health condition, who without this care could not live independently. It is possible the applicant may have to leave site in an emergency to provide assistance.	UHD Employee Non-UHD Cash UHD Bank Contract	To include regular sole carer for dependants other than children. This is linked to travel requirements within a limited timeframe that public transport may not serve well. This registered carer evidence may be required and for clarity is not

			ad-hoc attendance in case of need.
Health grounds	Occupational Health have provided a statement that the applicant cannot access the workplace using other means than car (or other such restrictions and conditions) for a stipulated duration.	UHD Employee Non-UHD Cash UHD Bank Contract	This gives eligibility for an automatic space within the staff parking. Where OH stipulate higher mobility issues then a D-Permit can be issued.
	Applicant holds a Blue Badge.	Blue Badge	
Other	Performs a voluntary role at the hospital.	N/A	Volunteers may apply for a permit at no charge.
Other	Resident - Living in Hospital Accommodation.	Resident permit	Residents will only be issued a permit if they qualify under other criteria, and will be charged in accordance with their Agenda for Change banding or equivalent. This gives space on the Hospital site for one vehicle in the residents parking zone, a waiting list will apply if demand exceeds capacity. Staff with need of a car for duties, or disabled staff, can apply under those specific criteria.

Excluded	Applicant has submitted deliberately misleading information in their application to receive parking.	Permit is revoked	Deliberately misleading information will bar the applicant for a period of one calendar year. This could also be referred for disciplinary action.
Excluded	Applicant has outstanding unpaid PCNs issued on Trust property.	Permit is revoked	Included to enforce adherence to policy.

Appendix D Useful Links

1. An overview of Morebus' network and pricing can be found at the following link: https://www.morebus.co.uk/period-tickets.

2. UHD staff can benefit from discounts of 50% on Morebus' 90-day fares. Further information on this can be found on the UHD Intranet, at the following link: https://intranet.uhd.nhs.uk/index.php/guhd/travel/bus

3. UHD sustainable travel intranet web pages: https://intranet.uhd.nhs.uk/index.php/guhd/travel

4. UHD Car Parking intranet web pages: https://intranet.uhd.nhs.uk/index.php/car-parking

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 06 March 2024

Agenda item: 6.4.1

Subject:	Estates Masterplan
Prepared by:	Steve Killen
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: (if applicable)	BAF9 - Reconfiguration
Purpose of paper:	For information
Executive Summary:	The attached masterplan sets out changes to the physical estate across the next five years. This includes: • Funded schemes, Board approved. • Schemes subject to approval, but expected e.g. New Hospitals Programme • Future aspirations / direction of travel e.g. education, keyworker housing etc.
Background:	After 30 years of limited capital investment in Estates (since RBH was built), the major investment, already started across UHD, is set out in this plan. It is a “masterplan” and remains a dynamic, evolving process by looking many years into the future, at issues of service and population needs, and especially the environment sustainability and resilience.

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

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Finance and Performance Committee	22/02/2024	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

Estates Master and Development Control Plan for University Hospitals Dorset (UHD) 2023-28

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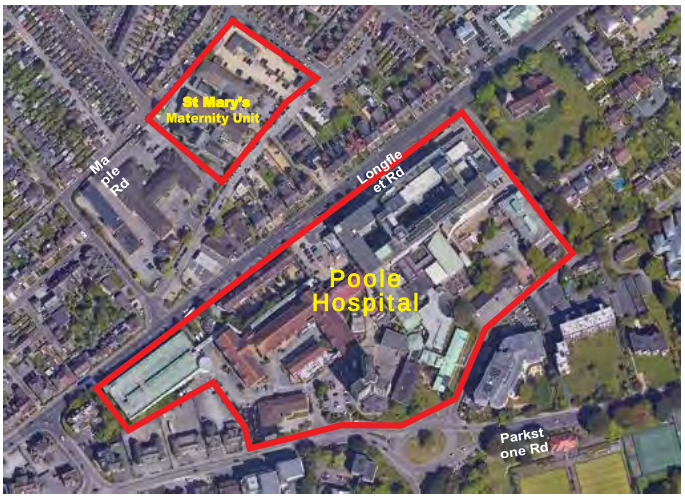
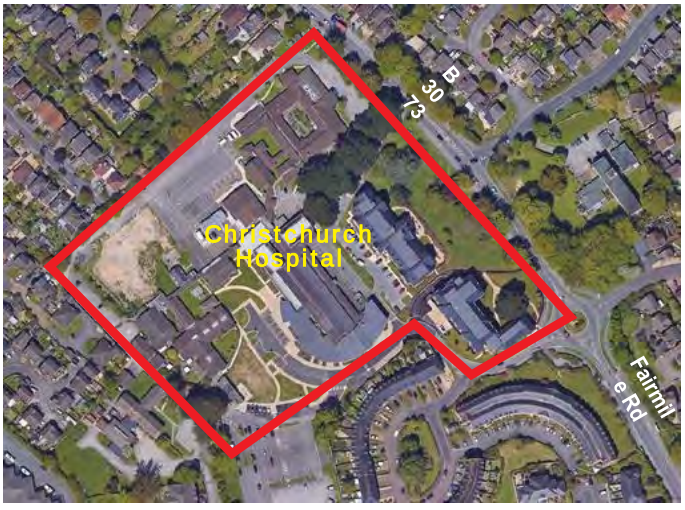


Poole Hospital

We are #TeamUHD

The Royal Bournemouth Hospital



Christchurch Hospital

1 Introduction

Serving our local population and reducing the need for healthcare informs the work of the Dorset Integrated Care System (ICS). When hospital services are needed the rightful expectations are that these are high quality, safe, convenient, caring and accessible.

To achieve the best outcomes from the excellent teams working in Dorset's NHS, there was an extensive review of best practice, and widespread public and staff engagement. This generated Dorset Clinical Service Review (CSR) in 2017. Following Judicial Review and Independent Reconfiguration Panel recommendation, it was supported by the Secretary of State for Health in 2019.

The CSR provides the clinical strategy to improve health outcomes and use the available skilled staff and partnerships to deliver the best care, within the resources available, for the public. Key aspects of the CSR are:

- Developing prevention at scale to avoid ill health, as set out in the Dorset '5 year forward view'
- Integrated community and primary care, to provide local, joined up health and social care, built around GP services in Primary Care Networks
- Digital Healthcare, harnessing technology to support patients, streamline care and ensure the right information at the right time
- Workforce development, to support and grow the health and social care workforce, develop new roles and responding to the challenges of recruitment and retention
- 'One Acute Network', joining up the hospital services to meet the challenges, with Poole Hospital becoming the Major Planned Hospital and Royal Bournemouth Hospital becoming the Major Emergency Hospital
- Mental health Acute Care Pathways (ACP) to ensure a similar approach is taken for improving these services.

The CSR reviewed health needs and trends including the growing and ageing population of Dorset, as well as health inequalities and access to care.

Since the CSR, the clinical and wider strategies have been further developed, including the learning from the COVID-19 pandemic. The following key changes are also important factors in the site masterplans.

Firstly, the creation of Integrated Care Boards (ICB's) with the explicit purpose to:

1. Improve outcomes in population health and healthcare
2. Tackle inequalities in outcomes, experience and access
3. Enhance productivity and value for money
4. Support broader social and economic development

Other changes include:

- Infection Control and wider resilience in the face of major changes and disruption to healthcare, some of which we cannot predict
- Better diagnostics and early detection by developing the Community Diagnostic Hubs
- Last, but most importantly, climate change, with the need to recognise the climate emergency is also a health emergency. This demands a change to how we live and work, while adapting to more extreme weather.

As well as hospital services being important to the community, the NHS is part of the community, an “anchor institution” that impacts the community as an employer, purchasing of goods and services, provision of education, research and wellbeing, and as a partner in many issues including transport. The support of the public, in volunteering, donating to hospital charities and standing up for healthcare being free at the point of delivery, is never taken for granted.

All these important trends inform the clinical strategy of University Hospitals Dorset (UHD) and from that informs the Estates Masterplan, as set out in this document.

2 Clinical Strategy for UHD

Within the context set out in the introduction, the clinical strategy for UHD has numerous key aspects which shape the Estates Strategy. These include:

a. Creation of the **Planned Hospital at Poole** with the construction of the new theatres block, extensive refurbishments, and reduction of backlog maintenance. This allows all year-round elective services, not affected by emergency pressures. This reduces the risk of cancellation, and supports modern, productive healthcare environments.

   In addition, Poole will retain many of its current services, including a 24/7 walk in urgent emergency care, outpatients, therapies, diagnostics and cancer treatments which will all continue to be delivered from the Poole hospital site. Additional services will include specialist inpatient rehabilitation, for trauma patients and community hospital beds. A new endoscopy unit is also planned. Due to the high volume of elective care, especially for day surgery and inpatient treatments, Poole will remain a busy hospital, at the heart of Dorset's NHS.

b. The **Emergency Hospital at Royal Bournemouth** will bring together teams currently split across the conurbation, to provide better services, with greater resilience, allowing consultants and specialist staff to be available for more hours in the week, and providing quicker access to specialist teams and equipment, in fit for purpose facilities. This includes:

   - New Maternity and Children's inpatient facilities, co-located
   - New Emergency Department (ED) and an Urgent Treatment Centre
   - New Pathology Hub serving all of Dorset, in cutting edge facilities
   - New and refurbished wards, with same day emergency care (SDEC) to provide prompt, expert care in a single day, avoiding the need to be admitted.

c. **Christchurch Hospital** has already undergone significant investment to create a vibrant community hospital, as well as co-location with GP and pharmacy services, care home and senior living. The ambition to fundraise and build a new Macmillan Specialist Palliative Care Unit and create a senior living village, remain the key aspects of a second phase.

d. UHD provides **other services from locations**, including:

   - Health Village at Beales, Dolphin Centre in Poole, providing flexible, high volume clinics and diagnostics, as well as supporting the high street and making access easier for patients
   - Sterile Services based at Alderney Hospital serving UHD, with the need for significant refurbishment over the next few years
   - Yeomans House and Canford House as offices for corporate office-based staff, including patient appointment bookings
   - Linear accelerator for cancer treatments, based at Dorset County Hospital, providing greater access for patient in the West of Dorset.

e. **Wessex Fields**, adjacent to RBH, represents a significant opportunity, working in partnership with BCP Council and other partners, including Bournemouth University, research and education sectors. This opens the way for creating med-tech, "high value-adding jobs" co-located with the hospital campus and linked into the Dorset ICS, with its well-developed informatics, and whole system working. In the long-term developing a medical school, would further add to the critical mass for use of this unique location.

   The location also has significant potential for further key worker accommodation, allowing walking to work and affordable housing to attract and retain staff to Dorset.

   The completion of the A338 link road and cycle access to the hospital, reducing congestion on Deansleigh Road and Castle Lane East, is part of the wider green travel plan for promoting better bus, bike, carshare and work from home as alternatives to single occupant car journeys.

3 Estates Strategy: Exec Summary

The estates strategy is based upon a masterplan for the 3 main UHD sites, which aim to:

- Delivery the clinical strategy for better patient care as per Clinical Services Review (CSR) requirements
- Support the Green UHD plan, including carbon reduction, sustainable travel, climate adaptation and biodiversity
- Offer value for money and best use of resources
- Meet all the planning requirements and conditions set by the Council.

The last set of significant clinical and estate changes in East Dorset were in the late 1980's with the creation of the Royal Bournemouth Hospital and the Philip Arnold Unit at Poole and a range of other changes completing in the early 1990s. Since then Dorset has not had significant clinical service or estates changes, or the capital investment to make this possible.

This has changed as a result of the Clinical Services Review setting the blue-print, and allowing investment from three sources: The £201m HM Treasury fully approved building works which are already underway; £263m of the New Hospital Programme which has been supported as an Outline Business Case (OBC) in 2023, along with a linked plan for St Ann's and Dorset County Hospital schemes; thirdly UHD's own funding plus charitable support. Together this represents nearly half a billion-pound investment in the local NHS to create a once in a generation step change improvement.

Combined with developing our workforce, investment in technology and equipment and the wider CSR service improvements and working as an integrated care system, this represents not just catching up, but a nationally significant step up, setting new standards in healthcare.

Planning applications have been successful for both Poole and RBH to support the current range of developments already underway. The first phase of Christchurch Hospital has also been completed.

The next stage of significant changes by site are set out in more detail in the later sections of this strategy. In summary they are:

- Poole: Significant internal refurbishments of wards, theatres and facilities, and removal of large amounts of backlog maintenance. This creates the planned and community hospital hub. The conversion of surplus outlying land and buildings can then create additional key worker housing.
- RBH: A new build ward block, significant internal refurbishments, creation of a link road to the Wessex way. This completes the major emergency hospital. A masterplan for Wessex Fields will be developed; until then use of the UHD land will be for a contractors' compound, to reduce congestion on site and disruption of services.
- Christchurch: Creation of the new Macmillan Unit, which then releases land to expand the affordable senior living and community hub facilities on site.

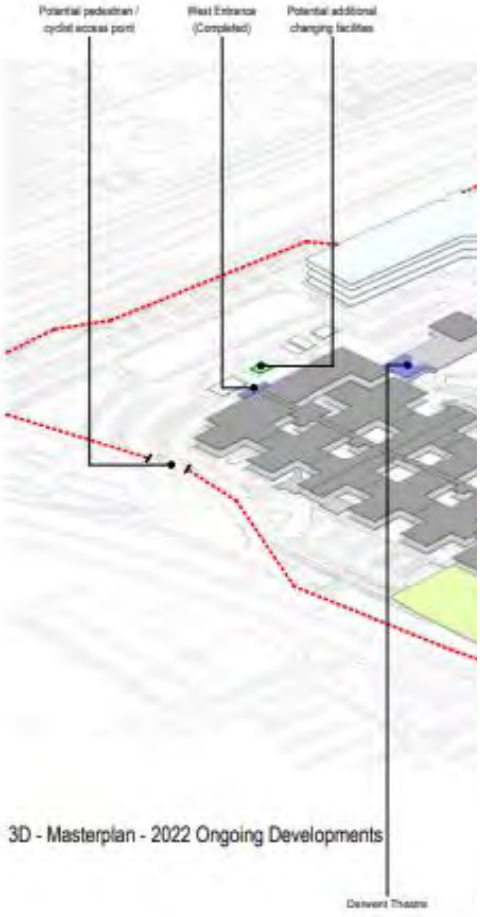
Our Green travel plan has already reduced traffic around the hospitals, and across the conurbation, whilst reducing air pollution and promoting healthier lifestyles. Significant further steps are planned and set out below. Supporting the masterplans are specific infrastructure plans, covering water, electricity, infection control, oxygen, ventilation, consequential improvements, and critical infrastructure requirements. These include a de-carbonisation strategy.

In developing a 5-year estates masterplan there is need for flexibility for the "unknown unknowns" - things that despite careful planning will still be required over the next 5 to 25 years. Therefore, reference is made to both firm plans and to potential opportunities, (the latter usually subject to funding and planning approval) and so some areas of each site are left for future master planning.

4 Royal Bournemouth Hospital

RBH site prior to start of building works in 2021

RBH site 2022



Zoned site plan

Most of the RBH site is directly providing patient care, based around the L-shaped main building. The wards are based on the nucleus designs in a cruciform shape, maximising light but providing some restrictions on layouts, which is a factor when areas are refurbished - a major part of the future plans for the site.

Other important clinical buildings on site include the Jigsaw Cancer & Women's Health building, the Derwent ward and theatres.

Ancillary buildings along the lake include the Education Centre, Dorset Heart Club Rehabilitation Centre and Tops Children's nursery.

There are over 200 residences, mostly made up of single rooms and shared living, for students and new staff relocating to the area.

The waste incinerator provides heat to the site, and treats clinical waste.

Site access

Since opening, the RBH site has had a single access road, Deansleigh Road, from Castle Lane East. As further developments have been granted for offices, a hotel, law courts etc., so Deansleigh Road and the Castle Lane junction have got busier, putting pressure on the road infrastructure.

RBH staff and visitors have had periods where traffic and roadworks on Castle Lane and onto Christchurch have created grid lock and slowed ambulances. As such, a strict limit of permits for NHS staff parking now mean over half of UHD's staff arrive at work other than by car, despite the limited public transport and cycle routes, compared to other city regions.

High volume services have also moved off site to reduce traffic and provide better access. These include 100,000 blood tests per year, 60,000 sexual health clinical appointments and 40,000 outpatient physio attendances (4,000 trips per week less). In addition, a significant number of clinic appointments are now undertaken "virtually." Further information and future plans are discussed in the later section on transport.

Planning permissions

The approved planning permission granted by BCP Council in 2020 included:

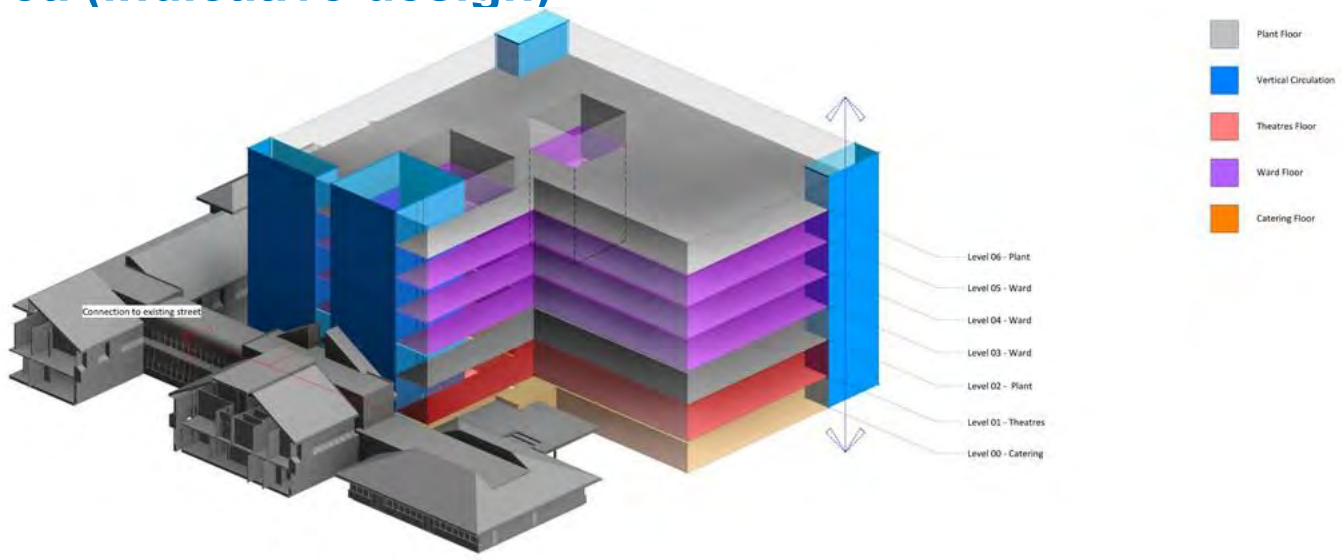
- The major new building at the front of the site, the BEACH building (standing for Births, Emergency department, Antenatal, Critical care and child Health). Next to this is the new Main Entrance, Patient and Visitor Centre (MEPV). Construction runs from 2021-2024.
- Dorset Pathology Hub, serving the whole county in a purpose-built facility on the corner of Wessex Fields.
- Improvements to cycle, bus and pedestrian access to the site, and new changing facilities.
- The moving of most public, visitor and staff parking to the rear of the site, to prioritise ease of access for sustainable travel and drop offs and disabled access.
- Permission for a multi-storey carpark, and an additional building for clinical use.

Since that approval two significant developments have occurred, necessitating an update to the masterplan and a new planning application. The first is new standards in healthcare space requirements, and the second is the purchase of 5 acres of Wessex Fields, adjacent to the site.

The **new NHS space standards,** required as part of the national funding for NHS buildings, has been updated. In particular the higher ratio of single rooms, plus clinical support and associated space, has required a larger footprint for the same level of services than envisaged when the original planning application was submitted in 2019. Other areas requiring greater space include operating theatres and same day emergency care (SDEC) facilities. These larger spaces are as a result of several factors, including infection prevention, which the pandemic brought into sharp focus.

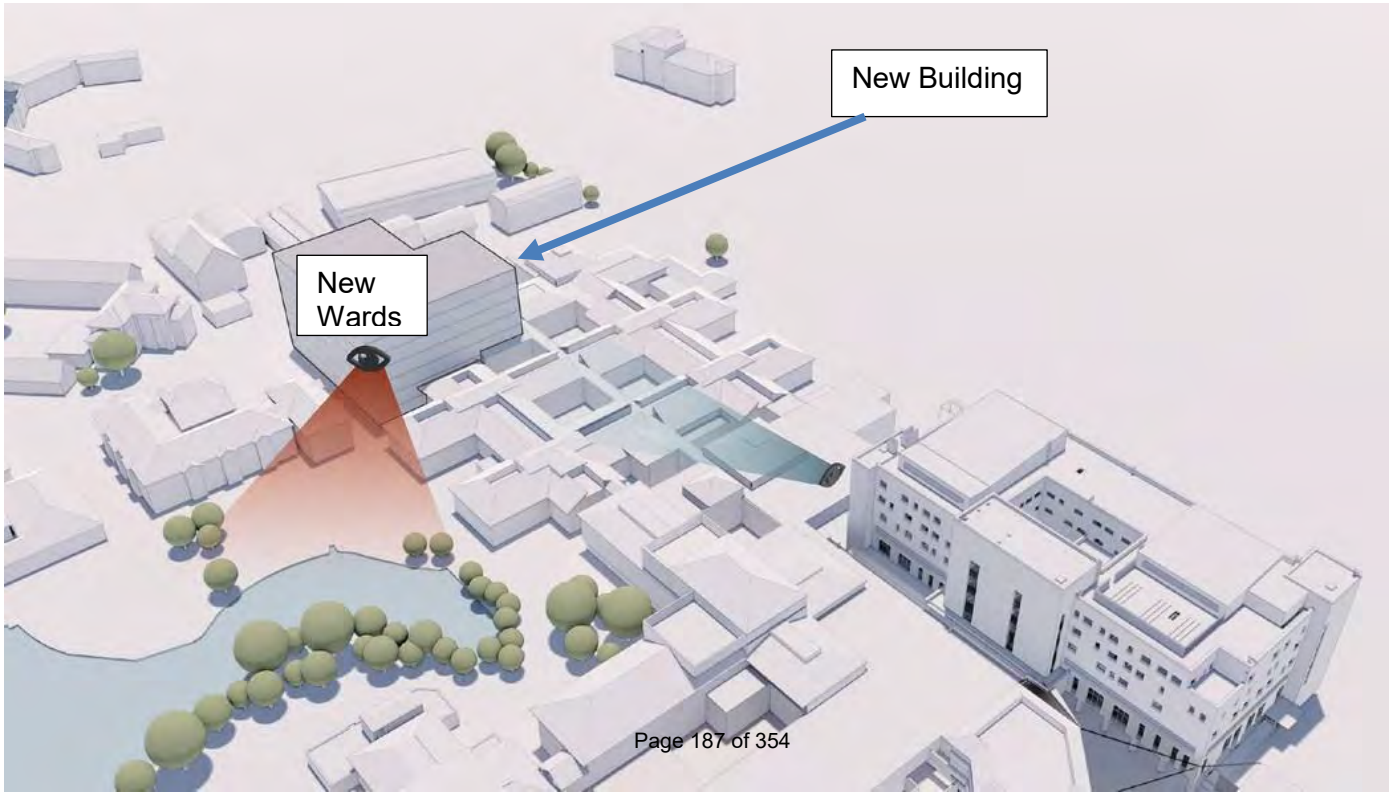
Single rooms will also enhance standards of privacy and dignity. The patient numbers, staff numbers and other planning assumptions remain the same, but the additional space required to house those services has increased significantly. Having undertaken a thorough options appraisal, the best solution is a new building on the current catering area.

Proposed new building on the current catering area (indicative design)



3D Concept Massing Model

This also enables a modernisation of the kitchens serving the hospital, which will allow greater food choice for patients and staff. The location of this is identified in the 2023 site plan below:



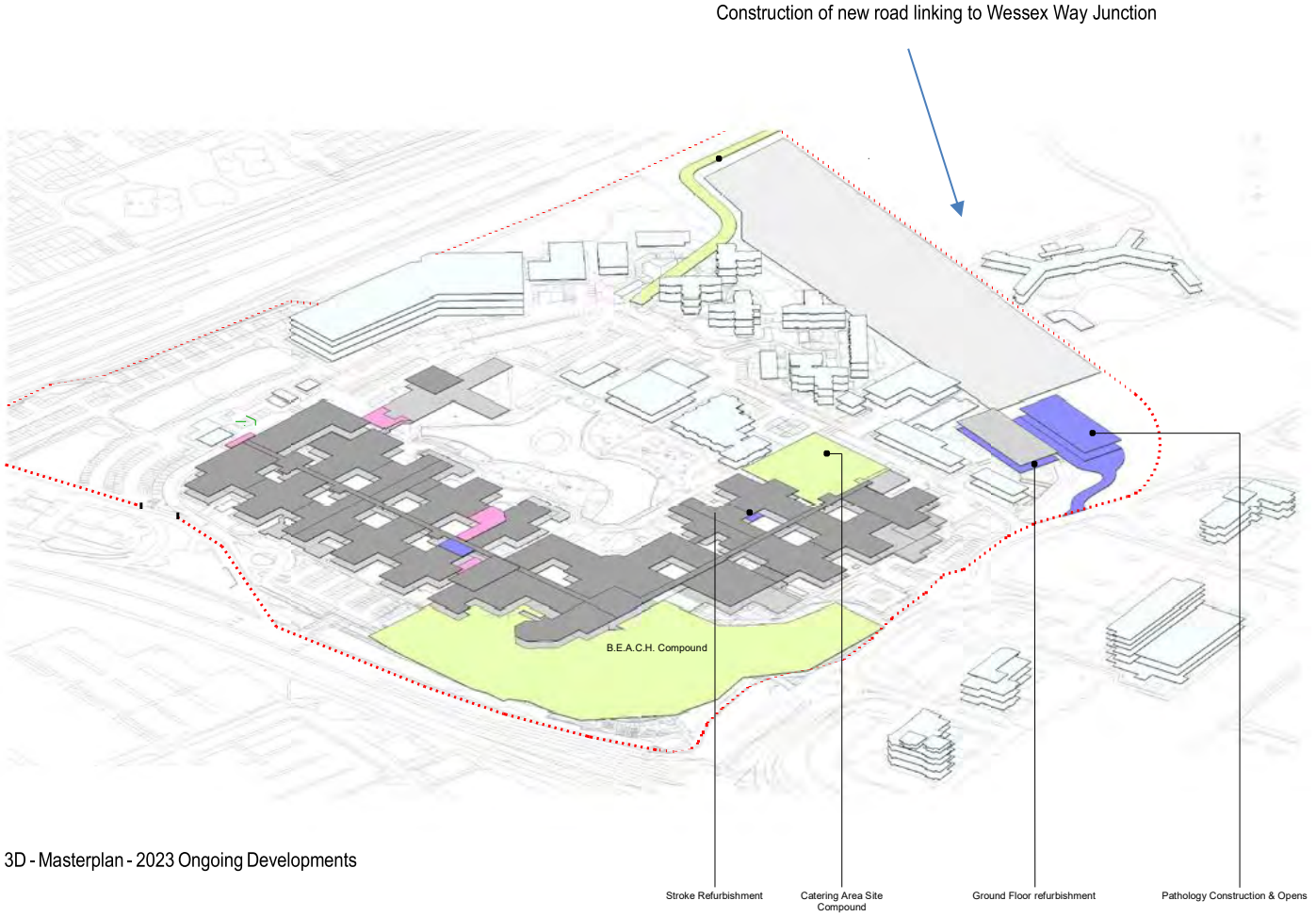
The inpatient wards will also have views onto the lake and grounds. It will complement the BEACH building having similar external materials and height.

Access and exit to the Hospital will be improved following completion of a new access road from the A338 south if Blackwater Junction. This new road will be “Left in” and “Left out”. Due for completion in the spring of 2024 the road will include improved cycle and pedestrian pathways.

Existing built junction

Cycleway and barrier-controlled road providing second access onto the Royal Bournemouth Hospital site. (space indicative only and subject to design and planning).

2023

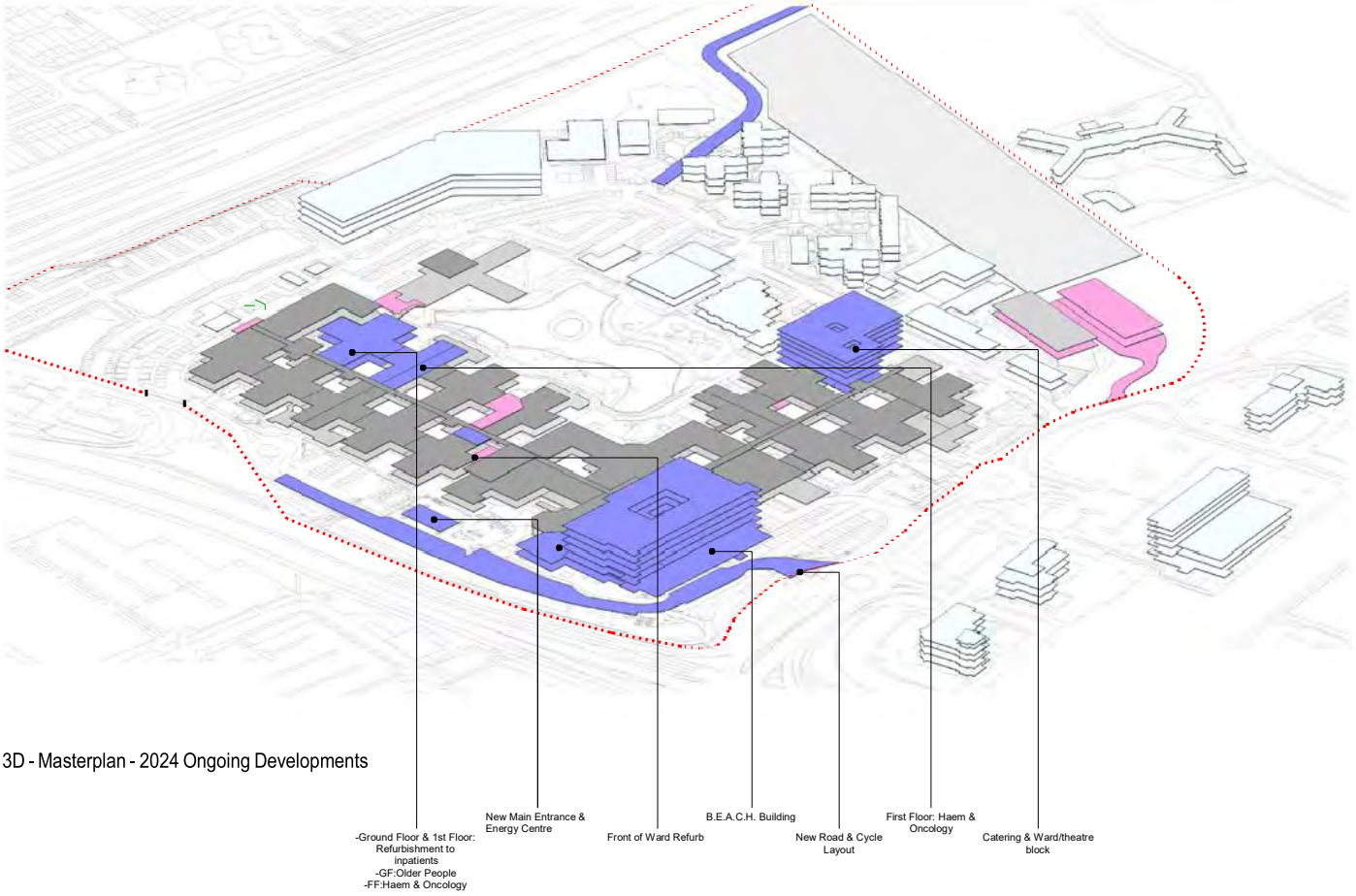


3D - Masterplan - 2023 Ongoing Developments

Key points

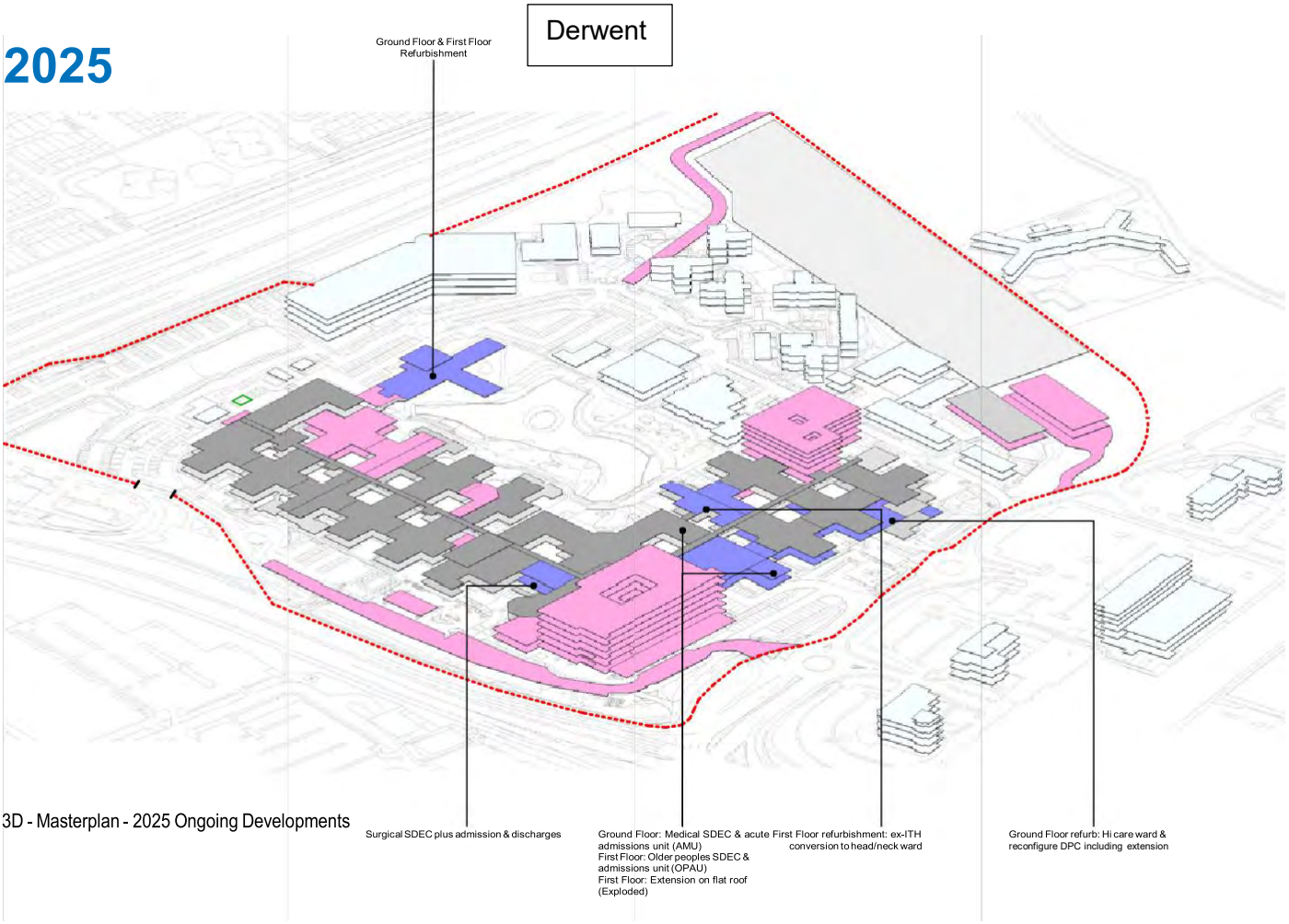
- The BEACH building construction continues
- Road access works to Wessex Way starting
- Enabling works for ‘Lakeside’ development (currently catering area).
- Numerous refurbishment projects (SAU/Stour/Wards etc.), planned or started
- Some minor enabling works (link to AMU and flat roofs/doctors mess).
- Pathology hub opens towards start of 2024
- Start of new, improved catering service
- Shower, change, cycle hubs

2024



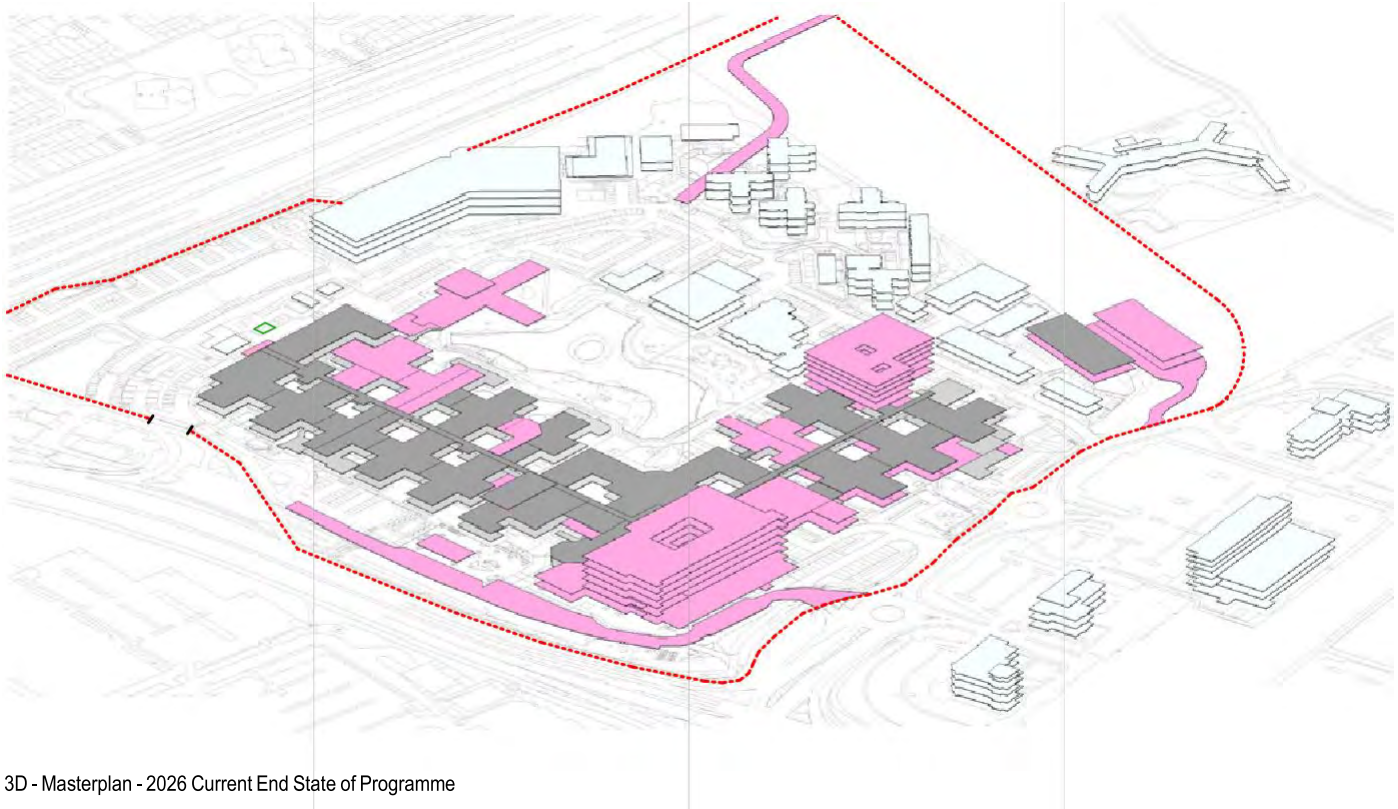
3D - Masterplan - 2024 Ongoing Developments

- The BEACH building, main entrance patient and visitor centre completes towards year end
- ‘Lakeside’ ward block construction starts
- Numerous refurbishments start, including turning ex-pathology space into wards
- Electrical infrastructure works



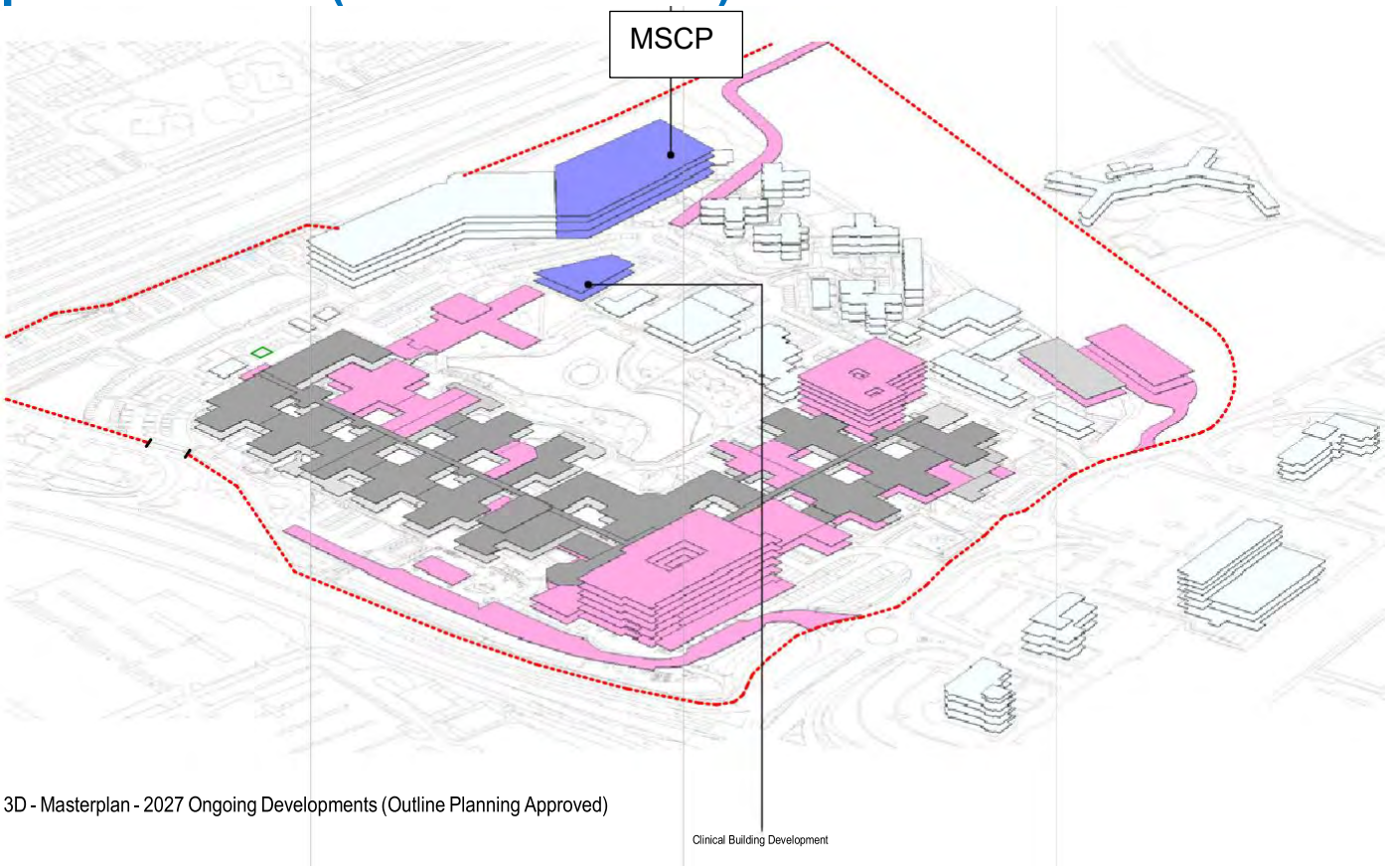
- Opening of the BEACH Building and ward block
- Refurbishment of ward areas

2026 end state of funded projects



- Completion of SDEC (Same Day Emergency Care) areas (in ex. emergency department)
- Completion of children's outpatients (in ex. Derwent area)

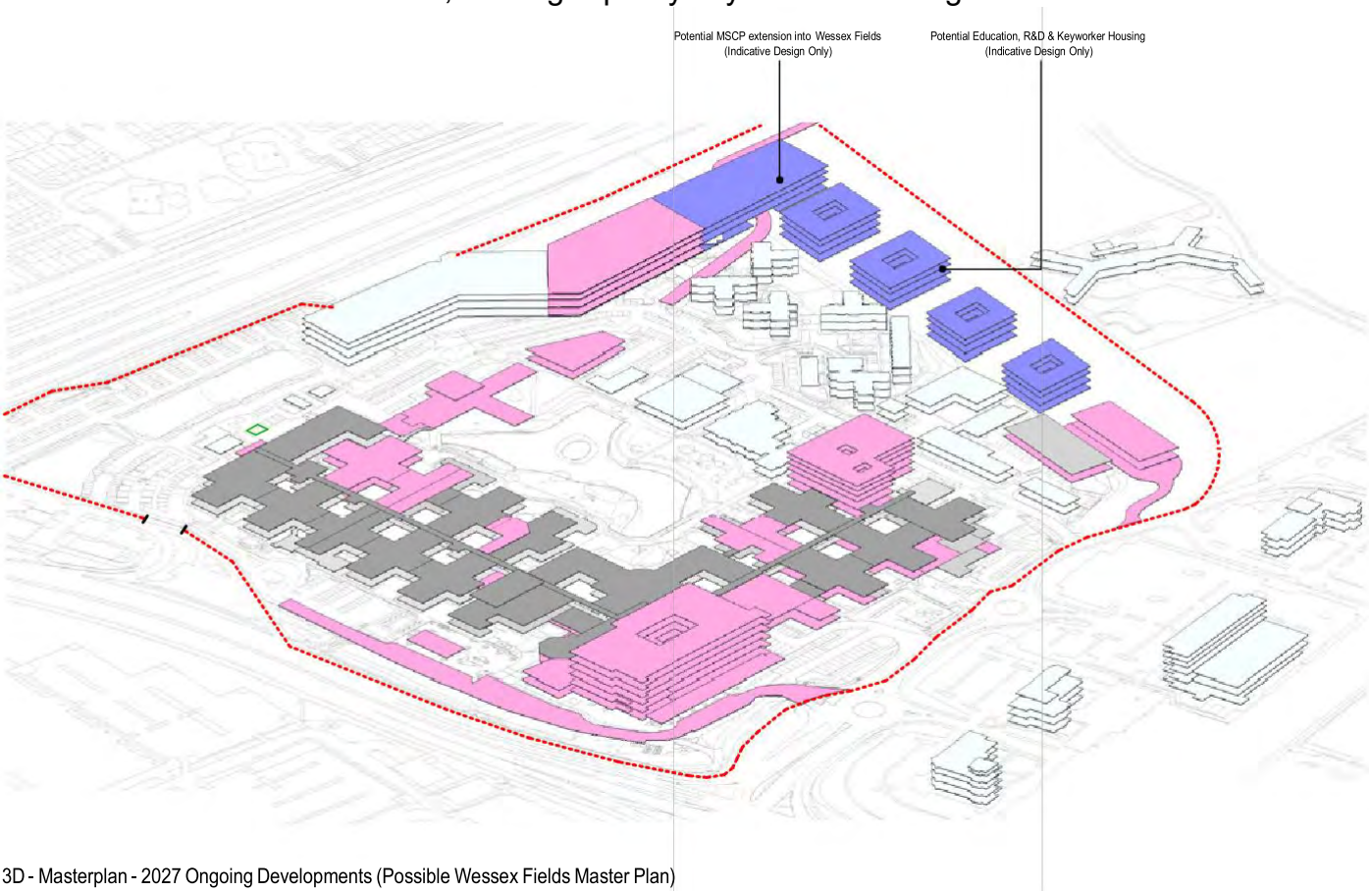
Long-term (2025+) - existing outline planning permissions (but not funded)



3D - Masterplan - 2027 Ongoing Developments (Outline Planning Approved)

Longer-term - indicative only.

A master plan for Wessex Fields may develop with BCP Council. This could include education, research and med-tech facilities, and high-quality key worker housing.



3D - Masterplan - 2027 Ongoing Developments (Possible Wessex Fields Master Plan)

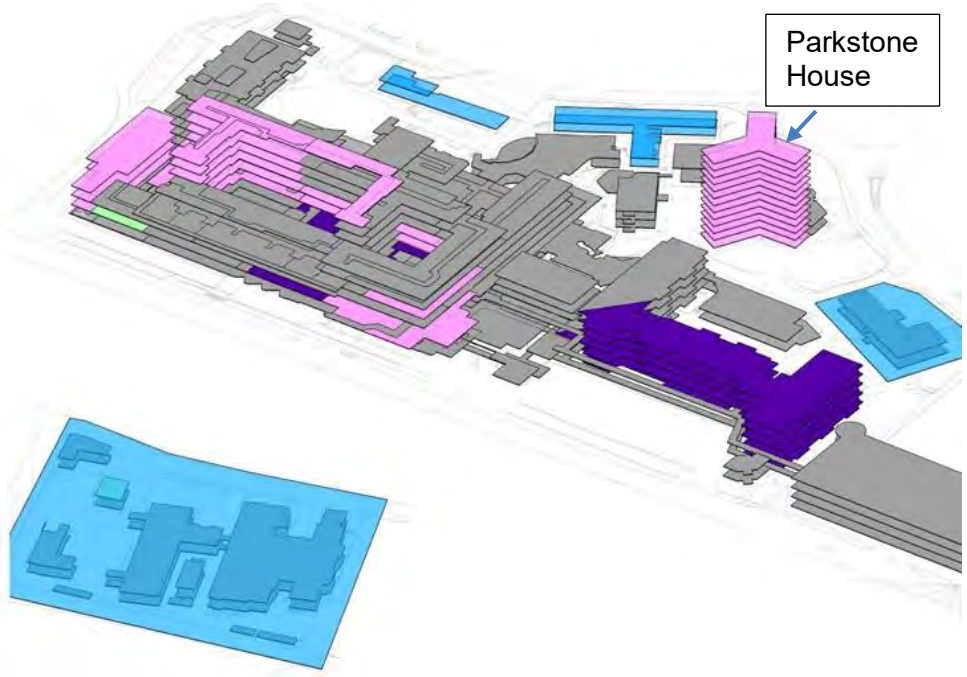
Visuals

The BEACH building

Pathology

5 Poole Hospital

The Poole developments are underway with major investment and change to become the Major Planned Care hospital for East Dorset. In addition, 24/7 walk in urgent care, outpatients, therapies, diagnostics, community services, rehabilitation and many other services will continue to be delivered on site. Major estates investment and changes will continue until at least 2027, including reducing the significant estates maintenance backlog.



There has been a hospital on this site since 1908 and the ‘new’ hospital was designed in the 1950s and opened in 1962. The major additions have been extensions to St Mary’s Maternity Hospital and the building of the Philip Arnold Unit which opened in the early 1990s.

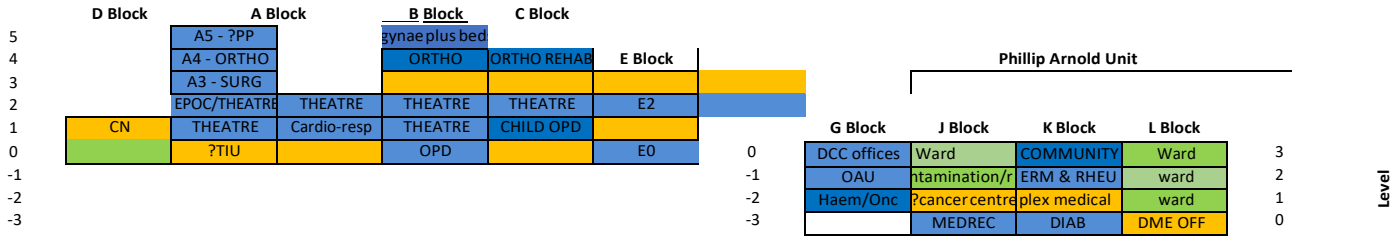
Extensive refurbishments have occurred over the years, to wards, clinics and other services, including the Ladybird Centre for breast care, the Eddie Hawker wing, including rehabilitation, and various other changes. The building works planned include extensive refurbishment and replacement.

Poole Hospital comprises a high-rise building occupying about one quarter of the RBH site area but having only a slightly smaller internal area. Many of the facilities do not meet modern healthcare standards. There are over 250 key worker residences, most in the 13 storey Parkstone House and the rest in houses nearby. A multi-storey car park provides patient and visitor parking, whilst most staff parking is at the nearby Poole Stadium. Being a town centre location bus and rail links are nearby.

Whilst the number of patients treated at Poole will increase, their time in hospital will be shorter, as 85% of surgery is now day case. As such the physical space required will be smaller. This allows the existing space to be used for larger bed spaces and support areas, retrenchment of offices and ancillary buildings into the main building and spare space to be potentially offered to partners in health and social care.

Rather than dispose of land that will become surplus, especially after the opening of the new Maternity and Child health units at RBH, UHD would seek to create key worker accommodation. The location close to town and Poole park with good transport links should make these attractive. This fits with the planning strategy for the local authority.

Given the complexity of the site the simplified schematics below represent the current and potential future allocations, noting this is still being developed and space use and clinical strategies develop.



Abbreviations	
CN	Clinical Neurophysiology
SURG	Surgery
TH	Theatres
PP	Private Patients
DCC	Dorset Cancer Centre
OAU	Oncology Assessment Unit
SPEC REHAB	Specialist Rehabilitation
COMM REHAB	Community Rehabilitation
MEDREC	Medical Records
DIAB	Diabetes
DME OFF	DME Offices
DERM	Dermatology
RHEUM	Rheumatology
TIU	Treatment & Investigations Unit
SRU	Stroke Rehab Unit
LUL	Lulworth ward
LILL	Lilliput ward
UTC	Urgent Treatment Centre
OPD	Outpatient Department
Cardio-Resp	Cardio-respiratory outpatients

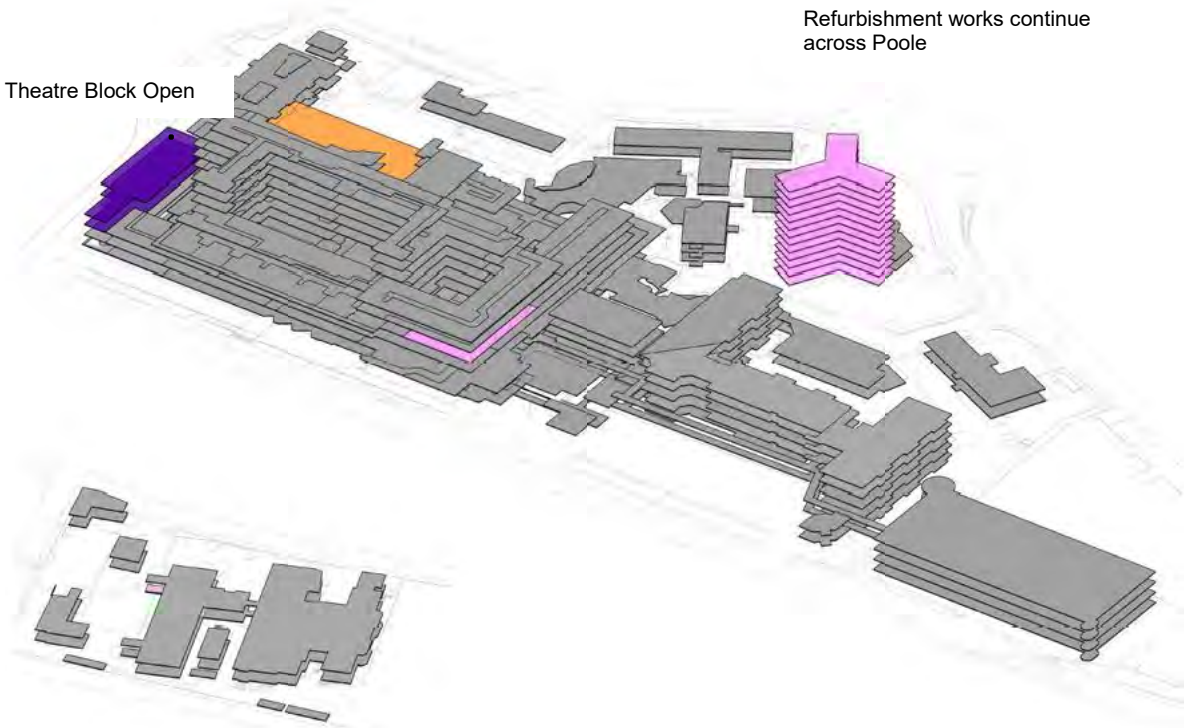
KEY	
	Provisionally Allocated
	Unanswered
	Free space
	Free space with intended use listed

2022

- Theatre block construction underway. Targeted backlog maintenance.

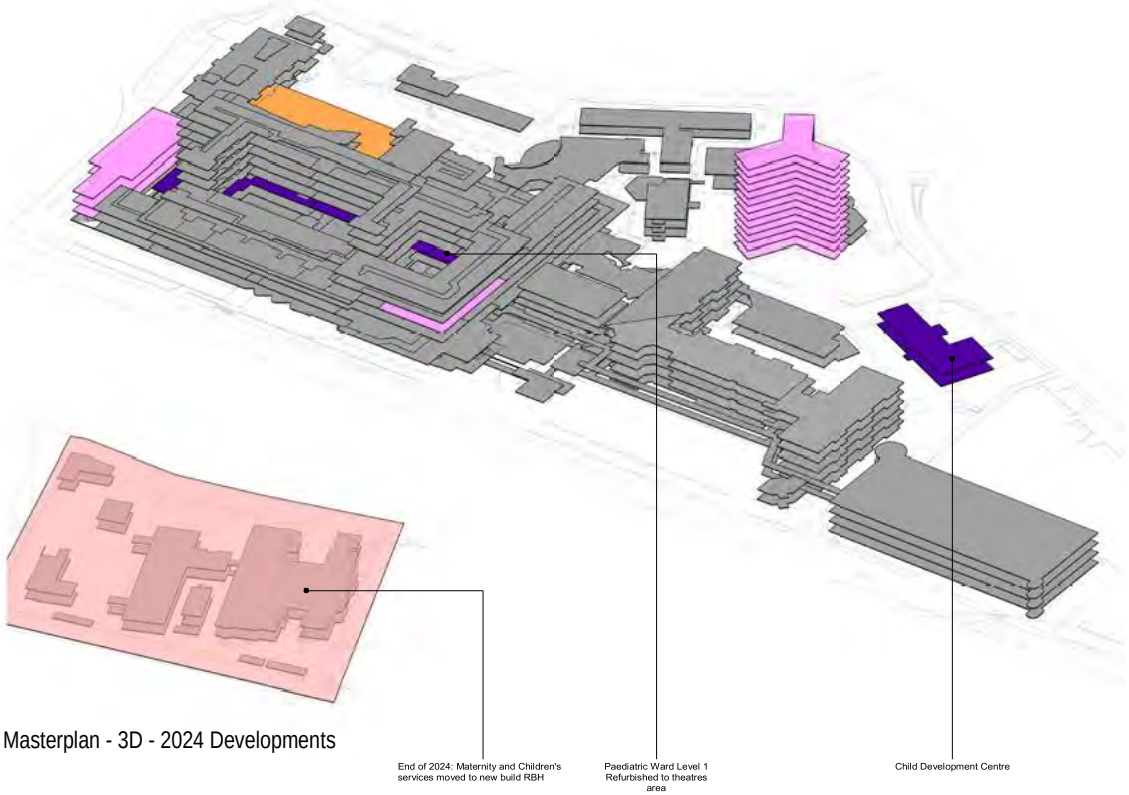
2023/24

- Theatres open. Targeted backlog maintenance continues.



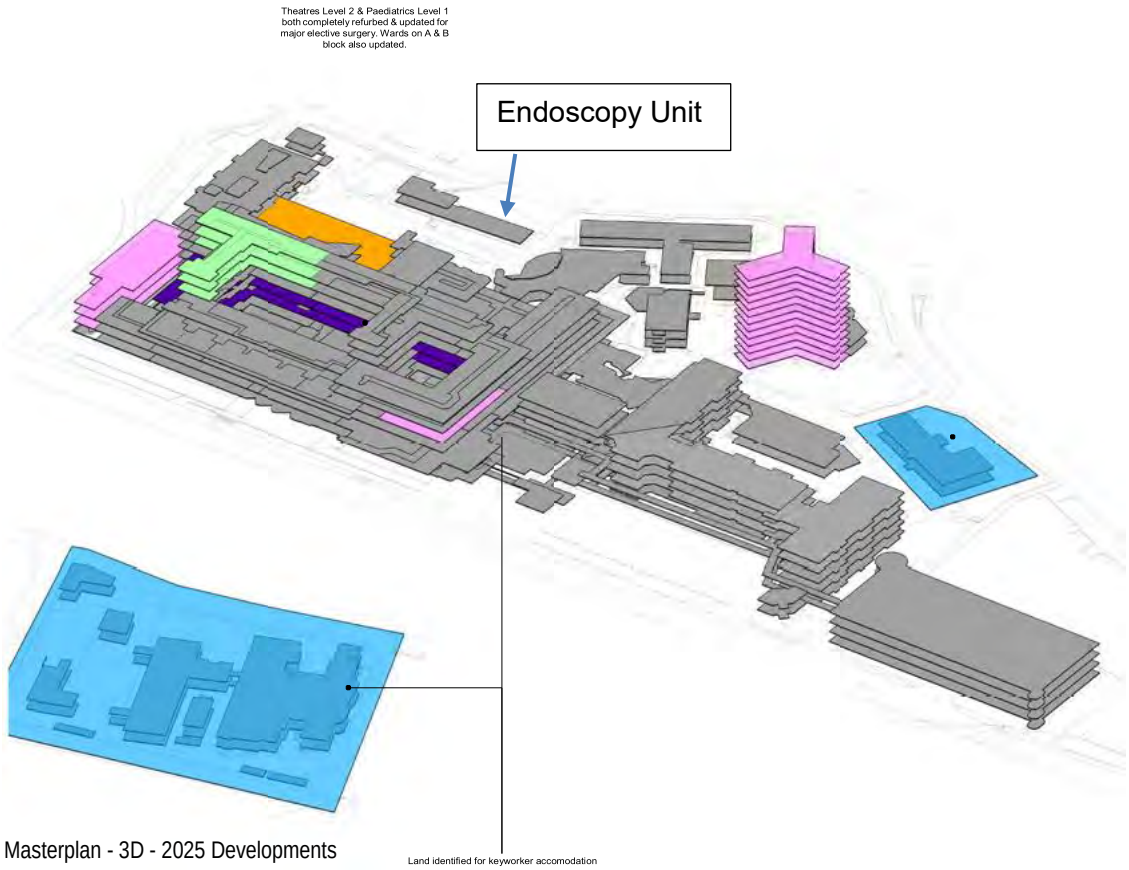
2025

- Move of maternity, children's and emergency care to RBH and some elective services in
- Work on new endoscopy unit.



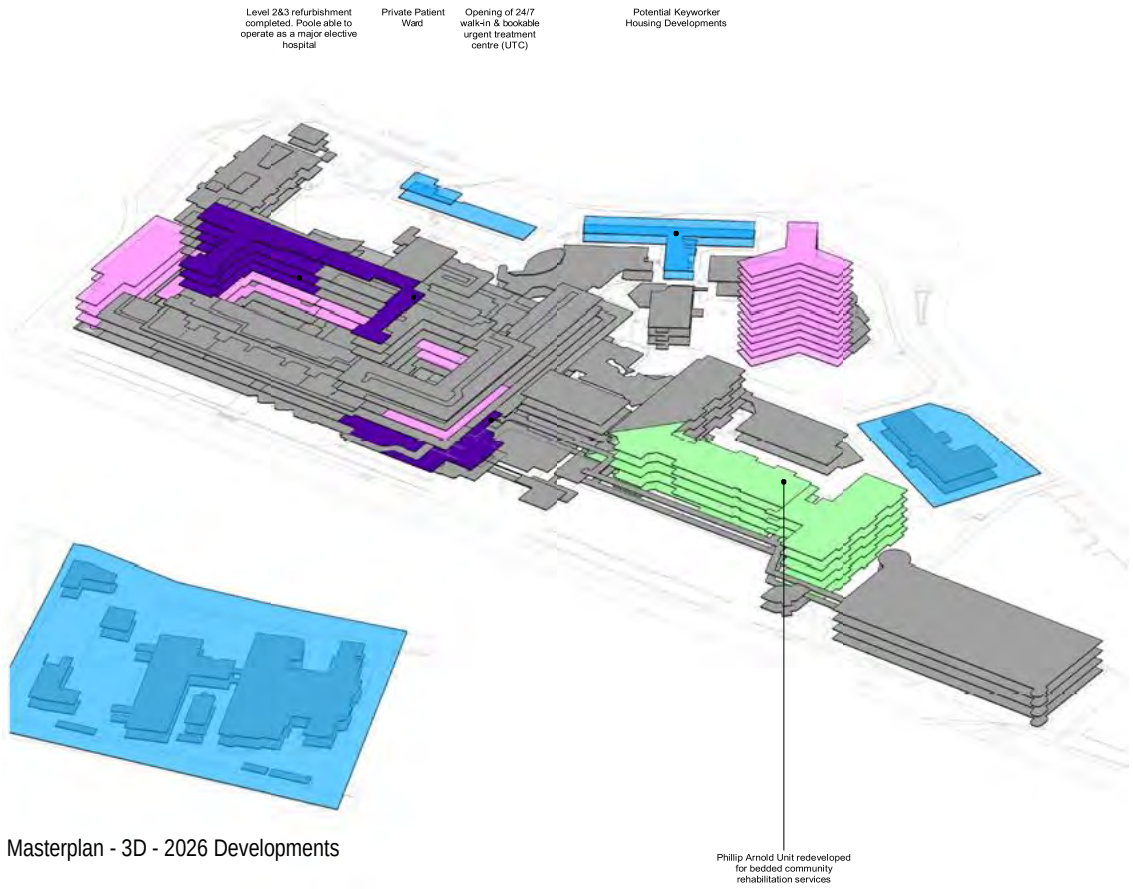
2026

- Refurbishments for theatre floors, ward and backlog maintenance.
- Earliest start date of potential redevelopment of St Mary's, CDC and Cornelia House areas.



Masterplan - 3D - 2025 Developments

2027



Masterplan - 3D - 2026 Developments

Future Proofing the Poole Hospital site

The areas within the main building, including Eddie Hawker and other buildings retained, include significant unallocated spaces. Creation of more community services space, mothballing wards in case of greater need for community and social care use, and office space for Trust Headquarters and Corporate teams will all be developed as part of the master planning.

Key worker housing.

Dorset has a very high ratio of house to salaries prices. This makes it difficult to recruit and retain staff. Adding to the existing but limited on site housing for staff and health students has significant benefits, and contributes to local housing supply.

The areas identified for key worker housing around the Poole site include St Mary's (photo on left).

The Child Development Centre may also become surplus with the new development at Royal Bournemouth Hospital, and use of the Children's clinic space within the main building at Poole.

These are indicative only and subject to further options appraisal work.

First patient helps celebrate theatres opening

UHD staff and partners came together in July 2023 to see patient Julie Hills cut the ribbon to officially open the new Poole Hospital theatres.

The five-storey, purpose-built theatres are an extension to the existing hospital building. They incorporate a four-table open-plan 'barn' theatre, with each patient treated in a dedicated space with an ultra-clean air canopy over each station.

Following the cutting of the ribbon, guests were invited to tour the new facilities, after which Jacqueline Swift, HM Deputy Lord Lieutenant of Dorset, unveiled a commemorative plaque to mark the occasion.

6 Christchurch Hospital and other Trust locations

Christchurch Hospital has already undergone significant changes in line with the masterplan agreed in 2013/14 and completed in 2017. This was phase one and the second phase is planned to allow a new build of the MacMillan Specialist palliative care unit, and additional senior living accommodation, so as to create the critical mass for a care village. Road and parking changes, and a spiritual centre will also be included.

Christchurch - site master plan at the end of phase one

Phase Two for the Christchurch site is under review. The two key elements of specialist palliative care and senior living remain.

The Mac Unit already provides excellent care and increasing ‘hospice at home’ services. It is in need of a modern, fit for purpose building.

The **senior living village** will have the following benefits:

- Living in a community with greater support and social networks
- Better mental and physical health for independent living
- Lower demand on statutory services
- Typically, family-sized housing freed up, aiding families in property searches
- Release of equity to support more economic freedom (ending “asset rich, cash poor” trap)
- Purpose built accommodation with lower maintenance, utilities, running costs and hassle of living in larger properties
- More support services such as domiciliary care, and in-reach, have a critical mass of clients allowing time saving travelling between properties (Note the model prepared has limited-service charges and all services such as domiciliary care are optional, and not tied to any provider)
- With sufficient critical mass (c 120 units) communal space can be allocated for a café, meeting/ exercise spaces, hairdresser etc, with low rents to maximise the service offer, and be a community hub.

The Mac Unit new build is being funded via charitable donations, thanks to the MacMillan Caring Locally charity. Significant building cost inflation, seen across the UK, means there remains a large gap between funds raised and the cost of the new building. A review of options will be undertaken on how to find a way forward.

The Trust also has other sites:

- The Health Village, based at Beales in the Dolphin Shopping Centre at Poole, offers outpatients and Breast Screening services
- Yeomans House and Canford House as offsite offices
- Sterile Services Department at Alderney Hospital which is undergoing a planned programme of upgrading equipment and facilities
- Key worker housing on Longfleet Road, Poole plus the RBH site and also one purpose-built off-site location in Pokesdown, Bournemouth called Abbotsbury House.

In addition, some staff also work from home, following major investment in technology and updated working practices following the Covid-19 pandemic.

Other staff also work in community settings, and visit patients at home, including older peoples and stroke services, and maternity and children's care, plus specialist services.

Digital Outpatients Future

UHD is also a leading site for digitising outpatients, and bringing Dorset's services into a modern, patient-centred approach. This is an ambitious, multi-year redesign of a significant part of the NHS.

The current model of care, requiring patients to attend hospital on multiple occasions, will change now, and instead join up information, decision making, monitoring, diagnostics and build upon the work accelerated by COVID 19 pandemic with more virtual clinics.

7 Sustainable Transport

The Bournemouth, Christchurch, Poole (BCP) council area is one of the most congested in the UK with slow travel times. In line with the Green UHD plan promoting sustainable transport includes a multi-year, multi-million-pound investment including:

- Creating more and better shower and changing facilities including free towels
- Creating cycling lanes and more bike storage
- A strict parking permit policy for staff, liming overall numbers and supporting individual travel plans and alternatives
- A bus route linking Poole and Royal Bournemouth Hospital now in place
- Subsiding bus passes to make bus travel cheaper than car travel
- Staff benefits to reduce the cost of bikes, electric bikes and accessories and incentivise electric cars
- Supporting home working where this is practical
- Creation of the Wessex Field link road (including cycle lanes) at RBH, reducing congestion at the main entrance on Deansleigh Road
- Supporting car shares, with apps to make this as easy as possible.

Reducing the need to travel to hospital at all is also a better way to cut congestion and pollution. Actions include:

- Increased virtual clinics and digital outpatients by up to 30%.
- Work from home (WFH) for staff and partners and more online training courses.
- More key worker housing so staff can walk to work.
- Shifting community services with over 200,000 trips a year (by outpatient physio, blood tests and sexual health clinics moving off the RBH site).

Travel patterns to the RBH site will also change. The mix of services will change, with more 24/7 services on site, such as enlarged ED, critical care, maternity, child health and more inpatient wards. This will be balanced by more ‘office hours’ work moving offsite including 150 corporate staff to Yeomans House and 300-400 regular work from home shifts; elective operating lists and rehabilitation wards moving to Poole; virtual clinics and one stop clinics reducing trips to site.

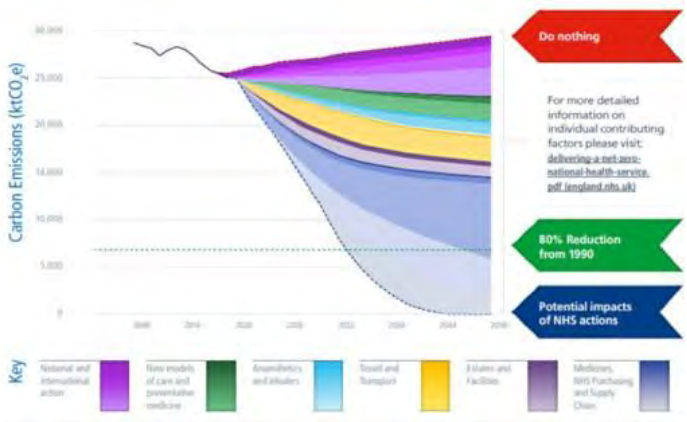
With the staff on site having a higher proportion of “long day shifts” (often 3 x 12 hour shifts per week, and spread over nights and weekends, so the net increase of 2,000 staff on site will lead to less staff journeys during peak hours of 8-9 and 4-5:30. Combined with the other measures listed above so the impact on traffic is designed to be neutral or beneficial to the conurbation and immediate Littledown area.Taken together this represents the biggest shift of any organisation in BCP towards reducing congestion, pollution and supporting the health benefits of walking and cycling.

8 Green UHD

The NHS and UHD have committed to an 80% reduction in carbon against the 1990 baseline. This entails a complete change in approach to how we operate. More detail is set out in the Green UHD plan. This also includes actions against the cornerstone targets.

Within the Estates Masterplan this includes the following key actions:

- 100% zero carbon electricity supply
- Low or net zero lifecycles for new buildings
- Smart buildings, minimizing energy usage including use of ground and air source heat pumps
- BREEAM excellent for new building, and very good for refurbishments
- Use of modern methods of construction (MMC) to standardize design and reduce time, cost and wastage
- Designing in climate adaptation to reflect expected climate change over the 50-60-year life of these buildings to cope better with extreme temperatures and rainfall
- Enhancing the biodiversity of all sites, including plans around planting, and supporting insect and wildlife habitats.



Taken together with changes in clinical practice to reduce wastage and high greenhouse gas emissions the trajectory to 80% reduction by 2030 is challenging but achievable.

Exploring local energy production via photo-voltaic (PV, or 'solar panels'), and geo-thermal for the wider Wessex fields development will also be explored during the life of this strategy.

9 Supporting Plans

This estates masterplan sits within the wider UHD and Dorset ICB plans, as well as those of the Local Authority, including the Local Plan. This strategy also takes into consideration national policies and recommendations, such as the Carter and Naylor reports. As these are updated so will this strategy.

This plan will also inform specific plans within UHD, for infrastructure investment and maintenance. These include strategies for:

- Digital strategies
- Infection control and prevention
- Waste management
- Energy (electrical, gas and back up)
- Decarbonisation
- Oxygen supplies
- Water supply and safety
- Fire prevention and control
- Ventilation
- Design quality assessment process
- Others as required

Backlog in estates work, in maintaining buildings and systems is a growing national issue, estimated at over £10 billion nationally. UHD is in line with this national benchmark. The major investments in all sites will reduce the current estimates of c.£140m backlog. The significant infrastructure works at Poole will be phased for 2026-30 when the site has greater flexibility following the emergency/planned service moves. Until then works are focused on the most urgent critical infrastructure. A robust Quality Management system is in place, and national reporting is via the Premises Assurance Model (PAM) reporting.

10 Public, patient and staff involvement

In developing this strategy, it draws on significant public, patient and staff involvement, over many years, including over 12,500 hours of clinical staff time in ensuring the buildings are designed to provide the optimal care for patients.

The recent NHS Dorset joint information event in Swanage in June 2023, was a great opportunity to share plans and updates about local changes to the NHS with visitors (see below)

Recent reports on the developments have recognised how UHD are taking both the opportunity, as well as the responsibility, of being a leading hospital within the current hospital development programme, with the UHD project team taking the opportunity to look at how projects fit within the overall ‘whole site masterplan’ rather than standalone individual projects. There is recognition of the emphasis being made to fully embrace a higher standard of health planning, design and construction requirements.

As designs are developed, they undergo design quality assessments (DQs) to ensure they are accessible, and patient centred against many criteria. In addition, many further opportunities will be designed into the programme of works to ensure patient, visitor and staff wisdom and insights are incorporated. Where designs are completed work on wayfinding, visual art and decoration, will also allow further opportunities for stakeholder input.

The NHS belongs to the people and so quite rightly those views should be asked for, and collated, to ensure this once in a generation investment and change in services is reflected in these plans. To comment please email **communications@uhd.nhs.uk** quoting “UHD Estates Masterplan.”

To receive updates on these plans and the work of the UHD team please become a member of UHD Becoming a member (uhd.nhs.uk)

For more information including floor plans of the new estate and “walk through” videos please visit the website **www.uhd.nhs.uk**.

We are #TeamUHD

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University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 06 March 2024

Agenda item: 6.4.2

Subject:	Green UHD Plan
Prepared by:	George Atkinson / Stuart Lane
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:	Sustainable Services
Purpose of paper:	To approve the updated Green UHD Plan
Executive Summary:	The five-year plan against our cornerstone objectives has been updated to reflect the progress over the past two years since the plan was initially agreed. The plan remains very ambitious but necessary to meet our legal and regulatory compliance.
Background:	The attached plan and slides in the reading room provide our plan for achieving the environmental sustainability goals. These are summarised in the graphic below.

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

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Finance and Performance Committee	December 2023	Supported with recommendation for Board 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 ☐

NHS
University Hospitals Dorset
NHS Foundation Trust

Green UHD Plan

2021-2026
Sustainable Development Strategy
2023 Revised Edition

Contents

- **Our Green UHD plan introduction**
  - Our Vision
  - Our Mission
  - Our Structure
- **Our Objectives**
- **Our Cornerstone Targets**
  - **Target 01:** Carbon reduction
  - **Target 02:** Staff Engagement
  - **Target 03:** Clean air
  - **Target 04:** Sustainability goals
  - **Target 05:** Use of resources
- **Our key Areas for Action**
  - Carbon and GHGs
  - Social value
  - Workforce and leadership
  - Digital transformation
  - Estates and facilities - utilities
  - Supply chain procurement
  - Sustainable models of care
  - Travel and transportation
  - Estates and facilities - waste
  - Medicines
  - Estates and facilities - capital projects
  - Food and nutrition
  - Climate adaptation
  - Greenspace and biodiversity
- **Communicating and embedding the Strategy**
- **Governance and reporting**
- **What can you do to help**
- **Annex:** A, B

Our button links will allow you to navigate through the GUHD Plan quickly and easily.

Our Green UHD plan

Welcome to our Sustainable Development Strategy, which we call our Green UHD plan. As one of the largest organisations in our area, University Hospitals Dorset (UHD) has the ability and the duty to help build healthy lives, healthy communities and a healthy environment.

By having this sustainability and carbon reduction strategy at the heart of what we do, we can drive long-term success and real change. We have made significant progress in many areas, but we need to do much more. This Green UHD plan will guide the design and implementation of our future services at UHD as they are developed in line with the requirements of the Dorset Integrated Care System.

This Green Plan acts as our organisational strategy to ensure that we embed this ambition into every aspect of our activity, in tangible and measurable ways.

It is only by working together, using our Values of "Caring," "One Team" and "Always Improving" that we will succeed, we all have a role to play, so please do read our Green Plan and get involved.

Siobhan Harrington

Siobhan Harrington
Chief Executive Officer

Try using our progress bar you to navigate to important parts of the GUHD Plan quickly and easily.

Our Vision:

To provide excellent healthcare to our patients and wider community and be a great place to work, now and for future generations.

Advancing the Vision

The World Health Organisation (WHO) have stated that 'the climate crises is the single biggest health threat facing humanity'. The NHS recognises that our services must adapt to a changing climate and also ensure that our work respects and supports the natural world upon which we all depend.

That is why, at UHD, our vision is: "to provide excellent healthcare to our patients and wider community and be a great place to work, now and for future generations."

Sometimes we need to set 'Moon-shot' ambitions to stimulate innovation and change. By setting the 2040 "Core" and 2045 "Footprint Plus" carbon targets, the NHS has done just that; signalling to markets and to our workforce what we are aiming for so that everyone can pull together to meet a common goal.

In 2021, UHD was one of the first NHS Trusts to publish a Green Plan aligning with the NHS dual 2040 and 2045 carbon targets. Since then, UHD has delivered an estates de-carbonisation strategy setting out how we can reduce our building energy related carbon emissions. The Trust has also made a significant investment to secure an upgrade to Royal Bournemouth Hospital's electrical feed connection from the national grid. This will support the trust carbon reduction plans and new electrical vehicle charging infrastructure; important for charging trust owned vehicles and those of our staff, patients and visitors.

This 2023 revision of our Green Plan embraces new national guidance such as for the trust to only buy or lease zero carbon or ultra-low emission vehicles. As ever, we continue to go much further than legal or NHS requirements. For example, we have aligned the staff salary deduction car leasing scheme so that we are encouraging our staff to transition to electric and ultra-low emissions vehicles also. The Trust has also eradicated the use of Desflurane, the most potent green-house gas used in anaesthetic procedures, well ahead of national targets.

We continue to work closely in partnership with NHS Trusts in Dorset and have together introduced a platform for staff to compete on a range of sustainability and well-being activities, earning points and prizes for the highest scorers. We have also created a car sharing scheme so that NHS staff across Dorset can commute together, reducing congestion and emissions.

Our partnership with Bournemouth University has also been productive. For example, we have helped inject sustainability learning into a new Dorset Leadership Course for the next generation of NHS leaders. Academics at BU have also been helping plan sustainability improvements for UHD staff travel by applying advance systems modelling techniques.

Of course, we have been invested heavily in ensuring that our new buildings such as the Poole Theatre Block, the Dorset Pathology Hub and the Beach Building at the Royal Bournemouth Hospital site, all meet high standards of building design and energy efficiency.

We have set ourselves ambitious targets that need to continue to be turned into effective action by our dedicated team, ensuring UHD delivers our vision for current and future generations.

Stuart Lane

Sustainability and Carbon Manager UHD

Climate emergency *is a* health emergency

"Unabated it will disrupt care and affect patients and the public at every stage of our lives. With poor environmental health contributing to major diseases, including cardiac problems, asthma and cancer, our efforts must be accelerated."

Sir Simon Stevens, NHS Chief Executive
In office 1st April 2014 to 31st July 2021

Overview of Structure

Our Vision

To provide excellent healthcare to our patients and wider community and be a great place to work, now and for future generations.

Our Green Objectives

- Healthy Lives
- Healthy Community
- Healthy Environment

Cornerstone Targets

- **Net Core Carbon Footprint:** Reduced 80% by 2030 (against 1990 baseline) Net Zero Carbon by 2040 **Carbon Footprint PLUS:** Net Zero Carbon by 2045
- Clean Air Hospital "Excellent" by 2026
- Use of resources: single use plastic, water, waste and energy targets
- Sustainability Goal score - 100% by 2030
- Staff empowered and leading the changes

Areas of Activity

supported by the Corporate Approach

1. Carbon & GHGs
2. Social Value
3. Workforce & Leadership
4. Digital Transformation
5. Estates & Facilities
6. Supply Chain & Procurement
7. Sustainable Models of Care
8. Travel & Transportation
9. Medicines
10. Food & Nutrition
11. Climate Adaptation
12. Greenspace & Biodiversity

Sustainability actions, processes and projects tracked by NHS sustainability assessment tool and **UN Sustainable Development Goals.**

Our Objectives

Healthy Lives

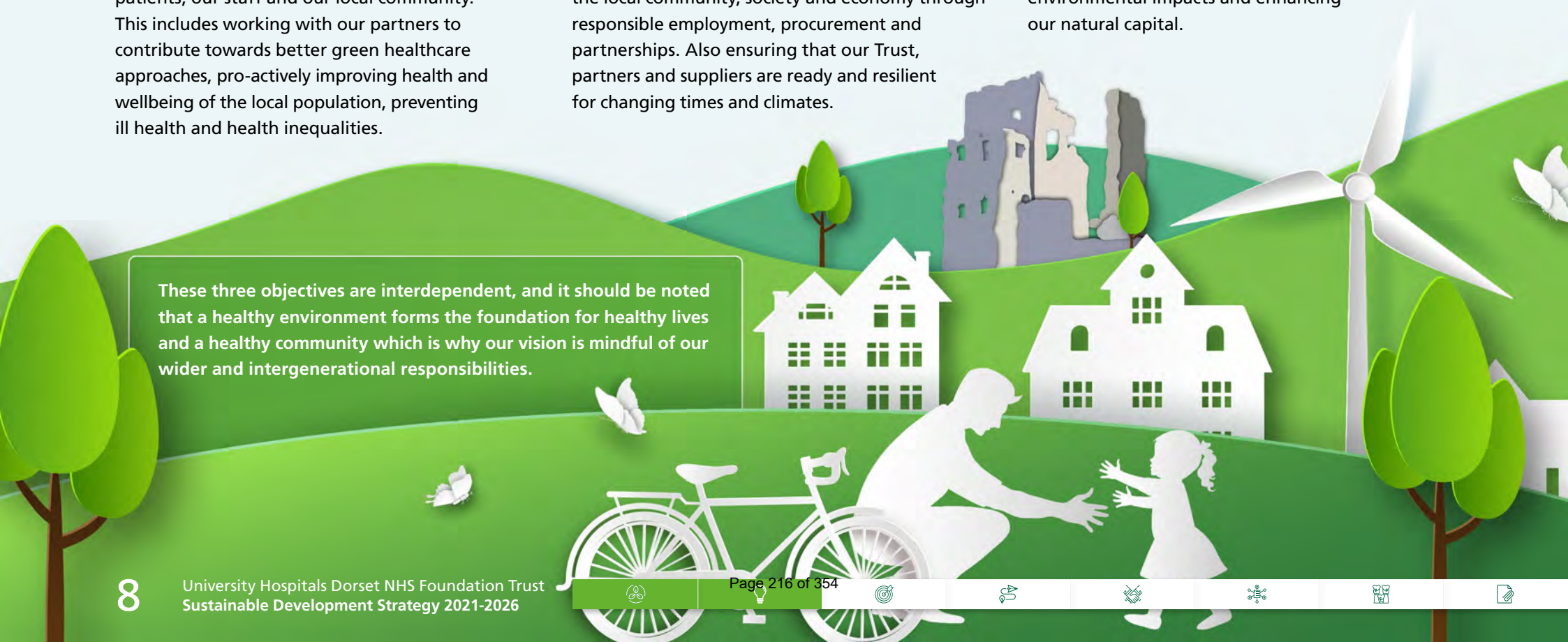
Improving the health and wellbeing of our patients, our staff and our local community. This includes working with our partners to contribute towards better green healthcare approaches, pro-actively improving health and wellbeing of the local population, preventing ill health and health inequalities.

Healthy Community

Being a positive "Anchor Institution" by supporting the local community, society and economy through responsible employment, procurement and partnerships. Also ensuring that our Trust, partners and suppliers are ready and resilient for changing times and climates.

A Healthier Environment

Managing and reducing our negative environmental impacts and enhancing our natural capital.



These three objectives are interdependent, and it should be noted that a healthy environment forms the foundation for healthy lives and a healthy community which is why our vision is mindful of our wider and intergenerational responsibilities.

Our Objectives

In October 2020 the NHS adopted a plan to become the world's first net zero carbon National Health Service.

University Hospitals Dorset is one of the largest organisations in Dorset. Our hospital Trust has a significant economic, social and environmental impact. We spend over £600m per annum much of which goes directly or indirectly to local businesses, we employ over 9,000 local people.

As a result of our activity, we consume resources, generate substantial waste materials and are responsible for significant carbon emissions. In addition to these elements the travel and transport to deliver the materials we need and to move staff, patients and visitors impacts on local air quality.

In line with the NHS Long Term Plan and as an "anchor Institution" in Dorset we are committed to embedding sustainability across our own organisation and with partners, leading by example in our sector and improving the health and wellbeing of the communities we serve. We will collaborate with our healthcare partners and key stakeholders to ensure that our work is aligned to deliver a shared set of goals. Everyone has a part to play in delivering this plan and by working together, we will achieve more and deliver truly sustainable healthcare.

Cornerstone Targets

Net Core Carbon Footprint:
- Reduced 80% by 2030 (against 1990 baseline)
- Net Zero Carbon by 2040

Carbon Footprint PLUS:
Net Zero Carbon by 2045

Clean Air Hospital "Excellent" by 2026

Sustainability Assessment score of 100% by 2030

Staff empowered and leading the changes

Reduce Use of Resources:
- Reduce single use plastics
- Zero waste to landfill
- 100% renewable energy

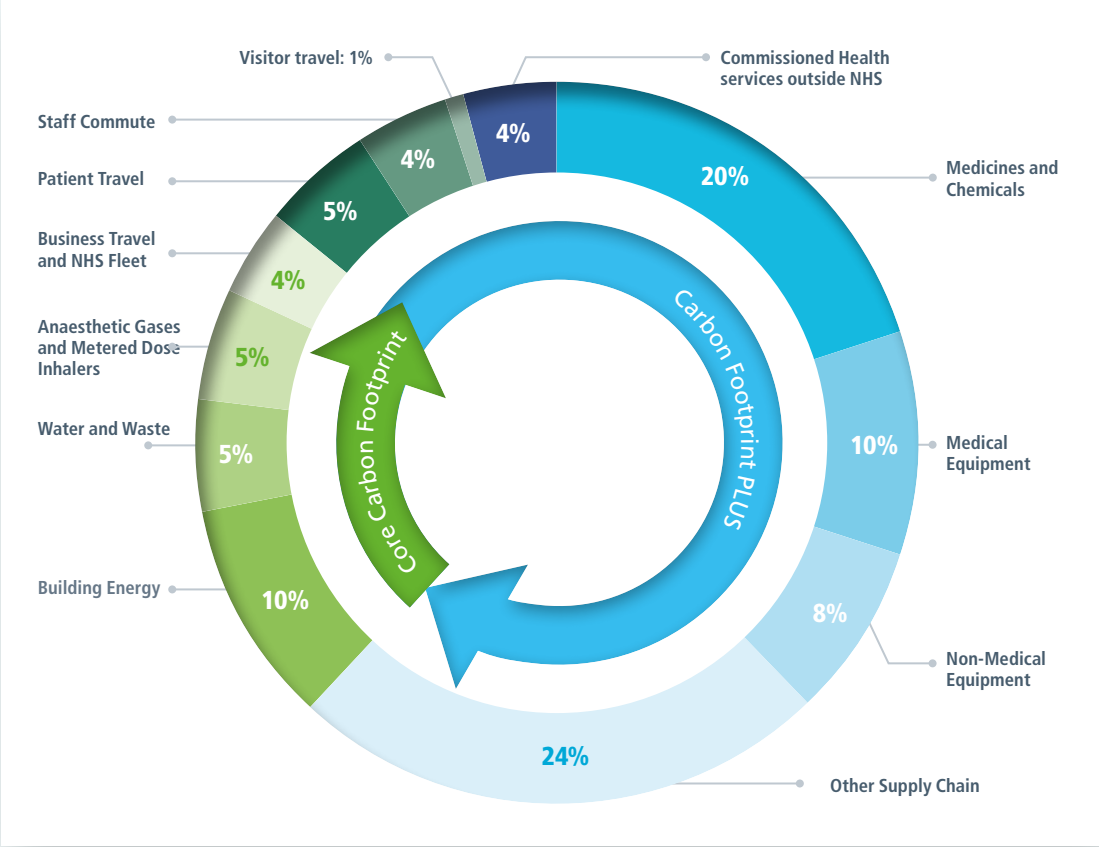
Target 1:
Carbon reduction

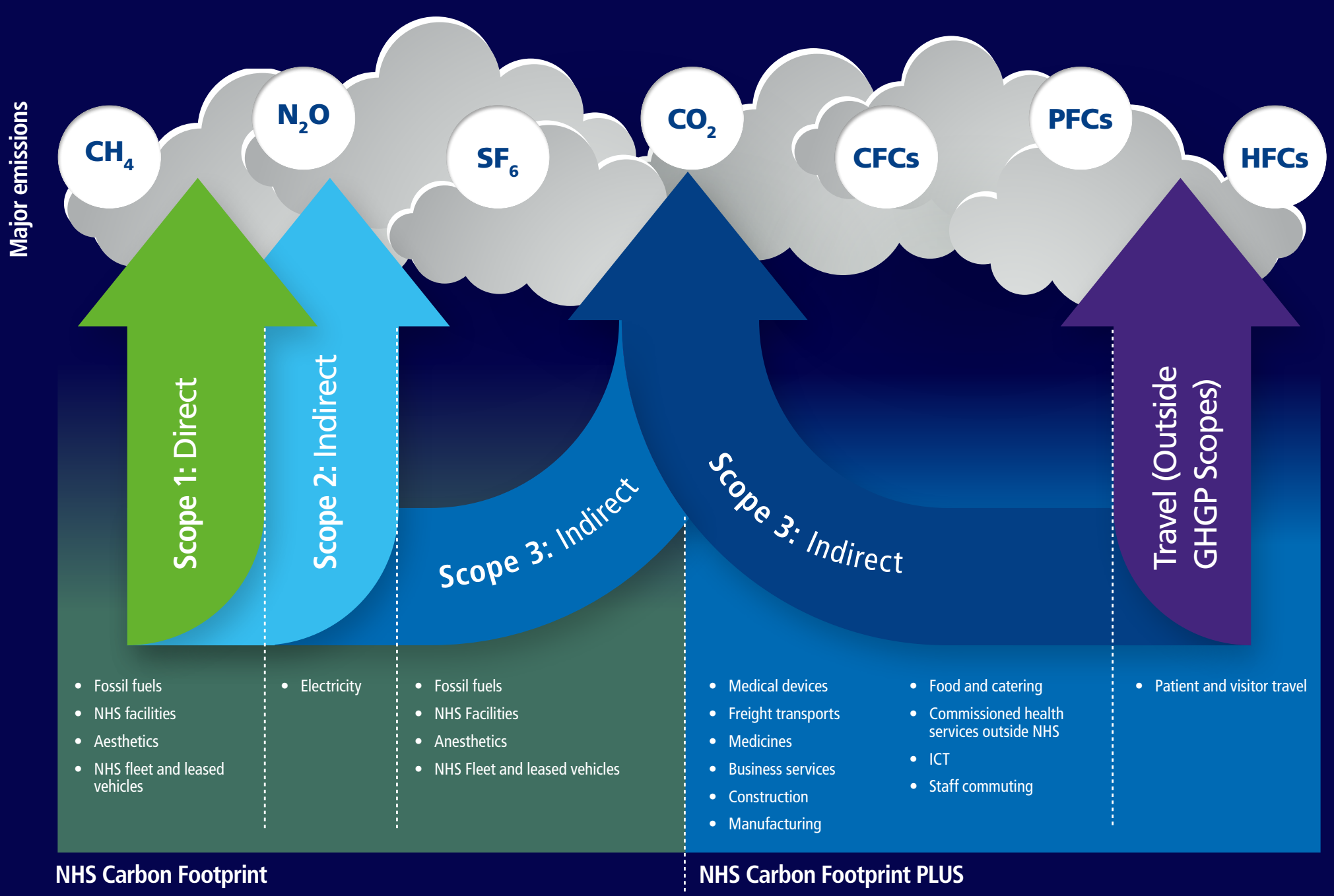
The diagram shows the elements that make up the NHS carbon emissions – the carbon "footprint". "NHS Core Carbon Footprint" (shown by the green arrow) includes carbon emissions that are directly produced through the use of building energy, water, waste processes, anaesthetics and inhalers and business travel. "The NHS Footprint PLUS" (shown by the blue arrow) includes the other emissions associated with products and services that we purchase."

In line with the NHS commitment to become the world's first Net Zero Carbon National Health Service, UHD is committed to the following carbon targets:

Core Carbon Footprint:
- Reduced 80% by 2030 (against 1990 baseline)
- Net Zero Carbon by 2040

Carbon Footprint PLUS:
Net Zero Carbon by 2045



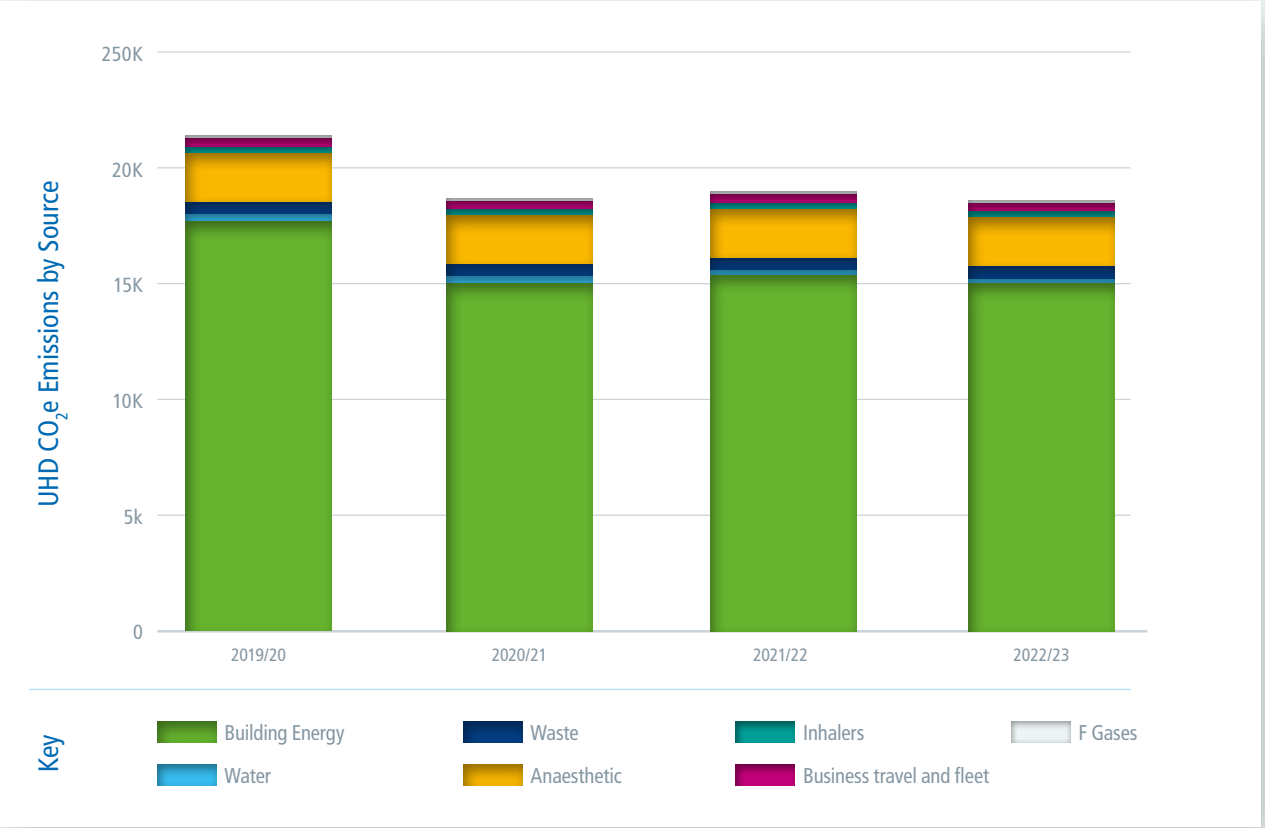

Major emissions
CH_4
N_2O
SF_6
CO_2
CFCs
PFCs
HFCs
Scope 1: Direct
Scope 2: Indirect
Scope 3: Indirect
Scope 3: Indirect
Travel (Outside GHGP Scopes)
Fossil fuels
NHS facilities
Aesthetics
NHS fleet and leased vehicles
Electricity
Fossil fuels
NHS Facilities
Anesthetics
NHS Fleet and leased vehicles
Medical devices
Freight transports
Medicines
Business services
Construction
Manufacturing
Food and catering
Commissioned health services outside NHS
ICT
Staff commuting
Patient and visitor travel
NHS Carbon Footprint
NHS Carbon Footprint PLUS

Progress so far:
Core Carbon Emissions

We strive to keep improving our understanding and assessment of trust carbon emissions.

We have improved accuracy of data capture and prudently now include the carbon emissions relating to heated water supplied to the Royal Bournemouth Hospital. Revised calculations for 2019/20 add 4,200 tonnes to previously reported figures. This increase is now back-cast through to 2009/2010 - our baseline year providing a baseline of 30,500 tonnes CO_2e Core emissions.

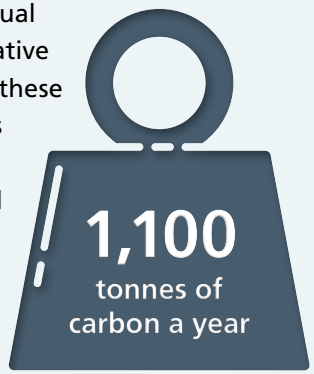
Between 2019/20 and 2022/23, the Trust has reduced core emissions to approximately 17,900 tonnes, an average reduction of just over 1000 tonnes per year. Note 2020 – 2022 emissions were lower due to Covid than would have been expected.

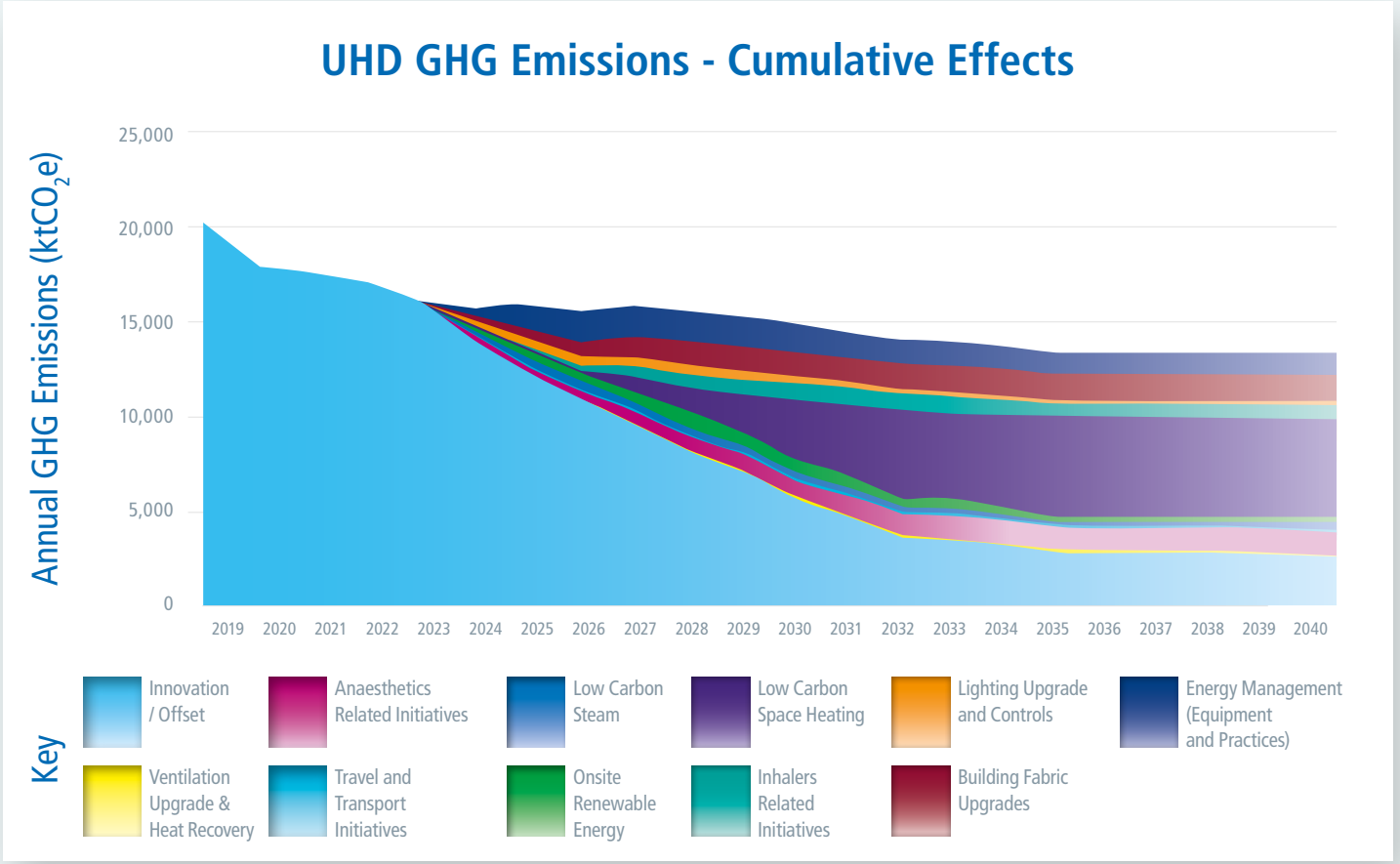


The Challenge Ahead:
Core Carbon Emissions

To reach our core net zero carbon target by 2040, we must continue to reduce our core carbon emissions by approximately 1100 tonnes of carbon a year.

The 'waterfall' diagram shows how the trust can decarbonise through various measures that have been identified within the trust decarbonisation strategy. The individual and cumulative impacts of these measures is laid out on a projected timeline.



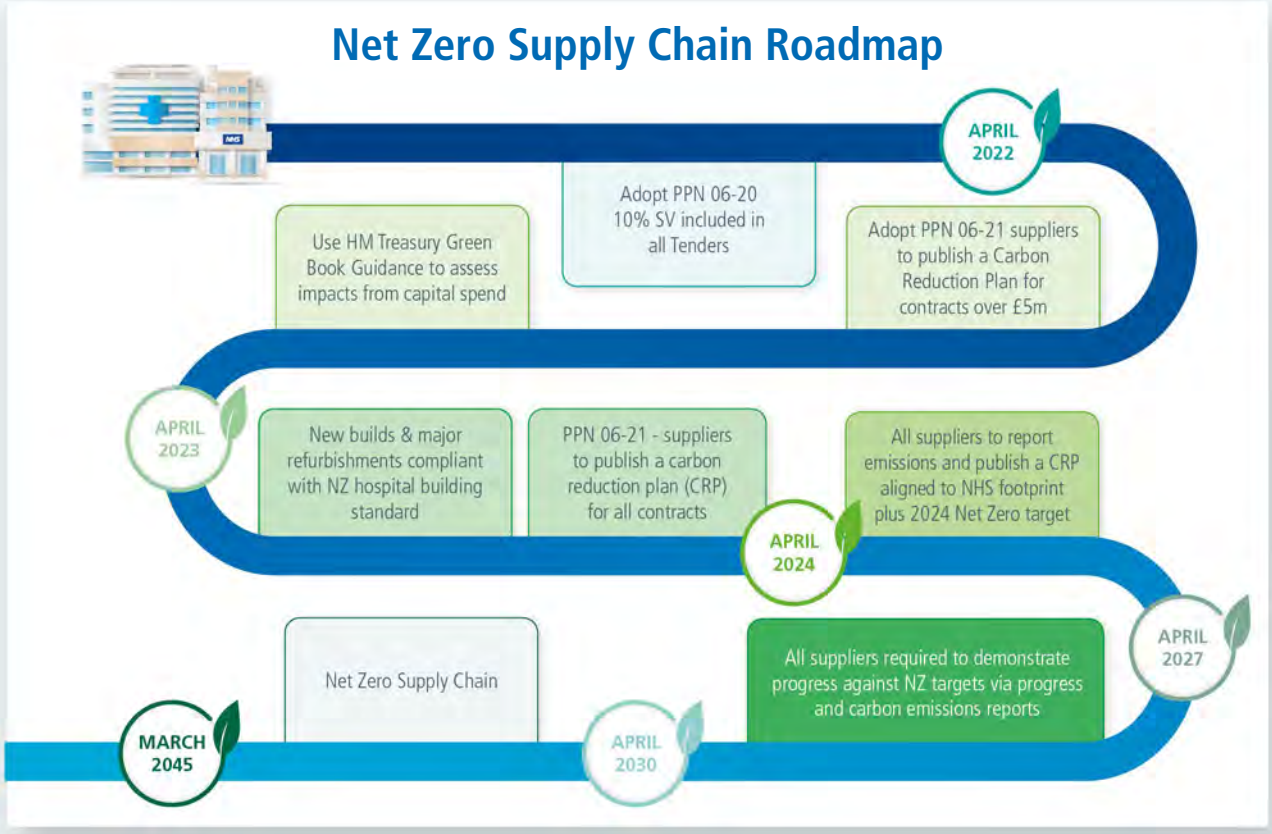


The Challenge Ahead:
Carbon Footprint Plus Emissions

Assessing and decarbonising NHS supply chain emissions is a complex undertaking The NHS is working step by step to both reduce emissions and the robustness of emission measurement and reporting.

During 2022/23, the central Greener NHS team carried out a nation-wide carbon footprinting assessment of NHS 2019/20 footprint plus emissions. This assessment provided disaggregated emissions down to trust level, providing UHD with the most comprehensive data to date for the trust footprint plus emissions.

UHD's Footprint Plus was 104,000 tonnes CO_2e for 2019/20. In collaboration with NHS-E and our suppliers, the trust must reduce this total by an average of 4200 tonnes each year to reach net zero by 2045.



Target 2:
Staff Engagement

Our ability to deliver on this ambitious Green Plan will be dependent upon the all parts of the organisation pulling together as one team. Whilst the sustainability steering group and committee will have co-ordination and assurance roles, it will be the actions of our thousands of staff members that will make the plan real. The role of our leaders in role modelling will be crucial.

The Trust will be supporting staff by setting expectations in staff inductions, including sustainability within all staff contracts and delivering Trust wide training. There will be additional support for specific roles such as our sustainability leaders and quality improvement team to enable them to help further embed sustainability as the business as usual approach for everything we do.

In addition the Trust will invest in sustainability programs to pull upon learning from outside of the organisation to inspire and offer new ways of working.

- **The Green Plan objectives are to be maintained as core Trust objectives and staff be will be appraised against these objectives.**
- **2024 all staff to have access to online sustainability training. 50% of staff to be trained by Dec 2022, and 90% by June 2023.**
- **2024 all sustainability leaders and QI staff to have undergone Sustainable Quality Improvement training.**

Target 3:
Clean air

As a healthcare provider dealing with the ill-effects of air pollution, UHD has a duty to play its part in reducing levels of harmful pollutants such as nitrogen oxides (NOx), carbon monoxide (CO) and particulate matter (PM) in our atmosphere. A majority of the UK's greenhouse gas emissions is now caused by road transport.

As one of the largest employers and healthcare providers in the Bournemouth Christchurch and Poole area, emissions caused by staff and patient transport will account for a significant proportion of air pollution in the local vicinity.

UHD recognises that road transport is not the only contributor to air pollution across its sites. UHD's hospitals feature on-site incineration, generator exhaust, and some hazardous gases from clinical activity, all of which generate emissions to the atmosphere.

This green plan commits UHD to measuring the level of air pollutants in the atmosphere at The Royal Bournemouth Hospital, Christchurch Hospital and Poole Hospital sites on an annual basis and work with key strategic partners including Bournemouth University and BCP Council to achieve the mutual aims of reducing air pollution across the conurbation.

Achieving excellent rating on the Clean Air Hospital framework by 2026

Target 4:
Sustainability goals

The NHS has developed a sustainability assessment tool to track progress against approximately 300 sustainability measures which are mapped against the United Nation's 17 Sustainable Development Goals (2015-2030).

The Trust commits to making year on year improvements in score against the NHS Sustainability Assessment Tool and to achieve 100% rating by 2030.

The scope of work to achieve this target is extensive and will require considerable team efforts across our organisation in collaboration with partners and suppliers.

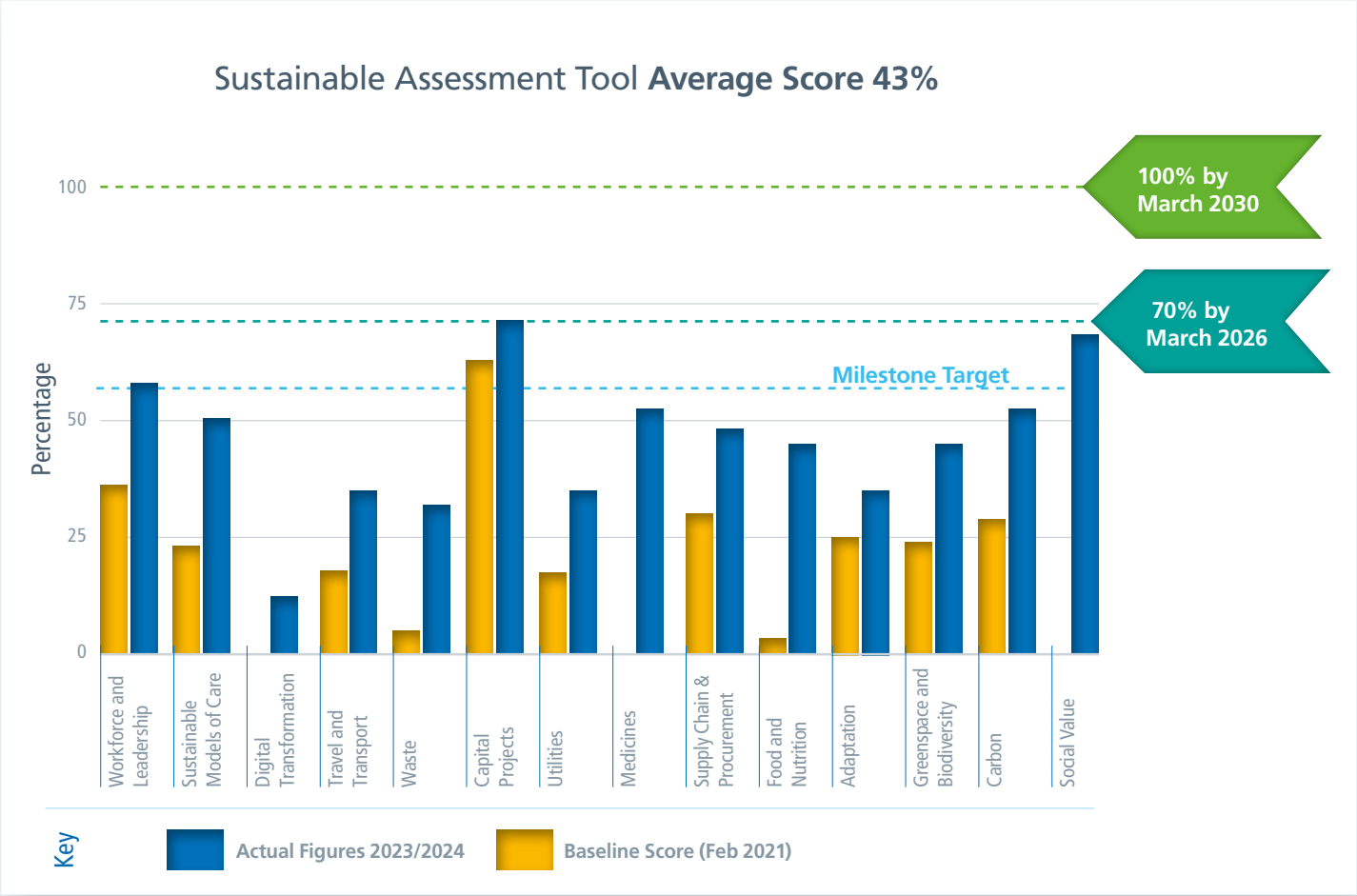
Sustainability Goals

We will measure our progress on sustainable development through the use of a revised version of the NHS Sustainability Assessment Tool - SDAT2.

Our baseline assessment for the trust was conducted in February 2021 and produced an average score of 34%. By March 2023, the average score hit 53%, (exceeding target set under SDAT1).

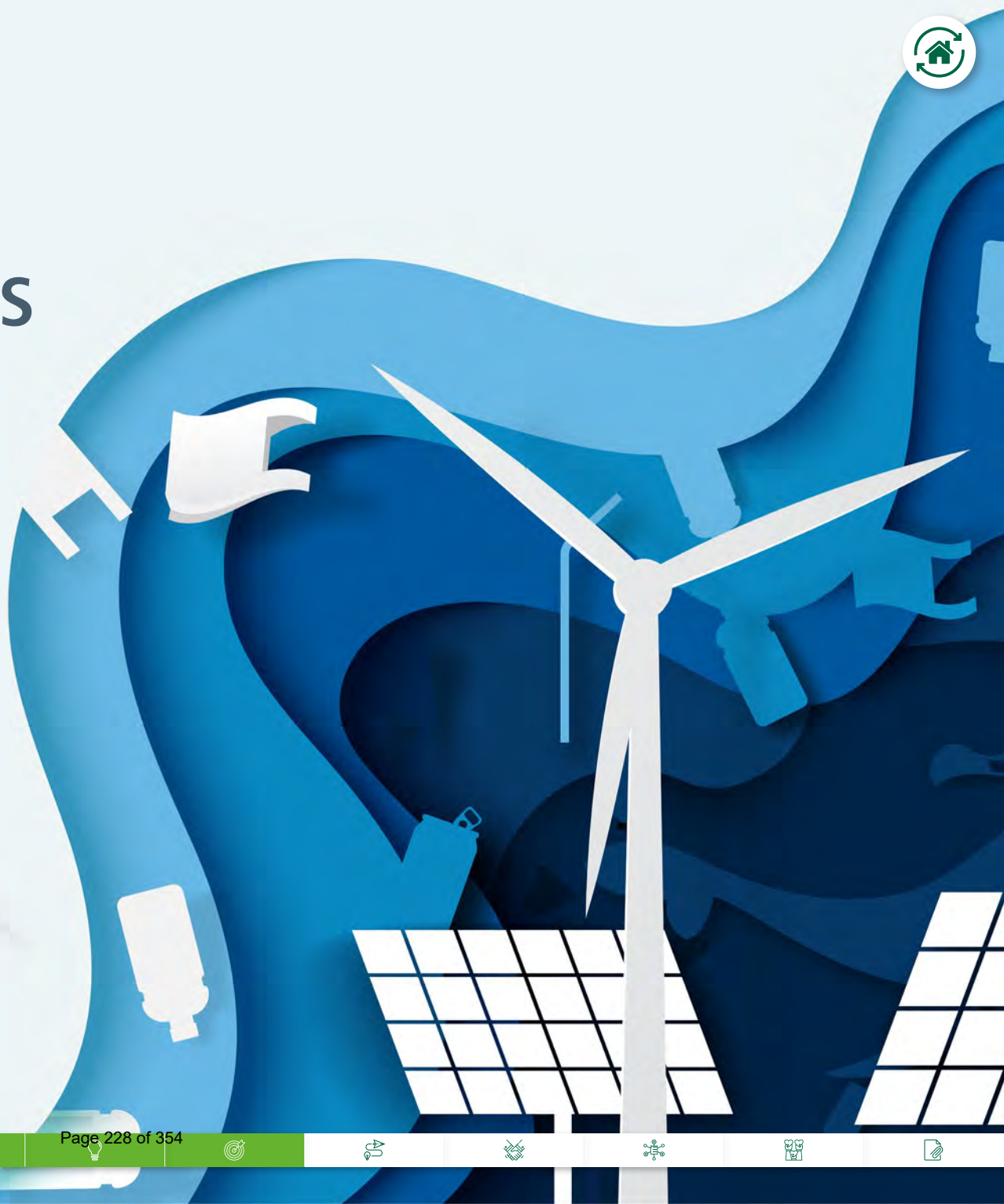
We have since added over 160 requirements and new distinct area of activity to the SDAT model and renamed it SDAT2. These changes necessitates a new baseline.

We go into 2023/24 with an SDAT2 baseline of 43% average across activity streams and will continue to aim for circa 10% improvement each year towards our 2026 and 2030 targets.



Target 5 :
Use of resources

- Maintain Zero Waste to landfill
- Maintain 100% zero carbon grid sourced power
- Reduce single use plastics and other waste in line with the NHS Clinical Waste Strategy 2023 and NHS Standard Contract
- Implement a Sustainability Impact Assessment for all business cases over £250k during 2024



Key Areas for Action:
Green Plan

Meeting our targets requires sustained effort across the organisation and with partners, over multiple years. To reflect this and to organise our activities, we have created 12 "Areas of Action". The Estates and Facilities action area has been further subdivided into Utilities, Waste and Capital Projects giving 14 sub Areas of Activity. Each of the 14 sub areas has an appointed sustainability lead that will report on progress to the Finance Performance Committee quarterly through the Sustainability Steering Group.

The Carbon and Social Value activity areas provide a way to collate and report on the cross threading activity mainly being actioned across other areas of activity. Progress is monitored using SMART targets captured within SDAT2. These will be reviewed and revised regularly.

The next part of the Green Plan dedicates a page to each area of activity and describes what we want to achieve, how we wish to achieve it and how we will measure this.

- Carbon and GHGs
- Social Value
- Workforce and Leadership
- Estates and Facilities - Utilities
- Digital Transformation
- Supply Chain and Procurement
- Sustainable Models of Care
- Estates and Facilities - Waste
- Travel and Transportation
- Medicines
- Estates and Facilities - Capital Projects
- Climate Adaptation
- Food and Nutrition
- Greenspace and Biodiversity

Carbon and Greenhouse Gases

What do we want to achieve?

- Measure our carbon emissions, identify hotspots and take targeted action to reduce emissions year-on-year in line with our Net Zero Carbon targets.
- **Core Carbon Footprint target** - Net Zero Carbon by 2040, and 80% reduction by 2030 (equates to reduction of approx. 1,000 tonnes CO_2 per annum).
- **Carbon Footprint PLUS target** - Net Zero Carbon by 2045 and 80% reduction by 2040 against 1990 baseline (equates to reduction of approx. 4,000 tonnes CO_2 per annum).

How can we achieve it?

- Board level commitment to the Green Plan strategy with Trust wide contribution to the identified priority activities.
- Develop Carbon reduction plan with RIBA stage 3 including design and costings and deliverability to enable prioritisation decisions.
- Calculate and report core carbon emissions, targeting hotspots and horizon scanning opportunities.
- Develop methodologies to measure Scope 3 emissions and improve methodology for calculations of Carbon Footprint PLUS.
- Engage with staff, suppliers and partners such as BCP Council and BU to reduce our carbon footprint.
- Work with our Dorset system partners and contribute to the system- wide strategies consultations and initiatives for carbon measurement and reduction.

How will we measure it?

- Drivers of core carbon footprint to be monitored via embedded processes as per ERIC and the Trust annual report.
- Scope 3 emissions to be monitored via spend based analysis.
- Track metrics that help identify factors that influence carbon emissions e.g. CO_2 per patient CO_2 per m² Gross Internal Area
- Track the consumption of anaesthetic gases and refrigerant gases.
- Enhance carbon analysis with national tools and factors supported by third party consultancy where appropriate.
- Carbon Reduction Plan ready for review by April 2024.

l Social Value

What do we want to achieve?

- Positively contribute to BCP and the wider area in ways that go beyond the direct delivery of healthcare. UHD seeks to invest into out local community, having a broad impact on the wider factors that influence health and wellbeing.

How can we achieve it?

- Procuring goods and services in ways that support social benefit including local inclusive growth and reduced inequalities.
- Managing our land and buildings for social, environmental and economic benefit.
- Widening access for local people to quality work and training.
- Mitigating against and adapting to the impacts of climate change.
- Working with partners towards the commitments laid out under the Dorset Anchor Institutions Charter.
- Employ software systems to better capture and report on social value.

How will we measure it?

- Monitor the application of 10% or greater weighting for social value in tenders
- Track the number of apprentices, work placements and volunteers employed.
- Employ the Evergreen system to monitor social value relating to supplier contracts.

UHD's Workforce and Leadership

What do we want to achieve?

Ensure sustainability is embedded within organisational decision making:

- Deliver, monitor and report on sustainability progress.
- Senior staff, stakeholders and governors are engaged in, and accountable for, delivering our Green Plan.
- Strategies, policies, procedures, business cases and processes always have a meaningful sustainability impact assessment section.
- Staff are supported and empowered to improve sustainability at work and home.
- Staff engaged and enabled to adopt sustainable practices and to take ownership within their own areas of influence.
- Responsible anchor institution showing sustainability leadership and a positive impact for our communities.

How can we achieve it?

- Maintain an ambitious strategy – the UHD Green Plan underpinned with up to date activity plans with SMART targets and supporting policies as required.
- Report performance quarterly to the sustainability steering group and finance performance committee plus via the trust annual accounts.
- Support NHS Supply Chain and Regional Procurement initiatives to develop and deliver sustainable procurement.
- Play an active role as an Anchor Institution in Dorset, creating opportunities for local communities to become more sustainable.
- Incorporate the Green Plan into the Trust annual objectives.
- Expand participation in staff sustainability programmes and awards, main-streaming a sustainability mind-set and recognising good practise.

How will we measure it?

- NHS Sustainability Assessment Tool score in line with target of 70% by 2026.
- Number of policies and business cases including a sustainability impact assessment.
- Number of staff registered with EcoEarn staff sustainability platform.
- No of staff that have undertaken sustainability training including sustainability induction for new staff.
- Number of apprentices, work placements and volunteers employed.
- Clear, measurable targets in annual care group and corporate operating plans, and in senior leaders objectives.
- Carry out annual sustainability surveys to measure staff awareness levels.

Digital Transformation

What do we want to achieve?

- Digitally enabled care models that will improve efficiency and effectiveness of our operations.
- Digitally enabled care models that significantly reduce travel and journeys with care closer to home being delivered through remote consultations and monitoring
- Reduce the environmental impacts from IT related activity such as carbon emissions due to energy consumed by IT systems and services.

How can we achieve it?

- Embrace new and existing digital technologies to reduce the environmental impact of care eg cloud first, automation and AI.
- Apply 'What Good Looks Like' for low carbon digital care, across the system – Louisa Way – Chief Information Nursing Office (CINO).
- Apply a 5 year hardware refresh plan, updating to new efficient equipment.
- Support front-line digitisation of clinical records, clinical and operational workflow and communications, aided by digital messaging and electronic health and care record systems.
- Support working from home.
- Ensure IT service providers minimise their environmental impact using procurement levers and contract management KPIs.

How will we measure it?

- Carbon emissions from IT devices measured via dedicated software tools.
- Proportion of retired PC's and Laptops sent for resale & Recycling.
- Proportion of retired Hard disks and solid state drives recycled.
- Total number and proportion of virtual and remote consultations.
- Total number and proportion of staff homeworking.

Estate and Facilities - Utilities

What do we want to achieve?

Derive 100% of our energy from renewable sources, embed energy and water efficient technologies and practices throughout our Estate and services and deliver year-on-year reductions in consumption:

- Accurately measure utilities and reduce consumption to make sure we're getting the best value for money and minimising environmental impact.
- Embed more efficient practices, new technologies and improve staff awareness to improve utility efficiency across everyday activities and as part of longer-term plans.
- Inform and educate staff, patients and visitors about how their actions affect energy and water consumption.
- Strategies, policies, procedures, business cases and processes always have a meaningful sustainability impact assessment section.

How can we achieve it?

- Improve metering, measurement and monitoring systems including updating BMS systems and adopting a Trust wide Energy Management System.
- Deliver a programme of targeted energy and water efficiency schemes to manage and drive down use.
- Work collaboratively with community partners to maximise the use of built assets and grounds including exploration of geothermal potential.
- Assess lifecycle costs of energy and water usage when purchasing new equipment and use this as a criteria in decision-making.
- Develop a Trust wide estates decarbonisation plan demonstrating timelines to achieve Net Zero Carbon and a business case for the required solutions to deliver the carbon savings.

How will we measure it?

- Annual ERIC return and model hospital metrics.
- Monitor monthly utility consumption and cost at a suitably granular level e.g. building, department, service or device.
- Percentage of energy from renewable sources.
- Amount of on-site renewable energy generation.
- Monitor energy saved through efficiency measures to ensure that performance is in line with the agreed plan.

Supply Chain and Procurement

What do we want to achieve?

- Meet national legal and regulatory requirements such as NHS Standard Contract and Net Zero Procurement Roadmap.
- Pro-actively support sustainable models such as the circular economy approach.
- Minimise unnecessary procurement and resource use.
- Re-use of materials and items where appropriate.
- A sustainable procurement culture and processes that shift consumption to sustainable products and services and considers broad criteria including materials, workforce, manufacturing processes, transport and social value.

How can we achieve it?

- Replace single use products with reusable alternatives where there is a viable, more sustainable option e.g. re-usable sharps bins.
- Promote a culture of reuse and refurbishment of items.
- Deliver / attend sustainability and social value training for procurement teams.
- Work with organisations innovating new sustainable approaches.
- Include sustainability criteria in procurement, tender evaluations, framework design and selection, and product selection, in line with PPN 06/20.
- Adopt the NHS plastics pledge.
- Work with NHS, partners and suppliers to better understand supply chain scope 3 emissions.
- Embed a Sustainable Quality Improvement approach.
- Develop scope 3 carbon foot-printing process.
- Assess the use of Evergreen system to support trust green plan objectives.

How will we measure it?

- Track the positive carbon and other environmental impacts from procurement initiatives e.g. introduction of reusable materials.
- Tracking departmental level requisitions of single use 'hotspot' materials.
- % of contracts awarded to suppliers with a carbon reduction plan (CRP).
- Reporting by exception any procurements awarded without min 10% social value weighting.

Sustainable Care Models

What do we want to achieve?

- Deliver the best quality of care while being mindful of its social, environmental and financial impact and take a whole systems approach to the way it is delivered.
- Improve the environmental sustainability of care pathways, and better integrate healthcare services to improve efficiency.
- Work with partners and stakeholders to identify and deliver solutions that reduce the number of hospital visits, such as the provision of treatment closer to or within home.

How can we achieve it?

- Identify carbon hotspots such as medical equipment and pharmaceuticals and ensure that action plans identify and mitigate environmental impacts.
- Reduce carbon emissions associated with areas of high impact by educating staff and encouraging lower impact alternatives.
- Work with partner organisations to support vulnerable patients upon discharge such as improving home energy efficiency.
- Pilot the redesign of selected care pathways to drive out any unnecessary stages or low value adding activities.
- Increase digital and other options for outpatient and other stages of care.
- Mainstream Sustainable Quality Improvement methodology through training.
- Facilitate virtual and telephone patients consultations in line with sustainable care pathways.

How will we measure it?

- Feedback relating to the care environment (e.g. temperature, light, services using PLACE surveys).
- The number of sustainable quality improvement projects.
- Model Hospital metrics such as weight activity units to monitor impacts from interventions at procedure, department, site and trust level.
- Reduction in onsite outpatient follow ups.
- Number or % of medical devices reduced or recycled.

Travel and Transportation

What do we want to achieve?

- Minimise the environmental and health impacts associated with the movement of goods and people through Trust activity.
- Increase use of sustainable and active modes of travel that deliver environmental and health benefits.
- Decarbonise the travel and transport relating to our operational activity.
- Prepare for and implement the opportunities from planned major service changes.

How can we achieve it?

- Facilitate active and sustainable travel options for staff, patients and visitors.
- Work with our strategic partners to reducing congestion and improving air quality.
- Better capture of travel related data through systems and surveys.
- Increase take-up of the Trust's cycle to work scheme, car sharing scheme and discounted bus fares.
- Consider travel options and impacts when planning changes to our services.
- Develop our electric vehicle fleet.
- Become a Clean Air Hospital.
- Become an accredited "Cycle Friendly employer".

How will we measure it?

- Staff and patient travel surveys to assist with travel data gathering for snapshots and trends.

Maintain a suite of key performance indicators, including:

- Reduction of single occupancy vehicle use by 2% per year and 10% by 2028
- Increase awareness of travel schemes by 10% from baseline and a minimum of 50% total awareness.
- Number of electric vehicles charging points per site.
- Air pollution monitors on each major site.
- Accurate recording of fleet mileage, fuel consumption and CO_2e emissions
- Accurate recording staff business travel mileage fuel consumption and CO_2e emissions.
- Ratio of cycle storage and changing facilities to staff number.

Estates and Facilities - Waste

What do we want to achieve?

- Meet legal responsibilities for waste.
- Optimise waste processes against the waste hierarchy.
- Widespread correct application of Trust sustainable waste policies and procedures.
- Apply best practise and seek to innovate to reduce waste and reduce the impacts from waste including carbon emissions.

How can we achieve it?

- Update the Trust Waste Management Strategy and Plan.
- Replace single use products with reusable alternatives where there is a viable, more sustainable option e.g. re-usable sharps bins.
- Promote a culture of reuse and refurbishment of items.
- Regularly audit waste and follow up on issues identified.
- Develop and implement e-learning modules for waste and sustainability.
- Work with organisations innovating new sustainable approaches.
- Drive out single use plastic waste where possible.
- Work with NHS, partners and suppliers to better understand and manage supply chain scope 3 emissions.

How will we measure it?

- Volume of waste for each stream.
- Monitor and manage proportion of waste being recycled.
- Monitor and manage proportion of clinical waste being segregated to meet NHS Waste Strategy 20:20:60 target by 2025/26.
- Quantity of packaging and single use plastics reduced or removed from services.
- Track the Carbon impact from waste and supply chain initiatives.

Sustainable Medicines

What do we want to achieve?

- Sustainability lens applied to medicines use in line with national best practice & contractual requirements.
- Reduce use of single use plastics in medicines distribution.
- Ensure medicines are specifically considered within the wider climate change adaption plan.
- Reduction of environmental impact of medicines prescribed by UHD NHS Trust (carbon footprint and ecotoxicology).

How can we achieve it?

- Appointment of Trust medicines sustainability lead.
- Annual action plan review for NHS Standard Contract, NHS-E updates and Dorset Green Plan.
- Replace use of single use plastic bags.
- Review Trust policy on medicines management during heat-waves & develop Trust policy on medicines most likely to aggravate heat-related illnesses.
- Support appropriate inclusion of non-pharmacological health interventions and medication cessation recommendations in Trust clinical guidelines.
- Inclusion of carbon-footprint and ecotoxicology risk assessments in formulary proposal form.
- Use Dorset Green Respiratory Care guidance to reduce the environmental impact of inhaler therapy.
- Cessation of Desflurane use by March 2024.
- Establish Nitrous Oxide waste minimisation programme and review of volatile anaesthetic gas emission reduction options.
- Educate staff/patients on sustainable medicines use and disposal.

How will we measure it?

This will be monitored through a suite of medicines specific sustainability dashboard of Key Performance Indicators, to include:

- Monthly consumption of all anaesthetic gases by type.
- Quantity of salbutamol pressurised metered dose inhalers issued (by brand / CO_2e profile)
- Nitrous oxide consumption per birth (home and within maternity unit).
- Monthly quantity of single use plastic bags purchased by pharmacy.

Estate and Facilities - Capital Projects

What do we want to achieve?

The trust has a major phase of building projects through to 2027 and we want to reduce the environmental impact of these building works during the design, refurbishment, construction, operation and decommissioning stages.

- Embed sustainability and efficiency using smart design and emerging technologies across our improvement works, including refurbishment and new build.
- Take a whole life cycle approach to projects by scrutinising sustainability in design, construction, commissioning, operation and decommissioning, helping to future-proof our organisation.

How can we achieve it?

- Include Sustainability Impact Assessments as a decision factor in all capital business cases.
- Develop sustainability guidelines for all capital projects, including major refurbishments, driving resource efficiency through the estates strategy and standard specification.
- Establish a process for the reuse of suitable furniture and equipment.
- Work with consultants and contractors to take a whole life costing approach to new building design and refurbishment to minimise in-use energy and water consumption.
- Give weighting to social value outcomes through procurement processes, including the support of local suppliers and SMEs.

How will we measure it?

- Energy and water consumption, both design and in-use performance (including soft landings).
- Achieve a rating of BREEAM "Very Good" or higher for major capital projects that are underway and refurbishment projects.
- Achieve NHS Net Zero Carbon Building standard for future major estates projects.

Food and Nutrition

What do we want to achieve?

- Optimise the economic, social and environmental impacts that result from trust activities in relation to food and nutrition.
- Meet the sustainability and wider standards set out in the National Standards for Healthcare Food and Drink.

How can we achieve it?

- Use respected accreditation systems to evaluate triple bottom line performance.
- Reduce food waste using industry best practice methods.
- Maintain prohibition of single use plastic cutlery, plates and cups.
- Replace other single use plastics items with suitable more sustainable alternatives.
- Review and adapt menus for lower carbon options.

How will we measure it?

- Attain the Soil Association - Food for Life 'Silver' accreditation across UHD.
- Monitor against food waste reduction targets set using WRAP food waste reduction roadmap toolkit.
- Assess food and drink services against the GB food and catering services GBS standards – chapter 7 Going Green checklist.
- Report on procurement for catering to monitor single use plastics and high carbon ingredients.

Climate Change Adaptation

What do we want to achieve?

Ensure our whole organisation is prepared to deal with the effects of climate change, particularly extreme weather events such as heat waves and flooding, and continues to invest in adaptation and mitigation measures:

- Assess the impacts of climate change and adapt to mitigate the negative effects of past and future climate-altering actions.
- Reduce the impact on public health from climate change.
- Ensure our infrastructure, services, procurement, local communities and colleagues are prepared for the impacts of climate change.

How can we achieve it?

- Nominate an adaptation lead and incorporate adaptation into our sustainability governance structure, corporate risk register and reporting processes.
- Work with Dorset system partners and other stakeholders to deliver and update our Climate Change Adaptation Plan (CCAP).
- Update our Trust climate change adaption risk assessment.
- Ensure that our emergency plans for extreme weather, consider support for vulnerable communities during any extreme weather events.

How will we measure it?

- BREEAM Building Standard or other sustainable buildings methodology scores.
- Monitor and report the progress of our Climate Change Adaptation Plan.
- The overall risk rating in our climate change risk assessment.
- Testing of emergency planning policies.

Greenspace and Biodiversity

What do we want to achieve?

- Maintain and improve our green spaces and biodiversity on-site.
- Help improve the physical and mental wellbeing of staff, patients and the wider community through access to green space, biodiversity and interactions with nature.
- Help to mitigate climate change and biodiversity loss through our biodiversity strategy.

How can we achieve it?

- Develop a biodiversity and greenspace strategy that encompass the challenges and opportunities across our Estate.
- Produce a biodiversity and greenspace action plan that details actions and those responsible for maintaining our green spaces.
- Explore the concept and viability of introducing NHS Rangers in Dorset.
- Ensure tight integration of biodiversity and greenspace plan with capital projects policy to underpin the approach for major new works and refurbishments.
- Repurpose unused areas with a focus on improving green space.
- for biodiversity including wildflower areas supporting pollinators.
- Work with staff, local community organisations and strategic partners to enable increased access to green space and nature both on-site and traveling to and from site.

How will we measure it?

- NHS Sustainability Assessment Tool score for Greenspace and biodiversity section.
- Green Flag certification.
- Habitat and biodiversity site surveys.
- Progress against delivery of biodiversity and greenspace action plan.
- Assessment of staff and patient use of and interaction with greenspace via staff surveys.

Shout it from the cliff top:
Communicating our strategy

Communicating and embedding the Strategy

To help drive change across the whole organisation, we will take a considered, structured and engaging approach to disseminating the strategy and embedding our approach to sustainability.

A communication plan for the strategy will be developed that shows what we are doing both within and outside of the organisation, highlight key priorities and show excellence in sustainable development leading others to join us in making improvements. We will employ some key themes:

- **Collaboration:** leading on more joined-up-thinking as well as creating stronger links with the communities we serve.
- **Development:** showcasing sustainability initiatives for staff as well as opportunities to work outside the parameters of core roles.
- **Progress:** highlighting visible progress in delivering sustainability across the 10 areas of action.

Use of media

- Dedicated sustainability portal on both the UHD website and staff intranet.
- Regular articles in UHD staff bulletin and other corporate publications.
- Share positive progress on sustainability matters with our staff, our partners and the wider community.
- Promote progress against our Green Plan and wider sustainability matters across UHD's social media platforms and EcoEarn.

Engagement campaigns

- Embedding sustainability in decision making from individual actions to major projects e.g. EcoEarn, e-learning, induction, local champions.
- Reinforce engagement in the Green Plan through involvement in local and national sustainability campaigns and encourage staff to get involved e.g. NHS Sustainability Day.
- Make best use of corporate open days and community events.

Awards and rewards

- Apply for national sustainability awards.
- Run annual sustainability awards to recognise the most environmentally and socially sustainable team/department e.g. Sus QI Awards and EcoEarn.
- Recognise and celebrate progress against the targets in this plan.

Governance and reporting

Clear leadership is vital to ensure we successfully deliver the commitments in this strategy. Our sustainable development policy sets out governance arrangements.

As this strategy is broad and encompasses a wide range of work areas, there are other detailed documents that underpin our approach. Some of these have already been developed, such as the UHD Green Travel Plan, and some will be developed or revised in the future, such as a Greenspace and Biodiversity Strategy, Waste Management Plan, Climate Change Adaptation Plan, Estates Strategy, Estates Standard Specification and the sustainability section of the Care Group Operating Plans.

Clear reporting is required to monitor progress and ensure delivery is on track:

NHS Sustainable Assessment Tool: This will measure our qualitative progress on sustainability for the previous year, inform plans for the coming year, and will enable comparative performance against similar Trusts.

Clean Air Hospital framework: This will measure our qualitative progress on air quality for the previous year, inform plans for the coming year, and will enable comparative performance against similar Trusts.

Trust Annual Report Sustainability section: This reports progress against the Green Plan and provides highlights of the main activities delivered throughout the year.

ERIC (Estates Return Information Collection): A mandatory data collection for all NHS Trusts required by the Department of Health.

Progress reports: Internal progress reports are produced for the quarterly Finance and Performance Committee which feeds up from monthly Sustainability Steering Group meetings and sub group meetings for the 12 Activity Areas, each of which will track progress against their individual action plans and report on a suite of key performance indicators. The detailed action plan with SMART objectives will continue to be developed. A resource plan will be maintained demonstrating where staff time, finance and other resources are required together with savings and actions planned and achieved.

Related Internal Policies: Our Green Plan is to be supported by various related policies and guidance documents including the: Green Travel Plan, Waste Management Policy, Biodiversity and Greenspace Policy, Sustainable Procurement Policy, Climate Change and Adaptation Plan, Sustainable Construction Policy, Decarbonisation Strategy, Equality and Diversity Policy.

Join us on our journey

What can you do to help?

- Visit the GreenUHD pages
- Share your ideas in the GreenUHD online forum
- Get advice and support email: **greenuhd@uhd.nhs.uk**
- Join the Dorset NHS EcoEarn Community

You can contribute within your own role every day.
No matter what your role is at the Trust or as a partner there will be something for you!

GUHD

Annex A: Live links to Drivers: Legislative, Economic, Technological, Political, Environmental, Social, NHS Long term plan, UN goals

Economics of Climate Change - Stern Review 2006	Government Buying Standards	Health Equity in England: Marmot Review 10 Years On	NHS Standard Contract 2022/23	EU Directive on Public Procurement	HPS Health Effects of Climate Change 2012
Health Co - benefits Evidence	National Adaptation Programme (2018-2023)	Defra Economics of Climate Resilience Report 2013	Principle 6 - NHS Constitution	HM Treasury Sustainability Reporting Framework 2020/2021	Civil Contingencies Act (2004)
Public Health Outcome Framework	Inter-governmental Panel on Climate Change AR5 2013/2014	Climate Change Risk Assessment 2017Defra Economics of Climate Resilience Report 2013	Health Sector Report on Adaptation 2015	Climate Change Act 2008	PHE Cycling and Walking for Individual and Population Health Benefits
WHO Europe - Social Determinants and the Health Divide	Taking Account of Social Value PPN 06/20	Delivering a 'Net Zero' Health Service	Health and Care Act 2022	NHS Marginal Abatement Cost Curves	Health 2020 WHO
MET UK Climate Projections (UKCP)	The Living Planet Report 2022	National Policy and Planning Framework	UN Emissions Gap Report 2022	Lancet Countdown Report 2022	

Click the box to explore each link

Annex B: What the UN Sustainable Development Goals mean to University Hospitals Dorset

Goals	Contributions
 **No Poverty** End Poverty in all its forms everywhere.	We helped to set-up Poole Africa Link in 2009 and continue to be actively involved with the charity. Our staff helped to train doctors, nurses and midwives in both Sudan and Uganda. The Trust also provides a range of retired equipment for the charity. The Trust helps to promote awareness about Healthy Homes Dorset – for free energy advice and home insulation. We will seek to embed this fuel poverty project within the hospital discharge processes to refer suitable patients for home energy efficiency measures. This should help with patient recovery, reduce re-admissions, and provides environmental benefits. The Trust has also helped to marry up the priority services register to the Healthy Homes Dorset scheme so that some of the most vulnerable in our community are given priority support if power is lost in their homes.
 **Zero Hunger** End hunger, achieve food security and improve nutrition and promote sustainable agriculture.	We take the nutritional value, environmental and ethical standards of the food we serve very seriously. During 2021 all of our hospitals are set to be certified Silver - Food for Life by the Soil Association. The Trust also only serves sustainably sourced fish and is accredited under Sustainable Fish Cities. The Trust's Nutrition and Dietetics team provide a wealth of healthy eating guidance to aid general understanding and to ensure that we best meet the nutritional needs of our patients.
 **Good Health and Well-being** Ensure healthy lives and promote well-being for all ages.	Maintaining and improving the health and wellbeing of colleagues is of paramount importance and central to our Trust values. Our Workplace Wellbeing Team coordinates numerous initiatives, including psychological support. We encourage staff to use active modes of travel to work and support them with initiatives such as free bike maintenance services.
 **Quality Education** Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all.	As a University Hospital Trust we support innovation and education. Central to our vision is to be a great place to work and learning and development help the Trust underpin this. We provide professional support to apprentices and medical students as well as providing a range of clinical, leadership and management training. Our strong focus on staff development covers areas such as mentorships, apprenticeships, quality improvement projects and essential staff training.

Annex B: What the UN Sustainable Development Goals mean to University Hospitals Dorset

2/4

Goals	Contributions
Gender Equality Achieve gender equality and empower all women and girls.	The Trust publishes reports each year to provide information on performance against its equality objectives, statutes and national standards. This includes a gender pay gap report, workforce equality reports and action plans. We have an equality, diversity and inclusion group (EDIG) who have approved a new 3 year diversity and inclusion strategy which was ratified by the Board in March 2021. A programme plan is in place to monitor the progress of five priorities that have been identified within the strategy by EDIG.
Clean Water and Sanitation Ensure availability and sustainable management of water and sanitation for all.	The Trust, in partnership with ADSM, supports the Water Aid scheme which has helped transform lives in rural Mozambique by bringing fresh water to over 49 thousand people. The Trust has a Water Safety Policy and Plan, managed by a Water Quality Group. Collectively, they manage and control the risk of water-borne pathogens within the Trust. Monitoring is in place for temperature and turnover of all tanks and hot water vessels. A programme is in place to replace oversized pipework and improve our usage.
Affordable and Clean Energy Ensure access to affordable, reliable sustainable energy for all.	The Trust has implemented a portfolio of sustainable energy projects. Royal Bournemouth Hospital generates approximately 22% of its energy requirements on-site through Solar PV installations and the heat generated as a by-product from clinical waste incineration. Poole Hospital generates approximately half of its electrical energy requirements with an on-site combined heat and power plant and is also set to install a large roof top solar PV array. Major lighting replacement projects have now installed LED lighting in large areas of the Trust. Our grid supplied energy is soon to become 100% REGO certified renewable.
Decent Work and Economic Growth Promote sustained, inclusive economic growth, full productive employment and decent work for all.	The Trust contributes to routes to employment and improved work opportunities by providing apprenticeships and work placements and will be expanding opportunities for students for Bournemouth University students in particular to compliment their studies with opportunities for project work, dissertations and placements with the Trust. The Trust is a Disability Confident employer and all employees wages meet or exceed the Living Wage. We support small and medium sized suppliers through our procurement processes.

Annex B: What the UN Sustainable Development Goals mean to University Hospitals Dorset

3/4

Goals	Contributions
 **Industry, Innovation and Infrastructure** Build resilient infrastructure, promote inclusive and sustainable industrialisation and foster innovation.	The Trust is embarking on several large capital projects. All new buildings will meet BREEAM Excellent and all major refurbishments will meet BREEAM Very Good. Innovation is supported at the Trust by our Transformation Team and their Quality Improvement programmes. Poole Hospital has installed a dispensing robot to eliminate patient medication errors. The trust has also opened a state of the art linear accelerator for radiotherapy in the Robert White Centre. Our care pathways are being transformed by digitalisation projects which is bringing benefits to our patients, our operations and reducing negative environmental impacts from our services.
 **Reduced Inequalities** Reduce inequality within and among countries.	The Trust has an Equality, Diversity and Human Rights Policy and is committed to developing and enhancing a diverse and inclusive culture. Equality, Diversity and Human Rights training is included in staff training. We are proud to have a diverse community and support active BAME, LBGT Q+ and Pro ability networks.
 **Sustainable Cities and Communities** Make cities and human settlements inclusive, safe, resilient and sustainable.	The Trust has a Board-approved Sustainable Development Strategy and we are developing a revised Sustainable Procurement Policy plus Sustainability Impact Assessment process for large projects.
 **Responsible Consumption and Production** Achieve gender equality and empower Promote peaceful and inclusive societies, access to justice and build effective, accountable and inclusive institutions.	The Trust has demonstrated strong governance with transparent reporting on organisational performance. We have a team of Freedom to Speak Up Guardians who provide confidential support for any concerns about patient or staff wellbeing.

Annex B: What the UN Sustainable Development Goals mean to University Hospitals Dorset

Goals	Contributions
 **Climate Action** Ensure sustainable consumption and production patterns.	We are working to embed sustainability within our supply chain by considering the sustainability of our suppliers and the products and services that we purchase including evaluations of carbon and whole life cycle costs where viable. We will seek to work in partnership with the wider NHS network and local partners to meet this challenge.
 **Life Below Water** Conserve and sustainably use the oceans, seas and marine resources for sustainable development.	The Trust recognises the risk to water courses from irresponsible handling of materials and works hard to embed tight controls to ensure that no pharmaceuticals or other unsuitable chemicals enter the waste water system. The Trust is committed to reducing unnecessary consumption of single use plastics.
 **Life on Land** Protect, restore and promote sustainable use of terrestrial ecosystems, reverse degradation and halt biodiversity loss.	The Trust is committed to improving biodiversity on our sites and ensuring that our staff, patients and visitors are able to receive valuable contributions to their health and wellbeing from contact with nature. We have protected and restored areas of greenspace and we commit to doing the work required to maintain a Green Flag status for our Bournemouth site.
 **Peace, Justice and Strong Institutions** Strengthen the means of implementation and revitalise the Global Partnership for Sustainable Development.	We are working in partnership with Our Dorset Integrated Care System, Bournemouth University, BCP Council, the Dorset LEP and other local healthcare providers. Our work with other anchor institutions is to ensure we are active corporate citizens in sustainable development.
 **Partnerships for the Goals** Take urgent action to combat climate change and its impacts.	Our climate change mitigation efforts have resulted in Trust carbon footprint reductions exceeding the NHS target of a 34% reduction over 1990 levels by 2020. We will now double down on efforts in order to meet the New NHS targets of Core Carbon Footprint – Net Zero by 2040 and Carbon Footprint PLUS by 2045. The Trust will capture climate change on the Trust risk register and track progress on adaptation measures through its Climate Change Adaptation Action Plan.

Green UHD Plan

NHS
University Hospitals Dorset
NHS Foundation Trust

2021-2026
Sustainable Development Strategy

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS – PART 1 MEETING

Meeting Date: 06 March 2024

Agenda item: 6.8

Subject:	Risk Register Report
Prepared by:	Natasha Sage, Head of Patient Safety and Risk Jo Sims, Associate Director for Quality Governance and Risk
Presented by:	Paula Shobbrook, Chief Nursing Officer and Deputy Chief Executive

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:	Information
Executive Summary:	

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

Risk no:	Title	Exec Lead
1872	Patient Flow: Risk to patient safety, statutory/performance compliance & reputation - downstream capacity/front door crowding	COO
1460	Ability to meet UEC National Standards and related impact on patient safety, statutory compliance and reputation.	COO
1950	Graphnet Electronic Patient Record (EPR) is not fit for purpose	CFO

Background:	The risk register report is provided in accordance with the UHD Risk Management Strategy. This strategy is currently under review, following discussions at the Audit Committee on 18 January, a Board development seminar on 7 February and discussions with the ICB.

	This summary provides details of the number of the current risks rated 12+ on the UHD NHS Foundation Trust risk register, which are aligned to and reviewed at the Board committees. 3 risks have been reduced and 2 closed this month. There are no new risks for Board review and approval this month.
Key Recommendations:	For information.
Implications associated with this item:	Council of Governors ☐ Equality and Diversity ☒ Financial ☒ Operational Performance ☒ People (inc Staff, Patients) ☒ Public Consultation ☒ Quality ☒ Regulatory ☒ Strategy/Transformation ☒ System ☒
CQC Reference:	Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well Led ☒ Use of Resources ☒

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
TMG	20/2/2024	
Quality Committee	27/2/2024	Noted.

University Hospitals Dorset
NHS Foundation Trust

Risk Register Report

The Board of Directors will review the Trust's significant risks at each meeting.

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

For the period to end January 2024 (as on 01/02/2024)

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	41
Potential new risks for Approval	0
12+ Risks that have changed score	0
Reduced, closed or suspended risk(s) no longer 12+ to note	5

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

Summary

1. **There are 216 approved risks on UHDs Risk register, of which 41 are rated as 12 and above**
2. **No new risks rated as 12 and above to be reviewed**
3. **There are 5 risks closed, reduced or suspended in month that were previously rated at 12 and above**

Ref	Risk rating	Description	Update	Exec Lead	Date risk accepted as a 12+ risk	Last review date	Risk Trend
1074	16.	There is a risk that there will be: patient harm from delayed pathways; increased NHSE or ICB regulatory oversight; and additional premium expenditure requirements if the RTT related targets are not met, namely: 1) Elimination of greater than 78 week waits by March 2023 and 65 week waits by March 2024 2) Total waiting list delivers to agreed operational plan trajectory for 2023/24 3) RTT standard is 92% (national NHS constitution target) and should be delivered where possible	The Trust is consistently achieving the target to reduce the total (RTT) waiting list – 68,967 at the end of December 2023. 7,240 below the operational planning trajectory (76,398) and an in-month reduction of 191 (5% reduction since March 2023). RTT performance 59.80% and remains above the Southwest Regional average however below the national standard. Reduction in >78-week waits delivered at the end of December 2023; 57 compared to 59 in November but the planned trajectory (37) was missed due to industrial action impacts. 65-week waits: Performance against this metric is not changing significantly. A revised H2 2023/24 trajectory has been submitted to achieve <553 65ww by March 2024. The Trust is 43 above plan at the end of December 2023. The cohort of patients at risk of breaching 65 weeks is down by 91% since 31 March 2023.	COO	05/05/2015	31/01/2024	Risk reduced from 16 to 9 ↓
1977	15	It is likely that commissioned, Dorset Non-emergency Patient, Transport, resources will be insufficient to meet the increased demand, that occurs during the winter pressures period. This is likely to impact patient flow, when the trust is experiencing operational pressures and could result in: failed discharges, missed care packages, lost community beds, bed blocking both on wards and in emergency or assessment areas, poor patient experience, increased staff stress, longer waits on ED trolleys, requirement to open overflow wards, and ambulances stacking outside of ED.	As of 31.01.24 ICB have agreed to a block booking of third party resource up until 30.04.24 to support the Emed fleet. Details about the service change from 25.04.24 are yet to be shared and there is limited time to implement changes to transport booking across UHD. Once the incumbent provider's staff are aware of the contract end date there may be staffing loss and this could create additional capacity issues.	COO	03/01/2024	31/01/2024	Risk reduced from 15 to 8 ↓

1647	12	Medical and nursing handovers are not always effective and the lack of consistent, safe and effective handover processes poses a direct significant and frequent risk of harm to patients.	This risk was opened in 2021 and was transferred to me as owner in November 2023. It is currently phrased as encompassing all of medical and nursing handover. It also has an action plan concerning results handover. The risks here have evolved and can be better described. Here they are not specific enough. I would suggest that this risk is closed and that two more focused risks are opened. One will be concerning transfers from ED where some work has been done and presented to the ED team. A second is a risk concerning transfers between sites where there have been a number of incidents. The results acknowledgment piece is part of the EPR work. It was work led by Matt Thomas and subsumed as the plans for EPR have become clearer. Finally, nursing handover is not a thematic source of concern. We will seek the opinion of our senior nurse colleagues but suggest that any risk here is currently tolerated and not on the risk register.	CMO	01/02/2024	27/09/2024	Risk closed
1604	20	Risk of delay in securing UHD and wider Dorset New Hospital Programme (NHP) funds in sufficient time to enable the wider reconfiguration by 2024/26. Risk is delayed benefits by later than planned reconfiguration. Securing NHP enabling funds required in year to allow progression of key capital works	In discussion with Chief strategy and transformation Officer and operational lead, risk to be closed and incorporated into risk 1784 (BAF risk 9)	CSTO	01/02/2024	28/06/2021	Risk closed
1260	12	If the organisation is non compliant with regulatory standards (SFG20/HTM00) across fire, water, electricity, gases and air handling, there is a risk to patient and staff safety, financial and reputational implications and regulatory actions from regulatory bodies. If standards are not maintained there is an increased risk of untoward events/ and or failures of systems could lead to patient harm and loss of operational activity	Risk reduced from 12 to 9. Risk reviewed and updated. Compliance with regulatory standards is now significantly better. Risk remains around the increasing costs of estates maintenance and estates workforce	CSTO	31/01/2024	23/08/2021	Risk reducd from 12 to 9 

Risk updates

Risk Number	Title	Rating (current)	Last review date	Review for Board		Executive lead
Partnerships and Population Health						
1460	Ability to meet UEC 4-hour safety standard and related impact on patient safety, statutory compliance and reputation.	20	01/02/2023	Overall UEC action plan has been updated and standardised. A3 now being drafted.		Chief Operating Officer
1872	Patient Flow: Risk to patient safety, statutory/performance compliance & reputation - downstream capacity/front door crowding	20	08/01/2024	08/01/2024 Alex Lister] Ongoing challenges with occupancy and flow are resulting in high levels of escalation beds in use >90 (40 funded the remaining unfunded) week commencing 8th January, with increasing No Criteria to Reside. There has been a transient offset with the Derwent closed over Christmas and due to Industrial action, however this will re-open on the 9th January. Peaks of 50 patients across our emergency departments waiting for beds (Dec and Jan). This presents a clear risk of harm to patients and impacts on the Emergency Departments ability to safely function - Adult bed occupancy has been consistently over 1000 - approaching 1100 at times (excluding patients in ED) This risk now encompasses risk 1387 and risk 1131 (to be closed as soon as this risk is accepted) and amalgamates control measures and the relevant action plans. Improvements in UHD data capture demonstrated an improvement in reported NCtR from a mean of 255 in July 2023 to <209 in September, however for November this has increased to a mean of 235. December was a month of significant variation with reductions in occupancy and No Criteria to reside before Christmas, however the first week of January has seen NCtR peak at 271 at midnight on 6th Jan, with a 7 day average of 238.		Chief Operating Officer
1053	Lack of capacity for elective & non elective activity and associated risk to patient harm due to LLOS and NCTR patients	16	08/01/2024	Improvements in UHD data capture demonstrated an improvement in reported NCtR from a mean of 255 in July 2023 to <209 in September, however for November this has increased to a mean of 235. December was a month of significant variation with reductions in occupancy and No Criteria to reside before Christmas, however the first week of January has seen NCtR peak at 271 at midnight on 6th Jan, with a 7 day average of 238. UHD remains one of the most challenged organisations in the SW with >21% of beds occupied by NCtR consistently		Chief Operating Officer

				Improvement Actions: Executive conversations are ongoing between partners to address the ongoing NCtR position in Dorset. Internally actions are in place to optimise discharges and continue to work with partners at an operational/tactical level to ensure opportunities maximised – Long Length of Stay meetings to a ensure consistency and value-added approach continues with all patients over 21 days, with weekly meetings to review all patients >100 days (many of whom require complex care packages or providers) and those that the discharge teams are unable to progress.		
1429	Ambulance handover delays - risk to patient harm, performance and organisational reputation	15	08/01/2024	Revised escalation Process in place to reflect SW requirements		Chief Operating Officer
1502	Mental Health Care in a Physical Health environment	15	01/02/2024	MH scoping exercise ongoing in terms of how best to operate. Meeting to discuss MH and the governance along with the planning of objectives. Study days are underway, and collaboration meetings with the Police and Front door are established.		Chief Nursing Officer
1697	Increased waiting list for SACT treatment/ Capacity on Day units	15	17/01/2024	Ongoing increase in referrals, this has increased waits for new patients to 5 weeks and 3 days. Meeting with Pharmacy to discuss challenges.		Chief Medical Officer
1665	School age Neurodevelopmental service	15	12/01/2024	Risk remains - a/w response from ICB regarding timelines for All Age ND review programme Mid -Jan. Some new LERNS to link to risk assessment.		Chief Medical Officer
1863	Impact of Industrial Action on provision of services	12	08/01/2024	Industrial action by the BMA in relation to Doctors in Training has impacted elective activity in December and January. Full and robust planning is in place to mitigate risk and maintain elective capacity where possible, focusing on P2 and Cancer activity, however IA during expected busy periods along with high seasonal leave remains a risk.		Chief Operating Officer
1292	Outpatient Follow-Up appointment Backlog - Insufficient capacity to book within due dates	12	01/02/2024	Agreed that the risk should remain open and under the monitoring responsibility of outpatients until such time that robust systems are implemented to prevent additional unnecessary follow up demand, at which point the risks will be devolved to the Care Groups if there is a remaining risk. Ongoing work: - Further focused efforts are required to improve PIFU rates in specialties where rates are <5%. Plan for 'Focus On...' events to include PIFU.		Chief Operating Officer

				- Implementation of e outcomes is imminent (awaiting final testing with IT development team, BI team and then clinical testing). Likely full roll out in April 2024 - Ongoing validation of FU waiting list through the access team with quick question to patients waiting 12-24 weeks		
1386	National Cancer Waiting Times Standards	12	30/01/2024	Positive recovery progress made in January. Both operational planning trajectories for FDS and 62D backlog expected to be met. Significant turnaround in dermatology, supporting the overall position. Focus required on Colorectal in the next reporting period.		Chief Operating Officer
1393	Endoscopy capacity & Demand	12	01/12/2023	Risk rating remains at 12. DM01 performance continues to approve - 93% for November. 18 Weeks have provided some complex capacity with GA lists to support access for patients with longest waits. CDC plans including recruitment continue. In Health mobile unit due to be off site by end of March 2024. However, the Service currently remains reliant on high cost options to provide required capacity. This is likely to be the case until the modular build is complete and fully operational.		Chief Operating Officer
1840	OPS Outlying patients	12	26/01/2024	Outliers meeting on 26/1/2024 mostly concentrated on the creation of a list for future working rather than current acute issues. Ward 8 has opened urgently in December 2023 with no funding which was planned to bring OPS back within bed base. We continue to have 40-60 outliers on Bournemouth site and also 20 on Poole site with Lilliput still open.		Chief Medical Officer
People						
1397	Provision of 24/7 Haematology/ Transfusion Laboratory Service	15	25/01/2024	3rd Locum scheduled to start but had another substantial role offered and has now left. Another resignation received Current vacancies: 2 x B6, 1 x B5. Interviewed and offered a B6 position 24/01/24. Potential internal candidate for 2nd B6 position but needs agreeing with TRAC along with the B5 position. Training has suspended for B7 to go onto OOH due to hub move. Currently OOH rota is at 1 in 5 for RBH and 1 in 8.6 for Poole.		Chief Nursing Officer
1483	Pharmacy vacancies are affecting patient care	16	18/01/2024	Staff vacancies and turnover tracked through Care Group reviews. 4 junior pharmacist joining in August, out with recruitment for another 10 junior pharmacists.		Chief Medical Officer
1202	Medical Staffing Women's Health	15	31/01/2024	Risk updated with Interim Associate Director present-grading to remain the same. Maternal Medicine substantive post is out to advert. 1x successful substantive Obs & Gynae Consultant post has been recruited into from a locum post. At present there are 1.7wte gaps in Consultant posts and 1 long term sick Cons post (new gap). SBARN was submitted and successfully approved for locum cover for this sickness- CVs are being reviewed today and UHD are optimistic to successfully fill this gap. Following the recent workforce review, it was identified that there are Consultants above the recommended age limit for working on calls overnight. This is having a further impact on the service.		Chief Medical Officer
1395	Lack of Capacity in Cellular Pathology	15	17/01/2024	In addition to the capacity shortfall, there are 8 members of staff on long term sickness (both scientific and support staff)		Chief Medical Officer

	Causing a Delay in Processing and Reporting.			The department is preparing another summary paper for presentation at the Financial Planning Group (25th January 2024).		
1811	Staff Vacancies and Skill mix deficit - Theatres	15	17/01/2024	No change to risk, recruitment plan continuing bank and agency staff required to support establishment		Chief People Officer
1221	Medical Staffing Shortages - Medicine and Older Persons Medicine	12	26/01/2024	Further increase in bedbase with ward 8 and lilliput remaining open with no funding for Consultant time. Increase in outliers of over 40 on RBH site and 20 on Poole site. We have already reduced consultant cover on downstream wards and now stretching our front door staff to cover outliers. Unable to supervise all trainees as well.		Chief Medical Officer
1283	Radiotherapy staffing and service demands	12	04/01/2024	Request to over recruit declined. Current vacancy out to advert. Using international recruitment to fill vacancies		Chief Nursing Officer
1303	Therapy Staffing	12	31/01/2024	No changes to risk rating at current time, Unfunded winter pressure and additional escalation beds are placing additional demand and pressure on IP teams. Winter funding has not been realised by the trust, therefore teams are reviewing patients against prioritisation guidance. Further meeting to review Poole OPS position planned for 2/2 to review action plan to mitigate risk.		Chief Nursing Officer
1492	Resourcing Pressures - Staffing	12	29/01/2024	Continuing challenges in recruiting to roles across the trust due to both skills shortages for clinical roles and competitive market for non-clinical posts. Nursing vacancy rates remain low as a result of successful international recruitment over the year and, with the significant amount of focus on HCSW recruitment, it is expected the current vacancy rate will be reduced by 25% as of end March 24. There has been agreement to over-recruiting for medical posts in some areas of the trust. Temporary staffing are focusing on conversion of bank workers to substantive posts. "Talk n Jobs" trial continues in the recruitment of HCSWs, with plans to use for other volume recruitment roles in the near future. The vacancy approval process has been reviewed and further controls included to provide additional assurance around recruitment spend in light of financial pressures across the Dorset system. [TGP]		Chief People Officer
1493	Absence, Burnout and PTSD	12	29/01/2024	Sickness data for December shows primary reason for absence remains stress/anxiety and depression though there is a small reduction since November. The number of staff accessing the Psychological Support and Counselling Service remains consistent at 12 new referrals per week. High stress and poor sleep remain the most common presenting issues followed by Depressive disorder. Thematic data suggests an increase in non-work related stressors such as finances and relationship difficulties presenting for support. Risk should remain at the same level.		Chief People Officer
1498	Patient Safety due to inadequate Medical Registrar Out of Hours Cover (RBH)	12	05/12/2023	Recruitment is ongoing and there are still gaps in the rotas. The risk remains and cannot be reduced currently, due to the number of gaps. This will be reviewed as recruitment continues. The action plan is completed with the exception of filled recruitment.		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.		Chief Medical Officer
1758	Chemotherapy production in pharmacy now at capacity and limiting patients accessing treatment	12	18/12/2024	Care Group discussion is needed to extend locum support further. Piloting moving to Poole APU and then evaluate capacity again during the pilot.		Chief Medical Officer
1771	Radiology Service Demands/ Radiologist staffing	12	26/01/2024	December outsourcing: Hexarad cold - 730, Hexarad Hot - 27, Hexarad OOH - 975. This equates to 17.08% of out-patient studies and 20.86% of inpatient and A+E work.		Chief Medical Officer
1876	Inability to provide Medical cover for Maternity Triage service out of hours	12	25/0/2024	Updated in the presence of the Associate Director for Women's and Children's health. Risk to remain the same. New 2 tier rota to commence on 12/2/24. Overall vacancies on the jr Dr rota are as following: 2 middle grades and 1 SHO. An advert is out for a middle grade. The SHO post has been filled and will join the rota on 1/4/24. Aim is to have full staffing accomplishment by end of April.		Chief Medical Officer
1690	Interventional Radiology Nurse Staffing	12	01/02/2024	Reviewed at Radiology Q+R meeting. 3 vacancies advertised 1 candidate suitable for interview. Service is being supported by bank staff. 2 rooms now running lists most days.		Chief Nursing Officer
1933	Medical Workforce ED	12	01/02/2023	Controls in place added. Recruitment in progress for both sites -All reviewed for agency posts and continue to review CVs -Recruited to 75% of RCEM ACP posts with plan to recruit further 25% in early 2024 -As risk remains, consideration will be given if recruitment not possible to recruit further ACP posts or consultants -Weekly and daily oversight of actions until situation eases -Clear trajectory of gaps and mitigation in the next 3 months to be included in a workforce plan, to be drafted by CD with support from senior leadership team		Chief Medical Officer
Quality (Safety and Outcomes)						
1214	Risk of misdiagnosis/ incorrect treatment from use of ungoverned Point of Care devices.	16	29/01/2024	December 2023 Glucose and Ketone meters External Quality Assurance had non-compliance of greater than 85% of meters in the trust.		Chief Medical Officer
1276	Unsafe and delayed patient care due to delays in surgery for # Neck of Femur patients	15	31/01/2024	Improved performance (>50%) No change to risk, action plan updated risk to be reviewed with care group as 4 months sustained improvement.		Chief Operating Officer
1378	Lack of Electronic results	15	22/01/2024	ICE Upgrade ordered and project will commence in January 2024 - this is a 12 month project. Issues will endeavour to be addressed as part of that project.		Chief Finance Officer

	acknowledgement system			Also the CCIO is working with Informatics to see what options exist around closed loop reporting and a better process to resolve this.		
Sustainable Services						
1950	Graphnet Electronic Patient Record (EPR) is not fit for purpose	20	31/01/2024	Discussed at TMG, risk rating to be updated. Report submitted to TMG providing detail on options and ICB plan		Chief Finance Officer
1784	Risk of not integrating teams and services and then reconfiguring to create the planned and emergency hospitals	16	31/01/2024	Risk has been updated to incorporate risk 1604 and better align to the BAF. 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. Maternity Big Room event scheduled for 19th Feb as one of the first services to move to test out moves issues and go/no processes. 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		Chief Strategy and Transformation Officer
1595	Medium Term Financial Sustainability	16	31/01/2024	The Risk was reviewed by FPC as part the financial report, no changes were noted.		Chief Finance Officer
1881	Financial control total 2023/24	16	31/01/2024	The Risk was reviewed by FPC as part the financial report, no changes were noted.		Chief Finance Officer
1416	GIRFT and Model Hospital	16	11/12/2023	Reviewed, no change		Chief Finance Officer
1355	Lack of integration between the Electronic Referral System (eRS) & Electronic Patient Record (ePR)	15	22/01/2024	Informatics are awaiting a decision on whether the Trust will move forward with Consultant Connect for all ERS bookings / ASIs / A&G as this will be a different project if that is the case. A&G for Dermatology is being taken forward only at this time while pending that decision.		Chief Medical Officer
1594	Capital Programme Affordability (CDEL)	12	31/01/2024	The Risk was reviewed by FPC as part the financial report, no changes were noted.		Chief Finance Officer
1409	Radiotherapy Ventilation/Capacity & Demand	12	31/01/2024	Contractors have been appointed. But new building safety regs have been introduced and a report submitted. Report still to be written and turnaround time by regulators unknown.		Chief Strategy and Transformation Officer
1924	Risk of not successfully and sustainably adopting the patient first	12	25/01/2024	Programme team established to include current QI and OD resource and skillset. Significant work to establish the programme, refresh of strategy – development of strategic themes including analysis of current state plus alignment of current work programmes.		Director of Improvement and OD

	approach across UHD			Executive & Programme Leads assigned to key programme pillars. UHD senior leadership team workshops (circa 40 staff) trained in A3 strategic problem solving. Positive feedback from first phase of Patient First for Leaders Training, now delivering final module 4, module 5-8 scheduled for Q4 for first cohort (150+ leaders). 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. Culture champions trained and undertaking appreciative enquiry activity with senior leaders and departmental teams. 2023 NHS staff survey record completion rate at 59%. Catchball#1 for all care groups now completed (Dec'23) with scorecard development in progress ahead of Catchball#2 (Feb '24)		

1. Risk Heat Map- UHD

Current Risk Grading		Likelihood				
		No Harm (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Severity	Almost Certain (5)	3	13	11	4	
	Likely (4)	4	30	13	7	
	Possible (3)	3	33	40	8	1
	Unlikely (2)		11	22	7	3
	Rare (1)		2	2	1	1

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

Current Risk Score– UHD total	Feb 23	March 23	April 23	May 23	Jun 23	Jul 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24
Very Low (1-3)	2	4	5	5	4	5	3	3	3	5	8	6
Low (4-6)	71	70	67	63	63	72	76	80	74	74	72	**78**
Moderate (8-10)	82	75	73	78	78	82	86	86	84	91	89	**91**
Moderate (12)	19	19	18	20	21	22	21	19	19	21	21	**20**
High (15 -25)	25	24	21	24	21	20	22	23	23	23	23	**21**
Total number of risks under review	199	192	184	190	187	201	208	211	203	214	213	**216**

2. 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	41	38	93%	↑16%
8 to11	91	84	92%	↑10%
4 to 7	78	74	95%	↓1%
1 to 3	6	6	100%	⟺
Total	**216**	**202**	**94%**	↑ **3%**

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

Meeting Date: 06 March 2024

Agenda item: 7.1

Subject:	Patient First Highlight Report
Prepared by:	Deborah Matthews, Director of Organisational Development
Presented by:	Professor Paula Shobrook, Chief Nursing Officer and Deputy Chief Executive

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)	BAF8
Purpose of paper:	Information
Executive Summary:	Patient First Steering Group was held on 12 February 2024. The highlight report shares progress from each of 4 pillars and communications for the Patient First Programme against programme plan. This also outlines the relevant risks and issues. Progress is being made in all areas and the overall risk score to delivery of the programme remains 12. As we move through the winter months, pressure to release staff invited to attend Patient First for leaders or Patient First Improvement System training and complete associated tasks remains a challenge, due to the operational pressures and prioritization of patient safety.
Background:	Programme plan with detailed gantt charts are reviewed monthly at the Patient First Steering Group with ongoing monthly assurance via TMG. The updates to Board will escalate any additional risks, or alerts.
Key Recommendations:	Note progress, with no areas to escalate.
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**
Patient First Steering Group	12/02/2024	Discussed & agreed no escalation – note operational impact going forward

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	☐

Patient First Highlight Report

University Hospitals Dorset NHS Foundation Trust

Pillar: Building Capability & Capacity					
Pillar Lead:	Bridie Moore	**Pillar SRO:**	Deborah Matthews	**Reporting period: Feb** 2024	**Workstream Status:** GREEN

Overall Workstream Status Update

Progress since last period

Patient First for Leaders training continues with 150 senior leaders completing Modules 5 & 6.
UHD Leadership Behaviours framework and Leadership compact produced and shared with Execs.
1 page summary report produced by Culture Champions on People themed "Big Conversation" focused on "People" theme. Training for "Patient Experience" theme began.
Received IQVIA Management summary and full reports with the Staff Survey 2023 results – still under embargo. January People Pulse closed with 1128 responses.

Key Milestones	Target Date	Status (B/R/A/G)	Estimated date of completion	Planned actions next period
Culture Champions to undertake appreciative enquiry with staff to inform Patient First	31 Sep '24	G	Sept '24	Jan/Feb focus is "Patient experience"
Hold ongoing staff conversations/ engagement activity	1 Apr '24	G	1 Apr '24	Deliver "Let's have a conversation" events (Feb & Mar)
Execs to complete *personal A3* to support adoption of Patient First approach	29 Dec '23	G	31 Mar '24	Workshop in diary in February
CI team to deliver *Patient First for Leaders Training* for 200 SLT & direct reports	29 Dec '23	G	31 March '24	Amend content of Module 7 & 8 and deliver module 7.
Develop a revised *leadership and behaviours framework* aligned to *Patient First Behaviours*	31 Aug '23	A	31 Mar '24	Finalise amendments and publish. Create roll out plan.
Staff survey 2023 IQVIA management report disseminated to Execs	31 Jan'24	G	31 Jan '24	Circulate Directorate & Team reports to Care Group Leads to align with their SDRs

Risks and Issues

Risk: Capacity issues impact ability of senior leaders to attend Patient First for Leaders training and fully support roll out of Patient First *(RPF006)*
Issue: Financial restraints within trust budgets further limiting use of external venues for training leading to reconsideration of planned PFfL training in Q4 *(RPF003)*

Patient First Highlight Report

University Hospitals Dorset NHS Foundation Trust

Pillar: Patient First Improvement System (PFIS)					
Pillar Lead	Jane Ward	**Pillar SRO:**		**Reporting period:** Feb 2024	**Workstream Status:** AMBER

Overall Workstream Status Update

Progress since last period
PFIS training delivery wave 1 on track, **improvement huddles starting in units.**
Planning for wave 2 PFIS underway.
Evaluation baseline survey data from wave one cohort shared and results used to inform programme development. Survey 2 template agreed.

Key Milestones	Target date	Status (B/R/A/G)	Estimated date of completion	Planned actions next period
CI team to deliver wave 1 PFIS – 8 full day modules over 16 weeks (plus observations)	29 Feb '24	A	27 Mar '24	Deliver formal training programme Dec '23 – Mar '24 – Wave I launched 6th Dec successfully.
Evaluate learning from first wave and make any necessary changes to PFIS	29 Feb '24	A	30 Apr '24	Continue to deliver surveys & workshops developed in association with BU Business School – 2nd survey due 21.02.24.
Agree further roll out of PFIS - Wave 2	29 Dec '23	B	30 Jan '24	ED, Paeds & Maternity dates set & venue booked at YMCA Stourvale (all 8 modules).
Identification of Wave 2 delegates.	31 Jan '23	A	15 Feb '24	Wave 2 units confirmed to date are Medical SDEC, AMU for ED. Units within Paeds & Maternity awaiting final identification from Care Group Lead.

Risks and Issues

Risks – Lack of ability to release staff for Patient First training leading to reduced skills transfer / lower value for money *(RPF011)*

Patient First

University Hospitals Dorset NHS Foundation Trust

Pillar: Continuous Improvement					
Pillar Lead:	**Ian Neville**	**Pillar SRO:**	**Pete Papworth CFO**	**Reporting period:** Feb 2024	**Workstream Status:** (RAG)

Overall Work Stream Status Update

Progress since last period:

CI Pillar focus moved to support of the 8 Corporate Projects in terms of Governance arrangements/documentation and Reporting.
Draft template for reporting corporate projects developed with S&T team.

Key Milestones	Target date	Status (B/R/A/G)	Estimated date of completion	Planned actions next period
Meetings Filter process complete	Revised to end Jan '24	R	tbc	??? Agree to waive? Or agree to review efficacy of each meeting as standing AoB?
X Matrix and *Project Charters* completion for Enabling Programmes and Breakthrough Objectives	Revised to end Feb '24	A	? End Feb '24	
PF Delivery Team member support per Corporate Project identified	End Jan '24	B		
Standard Governance arrangements and templates etc in place for Corporate Projects	1 Mar'24	G	1 Mar '24	Project Meetings, Plans, and Metrics established. Project Charters and A3s fully developed.
Corporate SDR reporting arrangements in place for Corporate Projects and Strategies *(see following draft template)*	1 Mar '24	G	1 Mar '24	Report template(s) finalised; Reporting schedule established.

Risks and Issues

No New Risks identified.

Issue: Meetings Filter task remains incomplete.

Patient First Highlight Report

University Hospitals Dorset NHS Foundation Trust

Pillar: Strategy Deployment and Review					
Pillar Lead	Dan Richter	**Pillar SRO:**	Richard Renaut	**Reporting period: Feb** 2024	**Workstream Status:** AMBER

Overall Workstream Status Update

Progress since last period

Scorecard development continued with BI team – draft ready for discussion Feb '24 PFSG.
Preparations for SDR continues - templates for corporate SDR developed (available in reading room).
Patient First methodology informing UHD annual plan.

Key Milestones	Target date	Status (B/R/A/G)	Est. date of completion	Planned actions next period
Build *score cards* for each strategic initiative	29 Dec '23	A	28 Feb '24	BI working on this; delayed due to BI capacity
Complete *Care Group Catch Ball* identifying how each Care Group will contribute to core business / strategic A3	30 Nov '23	A	28 Feb '24	Deliver second catchballs Feb 24
Establish *Strategy Deployment Reviews* at care group level	30 Oct '23	C	30 Nov '23	Agreed that Care Groups will transition to SDR from April 24
Check plan answers challenge demonstrated in *Readiness Assessment*	31 Aug '23	A	30 Mar '24	
Establish *Strategy Deployment Reviews* – corporate level	31 Mar '24	G	30 Mar '24	Planning for first corporate SDR due 5 March

Risks and Issues

Risks: Capacity of BI team *(RPF009)*
Issues: None at present beyond general delays

Patient First Highlight Report

University Hospitals Dorset NHS Foundation Trust

Communications					
Lead:	James Donald	**Reporting to**	Deborah Matthews	**Reporting period:** Feb 2024	**Workstream Status: GREEN**

Overall Workstream Status Update

Progress since last period

Next "Let's have a conversation" staff event advertised widely via *comms ebulletin* & *"The Brief"* (13.02.2024).
PFIS wave one teams journey shared with wider staff on Patient First page in February "The Brief" including pictures of their new transformation huddle boards on critical care unit.
Short video of staff highlighting PFIS implementation on the stroke unit developed and ready for dissemination via social media and staff channels once stroke huddle board in place (due Feb '24).

Key Milestones	Target date	Status (B/R/A/G)	Estimated date of completion	Planned actions next period
Staff engagement "Lets have a conversation" sessions with an Exec in place and advertised to staff	Apr '24	G	Apr '24	Deliver planned Q4 sessions as advertised
Support wave one PFIS teams to share learning within their teams and across UHD	July '24	G	July '24	Ongoing work to share PFIS journey with staff
Share benefits of Patient First journey with members via "Together"	Apr '24	G	Apr '24	Start to develop draft March 2024

Risks and Issues

Programme addresses known Risk (RPF005) – Lack of support from internal stakeholders within the organisation including poor clinical involvement and engagement

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 06 March 2024

Agenda item: 8.1

Subject:	Transforming Care Together – Terms of Reference (ToR)
Prepared by:	Catherine Hurst, Programme Manager
Presented by:	Mark Mould, Chief Operating Officer Richard Renaut, Chief Strategy and Transformation Officer

Strategic themes that this item supports/impacts:	Systems working and partnership ☒ Our people ☒ Patient experience ☐ Quality: outcomes and safety ☐ Sustainable services ☒ Patient First programme ☐ One Team: patient ready for reconfiguration ☒
BAF/Corporate Risk Register: (if applicable)	BAF Risk 9 - Risk of not integrating teams and services and then reconfiguring to create the planned and emergency hospitals Datix Risk ID 1784
Purpose of paper:	Decision/Approval
Executive Summary:	The purpose of the Transforming Care Together Group is to support the Trust in achieving its Patient First strategic themes. The key theme of "Sustainable Services" requires implementation of the Transforming Care Together Programme corporate project. This has two workstreams to ensure the transformation is "Build Ready" and "Service Ready." The **objective** of the Transforming Care Together Programme is to deliver safe, high quality and sustainable services by transforming care and establishing our Planned & Emergency Hospitals. This in turn unlock the benefits, as set out in the Clinical Services Review, and subsequent business cases. The specific responsibilities of the group can be found at section 2 of the ToR's attached at Appendix 1. The group will meet every 2 months and is a time limited sub-group of the Board, planning to run 2024-2026 in line with the vast bulk of service moves, and building works.

	The Group has no executive powers other than those specifically delegated in these terms of reference. The steering group is not an executive, decision making meeting, and not an operational oversight group. The membership of the group has been agreed with the representatives from Bournemouth, Christchurch and Poole (BCP) Council and DHC/DCH still be to be confirmed. The Transforming Care Together Group met on 26 February 2024 and the ToR's attached at Appendix 1 updated to reflect what was agreed at the meeting.
Background:	Based on the learning from other sites and the external reviews of the Programme, the Board agreed on 3 January 2024 to convene a Transforming Care Together Group constituted from Executive Directors, Non-Executive Directors and Chaired by a Non-Executive Director. Following discussion on the membership, the inaugural meeting took place on 26 February 2024 with the Chair of the Board chairing the meeting. Draft Terms of Reference (ToR) were also presented to and discussed at the inaugural meeting.
Key Recommendations:	The Trust Board is asked to **approve** the Transforming Care Together Terms of Reference (Version 0.4) attached at Appendix 1.
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
Transforming Care Together Group	26/02/2024	Terms of Reference presented and updates discussed at the inaugural meeting on 26/02/24

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 – Transforming Care Together – Terms of Reference (V2.2)

TERMS OF REFERENCE

for the

University Hospitals Dorset NHS Foundation Trust

Transforming Care Together Group

February 2024

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

DOCUMENT DETAILS

Author:	Alan Betts
Job Title:	Director of Integration
Signed:	
Date:	
Version No: (Author Allocated)	0.4
Next Review Date:	

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

Document History

Date of Issue	Version No:	Next Review Date:	Date Approved:	Director responsible for Change	Nature of Change
December 2023	0.1			Director Integration	New document
December 2023	0.2			Director Integration	Adopted trust format, added in content from Liverpool, amended for Service Ready Group feedback
December 2023	0.3			CSTO/COO	Feedback from NED discussion
26/02/2024	0.4			CSTO/COO	Version following TCT Inaugural meeting for Board Approval

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6. RELATIONSHIPS & REPORTING 10
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8. REVIEW 11

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

BOARD OF DIRECTORS/COMMITTEE APPROVAL			
If the Board/Committee has approved this document, please sign and date it and forward copies for inclusion on the Intranet.			
Name of approving body	Board of Directors	Date	6 March 2024
Print Name		Signature of Chair	

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

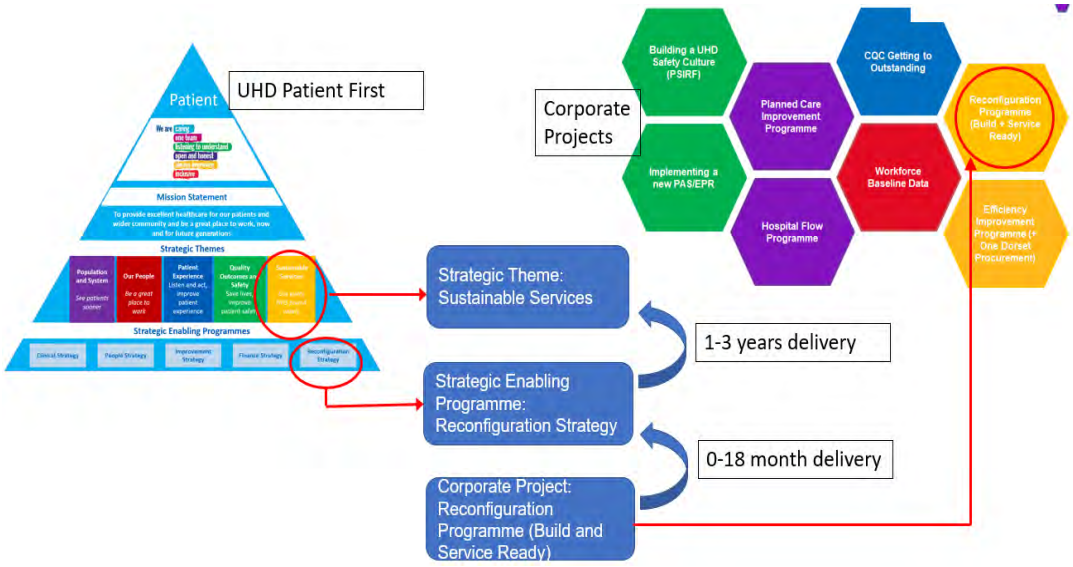
TRANSFORMING CARE TOGETHER GROUP

TERMS OF REFERENCE

1. PURPOSE

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

1.2 The purpose of the Transforming Care Together Group is to support the Trust in achieving its **Patient First strategic themes.** The key theme of "Sustainable Services" requires implementation of the Transforming Care Together Programme corporate project. This has two workstreams to ensure the transformation is "Build Ready" and "Service Ready." Explicit reference to the other 7 corporate projects will also be made, as they also mutually supportive of the Trust objectives, and progress against all the strategic themes. This is pictorially set out below:



1.3 The **objective** of the Transforming Care Together Programme is to deliver safe, high quality and sustainable services by transforming care and establishing our Planned & Emergency Hospitals. This in turn is to unlock the benefits, as set out in the Clinical Services Review, and subsequent business cases.

1.4 The Transforming Care Together Group will do this through:

a) Providing input and recommendations to the Trust's Board of Directors (Board) and/or relevant Board Committees for the delivery of the Service Ready and Build Ready programmes. The latter includes STP Wave 1 and New Hospitals Programmes. This will include work ahead of any Board Part 2 Gateway Reviews.

b) Assisting the Board in its oversight of the overall programme, and specifically achievement of the relevant breakthrough objectives and strategic initiatives relating to the Transformation elements of Sustainable Services.

c) Having oversight of the critical paths for both Service Ready and Build Ready workstreams
d) Having oversight of the strategic benefits and associated CIP's relating to the overall programme
e) Monitoring risks and mitigations relating to the programme
f) Co-ordinating the formal assurance held by Board Committees, (Finance and Performance, People and Culture, Quality and Audit)
g) To provide a forum for discussion and input into the programme, taking "go out and see" approach, in line with the Patient First methodology
h) To link frontline services and wider system partners into the transformation programme in a co-ordinated way

1.5 The Group is a time limited sub-group of the Board, planning to run 2024-2026 in line with the vast bulk of service moves, and building works. The Group has no executive powers other than those specifically delegated in these terms of reference. The steering group is not an executive, decision making meeting, and not an operational oversight group.

2. RESPONSIBILITIES

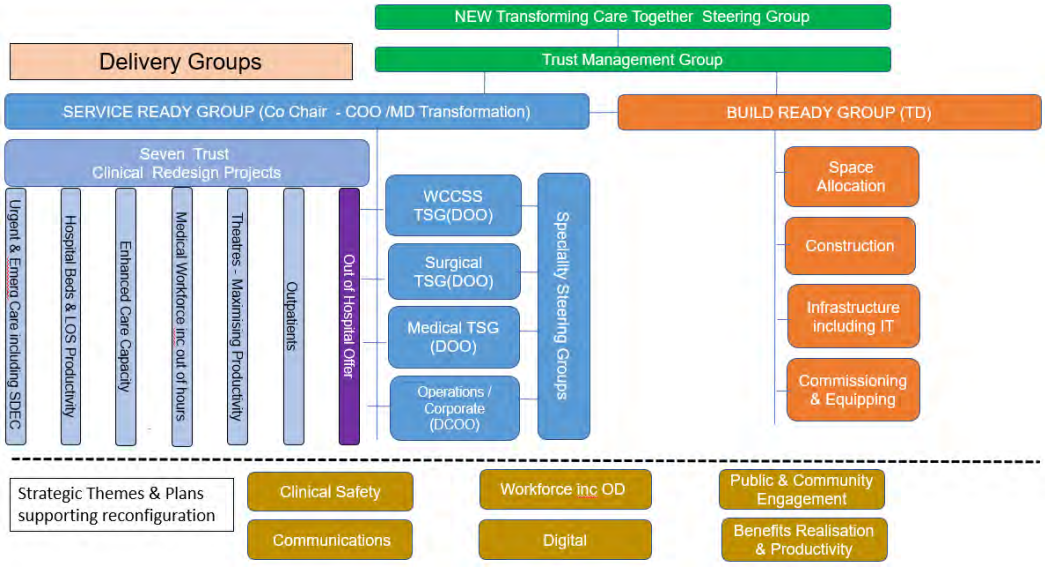
Strategies and delivery of the strategic agenda

2.1 To receive confirmation from the Board, on an annual basis, of the relevant breakthrough objectives, strategic initiatives and corporate projects within the remit of the Group, for which it is to be held to account.

2.2 To obtain assurance that the programme is being delivered effectively through monitoring progress, appropriate challenge and escalating to the Board, or relevant Board Committees when required.

Delivery of the Transforming Care Together Programme

2.3. Ensure the Service Ready and Build Ready programmes and associated groups and corporate workstreams are delivering activities on time and to expected quality to ensure the Transformation Programme delivers safe, high quality and sustainable services by transforming care and establishing our Planned & Emergency Hospitals. These are set out in the structure diagram below:



2.4 This includes for the service ready aspects:

- Assure the implementation of the future operating model, ensuring there is oversight of the wider project incorporating clinical redesign projects, service reviews and associated actions, integration activities and corporate transformation activities.

- Application of the principles of the Quality Strategy to ensure there is a single integrated approach to transformation that delivers safe, effective and caring services from day one and supports staff throughout the transition.

- Work with the Finance and Performance Committee to receive assurance that future clinical and administrative space is effectively utilised and that the estate delivers value for money.

- Meeting the Trust's requirements for effective communication and engagement regarding the Transforming Care Together Programme for staff, partners, patients, the wider public and their representatives, and regulators.

- Preparedness of the workforce for moves including organisational development, staff engagement, workforce capacity and capability, people processes and ways of working, and our statutory compliance the management of change.

- Working with ICB system groups to ensure the CSR is implemented safely and effectively.

- Any other duties as advised by the Board.

2.5. For the Build Ready aspects:

- The delivery of the construction programme, including compliance with the business case approval conditions and scheme of delegation set by the Department of Health.

- Co-ordination of the construction and handover process to minimise impact on the operational running of existing services.

Risk Management

2.3.3 To regularly review the Board Assurance Framework (including through in-depth review of specific risks) and to ensure that it reflects the assurances for which the Group has oversight, with risks highlighted being appropriately reflected on the risk registers. This shall include, but not be limited to the Group acting in accordance with Board approved risk appetite and risk tolerance levels when reviewing risks.

2.3.4 To be kept appraised of all new and current risks rated 15-25, clinical and non-clinical, identified on the risk register across the organisation and progress of action plans identified to mitigate these risks.

3. MEMBERSHIP/ ATTENDANCE

3.1 The Group shall be composed of the following members:

- Chair (who must be a Non-Executive Director)
- Chairs of Finance and Performance Committee, Quality Committee, People and Culture Committee, Population Health and System Committee and Audit Committee
- Chief Executive
- Chief Strategy and Transformation Officer
- Chief Operating Officer

3.2 In addition, the following will attend the Group to provide information and advice with prior agreement of the Group Chair and/or to present a report to the Group or a Chief Officer is unable to attend:

- Chief Finance Officer
- Chief Nursing Officer
- Chief People Officer
- Chief Medical Officer
- Member from NHS Dorset ICB [Chief Strategy and Transformation Officer]
- Member from Executive Team DHC/DCH [Rep TBD]
- Senior BCP representative [Rep TBD]
- Medical Director for Transformation
- Director of Integration
- Director for Transformation

3.3 The Group will be chaired by the Chair of the Board. A Non-Executive Deputy Chair should be nominated. In the absence of the Group Chair and/or any appointed Deputy, the remaining members shall elect one of the Non-Executive Directors present to chair the meeting.

3.4 Subject to paragraphs 3.2 above and 3.6 below, only members of the Group have the right to attend Group meetings. If a standing member is unable to attend, they may exceptionally send a deputy to the meeting, but the deputy will not have voting rights at the meeting.

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

3.6 Any member of the Board may attend any meeting of the Group with prior agreement of the Group Chair.

4. AUTHORITY

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

4.2 The Group is authorised to approve its governance cycle.

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

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

5. CONDUCT OF BUSINESS

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

5.2 The Group will normally meet bi-monthly and at such other times as the Group Chair shall require.

5.3 Meetings of the Group shall be quorate if there at least five members present, which will include the Chair (or a Non-Executive Director deputy), and two Executive Directors. For the avoidance of doubt, an Officer in attendance who has been formally appointed by the Board to act up for an Executive Director shall count towards the quorum.

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

5.5 Meetings of the Group shall be called by the Company Secretary at the request of the Chair.

5.6 The Company Secretary (or their nominee) is responsible for preparing the agenda for agreement by the Chair, with the Chair consulting with the Chief Strategy and Transformation Officer and the Chief Operating Officer, as considered appropriate. The Company Secretary (or their nominee) shall collate and circulate papers to Group members. Unless otherwise agreed by the Group Chair, papers should be provided not less than seven working days before the meeting and the agenda and papers should be circulated not less than five working days before the meeting.

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

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

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

5.10 Proceedings and decisions made will be formally recorded by the Company Secretary team (or their nominee) in the form of minutes, which will be submitted to the next meeting of the Group for approval.

6. RELATIONSHIPS AND REPORTING

6.1 The Group shall be accountable to the Board.

6.2 The Group shall make recommendations to the Board in relation to issues that require decision or resolution by the Board.

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

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

6.5 The Group shall receive reports from sub-groups of the Trust Management Group (including the Build Ready and Service Ready highlight reports). The Group shall also receive, from time to time, such reports from such sub-groups as it may require to provide it with assurance relating to matters within the scope of the Group's responsibilities.

7. MONITORING

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

7.2 The Trust's Annual Report will include attendance of members, frequency of meetings and whether meetings were quorate.

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

8. REVIEW

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

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

APPENDIX A

ATTENDANCE AT TRANSFORMING CARE TOGTHER GROUP MEETINGS

NAME OF GROUP:	Transforming Care Together Group								
	Meeting Dates								
Present (*include names of members present at the meeting)*									
In Attendance									
Was the meeting quorate? Y / N (*Please refer to Terms of Reference*)									

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 06 March 2024

Agenda item: 8.2

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

Strategic themes that this item supports/impacts:	Systems working and partnership ☒ Our people ☒ Patient experience ☒ Quality: outcomes and safety ☒ Sustainable services ☒ Patient First programme ☒ One Team: patient ready for reconfiguration ☒
BAF/Corporate Risk Register:	All
Purpose of paper:	Decision/Approval
Background:	The UHD Risk Management Strategy was updated following Board seminar and an interim version approved by the Board of Directors in June 2023. There has been ongoing focus and continuous improvement in the UHD governance structures and reporting, and as such has been an iterative process and will be reported though the Audit Committee. The attached Risk Management Strategy, is a further interim iteration, for the Board to ratify. The Risk Management Strategy is being reviewed and refreshed following the Board development seminar on 7 February 2024 and there are further conversations with the ICS aiming to align this with our partners across Dorset.
Key Recommendations:	To approve the attached interim Risk Management Strategy.
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**

University Hospitals Dorset
NHS Foundation Trust

Risk Management Strategy and Policy

When using this document please ensure that the version you are using is the most up to date either by checking on the Trust intranet or if the review date has passed, please contact the author.

'Out of date policy documents must not be relied upon'.

Approval Committee	Version	Issue Date	Review Date	Document Author
Shadow Interim Board	1	1st Oct 2020	1 Oct 2021	Head of Governance & Risk
Board of Director's	2	July 2021	July 2022	Head of Governance & Risk
Board of Director's	3	July 2022	July 2023	Head of Risk Management
Board of Directors	4	June 2023	July 2024	Associate Director Quality Governance and Risk, Head of Risk Management

Version Control

Version	Date	Author	Section	Principal Amendment Changes
2	16/07/2021	JH	2	Refreshed and in line with 21/22 Trust objectives. Risk escalation thresholds articulated
			5	Amendment to the definitions of roles
			6.1	Amendment to the responsibilities within the Trust's Governance Structure
			6.11	• Review of the BAF six monthly (Q2 and Q4) • New risks are presented to the committee by an in depth report by the executive sponsor or relevant Care Group Director (or designated deputy).
			6.10-20	Addition - Sustainability Committee
			6.21-22	Addition - Transformation Committee
			6.23 onward	'Quality Governance Group 'Title amended and report requirements in line with Risk Appetite statement
			7	Responsibilities and Scheme of Delegation for Risk Management Titles amended Role of Risk Manager added
			8.16	Reference to and link to the Risk Register Toolkit
			8.17-24	• Further clarity re: escalation, agreement and sign off prior to notification to Trust Board • Onward management and update of 12+ risk
			Appendix B	Update to the BAF report template
			Appendix C	• Added cover sheet template • Update to Risk Report template • Remove Risk matrix from subsequent appendix as repeated
			Appendix F	• Content table and link to Risk Register Toolkit
3	06/07/2022	JH		• Refresh risk appetite in line with 2022/23 board objectives • Add (4.0) specific risk management objectives for 2022/23 in line with national and local priorities • Appendix A updated governance chart • Appendix E refresh to provide additional information on risk matrix definitions • Section (5.0) additional guidance on risk controls • Section (7.7) additional clarity on the role of the Executive sponsor of a risk rated 12-25 • Section 8.23 additional clarity on risk escalation to Care Group Board and Quality Committee.

4	June 2023	JS/TS		• Refresh risk appetite in line with 2023/24 board objectives • Update organisational chart and committee structures • Amend risk reporting requirements to align with UHD Accountability Framework (approved May 23)

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1.	Executive Summary	
2.	Risk Appetite	
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6.	Organisational and Management Arrangements	
7.	Responsibilities and Scheme of Delegation for Risk Management	
8.	Risk Management Committee Structure	
9.	Risk Management Processes	
10.	Training	
11.	Process for Monitoring Compliance with this Policy	
12.	Approval, Implementation and Review	
13.	References	
14.	Links to Risk Register Toolkit	
Appendices		
A.	Clinical governance and Risk Management Committee Structure	
B.	Risk Matrix for Patient Safety Risk – Risk Level descriptors	
C.	Quality and Risk Group Meeting Toolkits – content and link	
D.	Risk Register Toolkit - content and link	
	EQUALITY IMPACT ASSESSMENT (EIA) SCREENING FORM	

1. Executive Summary

University Hospitals Dorset Hospitals NHS Foundation Trust aims to provide excellent person-centred emergency and planned care to the people we serve. The Board recognises risk is inherent in the provision of healthcare and its services, and therefore a defined approach is necessary to identify and contextualise risk, ensuring that the Trust understands the risks it is prepared to accept in pursuing the Trust's aims and objectives. This strategy sets out the Board's strategic approach to risk-taking by defining its boundaries and risk tolerance thresholds, and states how the delivery of the Trust's Risk Management Strategy will be achieved.

The Trust has key aims that the risk management strategy supports in the delivery of;

- Devolved decision making and accountability for the management of risk throughout the organisation; from the point of delivery to the Board.
- Promoting a culture of assurance, monitoring, and improvement, ensuring risks to the delivery of Trust strategic objectives are well understood.
- Supporting patients, carers, and other stakeholders through the management of risks to patient safety, patient experience, and service delivery.
- Refining processes and systems to ensure engagement in risk management is efficient and effective, enabling good decision making through robust reporting to relevant decision-making groups and scrutiny groups.
- Supporting the Trust Board, commissioners, and other key stakeholders in receiving and providing assurance that the Trust understands its risk profile and is working to mitigate key risks in appropriate and timely ways.

The overall aim of the Trust is to achieve a culture where risk management and safety is everyone's business, that there is open and honest recording of risks and a culture that encourages organisation wide learning and risks are continuously identified, assessed and minimised. A culture of ownership and responsibility for risk management is fostered and supported throughout the organisation.

The Trust Board of directors recognise that Risk Management is an integral part of the Trust's quality, governance, and performance management processes. The Board, with support from its committees will ensure a robust system of risk management is effectively maintained, and champion a culture whereby risk management is embedded across the Trust through policy, strategy, and plans (business planning, policy documentation, strategies, etc. should all explicitly reference risks they are seeking to manage)

Effective Risk Management is the responsibility of every member of staff, either permanent, temporary or to those contracted working within, or for, the Trust. Further; we require that organisations with whom we contract services to provide risk, assurance, and performance information.

The strategy covers all aspects of risk including clinical risk, staff related risk, environmental risk, corporate risk and financial risk. The principles and procedures described within this document and the Trust Risk Assessment and Risk Register Guidance are applicable for all types of risk.

This Risk Management Strategy is underpinned by policy and toolkits guiding staff on the day to day delivery of effective risk management processes. Policy guidance is provided as part of this combined Risk Management Strategy & Policy document.

The Strategy refers to two key documents for managing risk at a strategic level these are:

- The Board Assurance Framework (BAF) – The BAF is a key mechanism to reinforce the strategic focus of the board and better manage risk. It is used to help the organisation capture, report and monitor key risks to the strategic objectives, implement corrective action and report to Board on progress. It is designed to provide assurance that the organisation is delivering on its objectives and draw attention to areas of concern. The BAF also helps the organisation to assess the controls it has in place to mitigate the risks and review the assurances to check the controls are effective.

- The Risk Register – The Trust uses a risk register to record, prioritise and monitor risks across the organisation. Details of this process can be found in the section 8 of this strategy & policy. Risks that are scored in excess of the Trust appetite are presented to the Executive Directors and Committees in accordance with the relevant Governance Cycles.

Differences between the Board Assurance Framework (BAF) and the Corporate Risk Register (Reference**: WWW.GOOD.GOVERNANCE.ORG.UK)**

Board Assurance Framework (BAF)	**Corporate Risk Register**
Content	
Comprises strategic risks aligned to the organisation's strategic objectives – the risks which prevent the Trust from achieving the strategy.	Typically comprises of operational risks arising from the Trust' day to day activities.
Risks are trust-wide in their scope and impact	Some risks are trust-wide in nature, others are specific to particular services or departments but have been escalated to the corporate risk registers because of the high level of risk or because action is required by executives, or colleagues form other services, to mitigate the risk.
Usually contains no more than ten risks	The number of risks vary between organisations but can be up to 50 (or even more) in some Trusts.
For each risk, both controls and assurances (evidence that shows whether the controls are working) need to be identified.	Usually, only controls are identified.
Responsibilities	
Risks are identified, defined and assessed by the executive team or board (top down).	Risks are usually identified by services or departments themselves and escalated to corporate level (bottom up).
Decision to include risks in the BAF, remove them, or adjust risk scores, is taken by the board.	Escalation of risks to the corporate risk register, or de-escalation, is decided by the executive team or by a risk management group (an operational committee below board level).
Reporting	
Reported to the board in full and discussed usually quarterly or bi-monthly.	Not always reported to the board or reported in summary form only.
Board assurance committees review risks relating to their remit in detail.	Board assurance committees may receive and extract of risks relevant to their remit and discuss risks by exception, e.g., new risks or those for which there is a lack of progress with action plans.

Both the BAF and the Risk Register are managed through the Trust's Risk Management system (web-based); DATIX.

A copy of the strategy will be made available to all staff and external stakeholders via the Trust website and intranet.

2. Risk Appetite

The Trust recognises risk is inherent in the provision of healthcare and its services, and therefore a defined approach is necessary to identify risk context, ensuring that the Trust understands and is aware of the risks it is prepared to accept in the pursuit of the delivery of the Trust's aims and objectives.

The Trust's Risk Appetite Statement makes clear the Board of Directors' expectations in relation to the category of risks they expect the Trust's management to identify and the level of such risk that is acceptable.

The statement is based on the premise that the lower the risk appetite, the less the Board is willing to accept in terms of risk and consequently the higher levels of controls that must be put in place to manage the risk.

The higher the appetite for risk, the more the Board is willing to accept in terms of risk and consequently the Board will accept business as usual activity for established systems of internal control and will not necessarily seek to strengthen those controls. Risk Appetite will therefore be set at one of the following levels:

Level	Description
NO APPETITE	Avoidance of the risk is a key organisational objective
LOW APPETITE	A minimal appetite. The preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
MODERATE APPETITE	A cautious appetite. The preference for safe delivery options that have a low degree of inherent risk
HIGH APPETITE	Open and being willing. Consideration of all delivery options and choice while providing an acceptable level of reward or value for money
SIGNIFICANT APPETITE	Seek and be eager. An innovative approach and consideration of options offering potentially higher business rewards despite a greater inherent risk.

The Board of Directors recognise that complete risk control and/or avoidance is impossible, but the risks can be minimised by making sound judgments from a range of fully identified options. The Trust's aim is to promote a risk awareness culture in which all risks are identified, assessed, understood and proactively managed.

This will promote a way of working that ensures risk management is embedded in the culture of the organisation and becomes an integral part of management systems.

Strategic Themes

Our strategic goals are at Trust level and focus on where we most want to see significant improvements delivered in a sustained way over the next 3 years. These fit within our Dorset-wide role in the health and care system.

They are aligned to the following 5 strategic themes:

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

Risk Appetite Statement

The UHD Risk Appetite statement has been formatted to align with the ICS Risk appetite statement.

Appetite	None	Low	Moderate	High	Significant
OUR PEOPLE					
Education and Training		The Trust has a low appetite for risks associated with statutory and mandatory training and promotes a culture of individual responsibility and compliance and considers flexible approaches during the pandemic and recovery.	The Trust has a moderate appetite towards education and training in respect of personal and professional development. It promotes "in-role" and system opportunities for development, balanced with individual objectives		
Staff engagement		The Trust places a high value on staff engagement in our ambition for improving health. It balances appetite for individual risk through progressive workforce policy and a culture built on shared values and behaviours matched by individual contribution to the Trust goals. The appetite, therefore, in relation to risks to staff engagement is low.			
Recruitment and retention		The Trust aims to maximise the potential of every member of staff and is committed to recruit and retain staff that match our values and behaviours. There is a low appetite for recruitment and managerial decisions that could negatively impact upon this.	With regard to the financial implications of the current and future workforce sustainability the Trust has a moderate appetite. This is intended to support the innovation of workforce models and anticipate workforce demand and trajectories.		
Organisational design					The Trust has a significant appetite for organisation design which will meet the strategic objectives and seeks to create a culture

					that allows the organisation to flex to meet current and future challenges. The Trust requires its workforce to deliver innovation and to flex individual contributions to meet prevailing needs including local and system transformation. The Trust encourages effective workforce planning and redesign to meet these changing needs in a culture of shared values, behaviours, and professional role requirements
QUALITY (SAFETY and OUTCOMES)					
Quality (patient harm)		The Board will provide high quality services and in delivering such, has a low appetite for risks that that will have consequential effects upon patient safety, patient experience, or clinical outcomes.			
Outcomes		The Trust strives for optimal outcomes for all patients and therefore has a low appetite for risks that will result in variation and disparate health outcomes.			
Regulation and Compliance		The Trust has a low appetite for risks that impact on the ability of the Trust to meet statutory and regulatory duties.	The Trust has a moderate appetite, including mitigation wherever possible, to meet expectations set by regulators but which fall outside of any legal framework.		

SUSTAINABLE SERVICES					
Finance		The Trust has a low risk appetite for delivering services outside budgets modelled within our financial plans. All such financial responses will be undertaken only after all other available options have been considered and discounted, and will ensure optimal value for money in the utilisation of public funds		The Trust has a high risk appetite for exceeding budgetary constraints if required to mitigate risks to patient safety. All such financial responses will be undertaken only after all other available options have been considered and will ensure optimal value for money in the utilisation of public funds	
Facilities and Estates		The Trust has a low appetite for anything contrary to the requirements of the HSE Welfare at work guidance in the provision of facilities and estate for its employees'.			
IT				The Trust has a high appetite for transformation and innovation that has been tested elsewhere and proven to be transferrable and supports quality, safety, and operational effectiveness.	
Commercial				The Trust has a high appetite for commercial risk. The Trust will be open and willing to consider commercial relationships which contribute towards improving the safety and/or quality and/or patient and/or staff experience, either directly or indirectly, and which provides an acceptable level of reward and value for money.	

Information Security		The Trust has a low appetite for risks that will threaten information security			
Emergency Planning		The Trust has a low appetite for risks that will impact upon its ability to respond within the requirements of the Civil Contingences Act.			
POPULATION AND SYSTEM					
Innovation and Transformation				For transformation or innovation that supports quality, safety, and operational effectiveness the Board has a high appetite.	The Trust has a significant appetite for transformation, depending upon the nature of the transformation being proposed.

Risk Appetite and Risk Escalation

Strategic Objectives	Risk Appetite Statement	Risk Escalation threshold
Our people	The Trust sees protecting our staff and their physical and mental wellbeing as key priority. Our staff are vital in keeping patients safe and delivering the organisation's aims. We will not tolerate unprofessional conduct, bullying and harassment, or any activity that contradicts our values.	• Risks relating to staff wellbeing will be reported to the People and Culture Committee if they score 12 or more. • Risks relating to staff will be reported to the People and Culture Group if they score 8 or more.
	We are strongly averse to risks that might threaten staff members' health, safety and wellbeing, or team morale and cohesion, as well as risks to compliance with frameworks provided by national bodies.	• Risks relating to **Health & Safety** will be reported to the People and Culture Committee if they score 12 or more. • All **Health and Safety** risks will be reviewed at the Trust Health and Safety group if they score 4 or more
	The Trust is committed to developing its leadership and organisational talent through values based appraisal and agreed personal development objectives. The Trust is committed to investment in developing leaders and nurturing organisational talent through programmes of change and transformation. The Trust has a tolerant appetite to risk where learning and development opportunities contribute to improvements in quality, efficiency and effectiveness.	• Risks relating to **Training and Development** will be reported to the People and Culture Committee if they score 12 or more. • Risks relating to **Training and Development** will be reported to the People and Culture Group if they score 8 or more. • All **Training and Development** risks will be reported to Essential Core Skills Group or Education and Strategy Meeting if they score 4 or more.
	The Trust is committee to recruiting and retaining staff to deliver high quality care.	• Risks relating to **workforce and staffing** will be reported to the People and Culture Committee if they score 12 or more. • Risks relating to **workforce and staffing** will be reported to the People and Culture Group if they score 8 or more.

Strategic Objectives	Risk Appetite Statement	Risk Escalation threshold
Sustainable Services	We will strive to deliver our services within the budgets modelled in our financial plans. However, budgetary constraints will be exceeded if required to mitigate risks to patient safety. All such financial responses will ensure optimal value for money.	• Risks relating to **Finance** will be reported to the Finance and Performance Committee if they score 12 or more.
	This trust is committed to delivering a Covid restoration programme that returns waiting times and waiting patient numbers towards the national standards, for elective, cancer, diagnostics and emergency care	• Risks relating to **Performance** will be reported to the Finance and Performance Committee if they score 12 or more. • Risks relating to **Performance** will be reported to the Operational Delivery Group if they score 8 or more
	The Trust will agree and publish the multi-year Green Plan, to measure, and reduce our carbon footprint, improve air quality and make more sustainable use of resources as part of a multi-year sustainability strategy.	• Risks relating to **Sustainability** will be reported to the Finance and Performance Group if they score 12 or more • Risks relating to **Sustainability** will be reported to the Green UHD Sustainability Group if they score 8 or more.
Quality (Outcomes and Patient Safety)	Delivery of high quality, safe, services is at the heart of the Trust's way of working. The Trust is committed to the provision of consistent, personalised, high quality and safe services, a journey of continuous quality improvement and has an ongoing commitment to being a learning organisation. The Trust will not accept risks which compromise the delivery of high quality and safe services which jeopardise compliance with its statutory duties for quality and safety.	• Risks relating to **Quality** will be reported to the Quality Committee if they score 12 or more. • Risks relating to **Quality** will be reported to the Clinical Governance Group if they score 8 or more.

Strategic Objectives	Risk Appetite Statement	Risk Escalation threshold
Patient Experience	We have a strong commitment to engage in co-production to enable people to be at the centre of their care and treatment, and to empower and enable people and communities to be at the centre of the design and delivery of our services.	• Risks relating to **Patient Experience and Patient Engagement** will be reported to the Quality Committee if they score 12 or more
Population Health and Systems	The Trust will continue to support innovation as it is at the heart of developing successful organisations that are capable of delivering improvements in quality, efficiency and value. The Trust has an encouraging appetite to risk where benefits, improvement and value for money are demonstrated	• Risks relating to **Innovation** will be reported to the Finance and Performance Committee if they score 12 or more. • Risks relating to **Innovation** will be reported to the Operational Delivery Group if they score 8 or more

3. Background

The business of healthcare is, by its very nature, a high-risk activity and the process of risk management is an essential control mechanism. Effective risk management processes are central to providing University Hospitals Dorset NHS Foundation Trust's Board of Directors with assurance on the framework for clinical quality and corporate governance.

The Trust has identified standard processes and procedures for the identification, assessment and appropriate management of risks at all levels of the organisation describing:

- the process for assessing all types of risk
- the process for ensuring a continual, systematic approach to all risk assessments is followed throughout the organisation using a single risk register, held and accessed via a web-based system (Datix)
- risk appetite
- risk controls and assurances
- management responsibility for different levels of risk within the organisation
- risk monitoring, escalation and mitigation.

4. Risk Management Objectives

The Trust's Board aims to take all reasonable steps in the management of risks to ensure that the organisation's vision, values and objectives are achieved.

The Trust manages risks by:

- Undertaking an annual assessment of the organisation's objectives and identifying the principal risks to achieving those objectives (Board Assurance Framework risks)
- Regular monitoring of the effectiveness of the Board Assurance Framework by the Trust's Board and the Audit Committee
- Consideration of independent sources of assurance to verify the accuracy and completeness of the risks identified and the controls in place to mitigate them e.g. internal and external audit, commissioned independent reviews, Care Quality Commission (CQC) reports and other external/peer review inspections
- Regular monitoring and review of the risk register and risk appetite ensuring the risks are managed effectively and at the appropriate level within the organisation and escalated where appropriate
- Integrating risk management into business planning, quality improvement and cost improvement planning processes, ensuring that objectives that are set across the organisation with plans to manage risk in accordance with quality impact assessment and risk assessment procedures.

5. Definitions of Risk

Risk can be defined as the combination of the probability of an event and its consequences. The following risk definition is used by the Trust:

"The chance of something happening that will have an adverse effect on an objective."

Risk can relate to:

- **A threat** – an event or circumstance which could cause harm or loss, or affect the ability of the organisation to achieve its objectives.
- **An opportunity** – the organisation must take some risks in order to obtain a benefit; to innovate, grow and improve.

Based on this definition, consistent statement of risks can be framed as an 'if … 'then' statement, for example: ***If*** *we continue to or fail to do something* ***then*** *the result will be…..*

Strategic risks are significant risks that have the potential to impact across the organisation. These are captured and reported via the Board Assurance Framework.

Operational risks are risks that exceed the Trust's stated risk appetite. These risks are identified across the Trust, scored, managed, and escalated as appropriate, and reported to the Trust Board and sub-Committees.

Likelihood & Consequence reflect the probability of a risk occurring, and potential impact caused to the Trust if the risk were to occur. Both likelihood and consequence are scored

between 1 and 5 and are discussed in detail in the Risk Matrices provided within ***Appendix B***

Risk Score; risks are scored against impact and likelihood. This provides a risk a score of between 1 and 25 that reflects the prioritisation that the risk should receive. Risks are scored in three stages;

- **Initial Risk Score;** this score reflects the impact and likelihood of the risk, once, and at the point of assessment and articulation of the risk reflecting the prior management/actions that have been undertaken and the reflecting the identified gaps in controls at that time
- **Current Score;** this score reflects the current state of the risk, bearing in mind the controls in place to mitigate against both impact and likelihood. This score will reflect the progress to delivery of controls and the gaps that may increase or decrease during the life of a risk. This assessment and potential to re-grade will be considered and amended as appropriate at each risk review.
  Note: at the point of submission to the risk register initial and current risk score will be the same
- **Target Score;** this risk score reflects the future state of the risk, when gaps in controls have been addressed and any outstanding actions completed.

Risk controls: the identified actions processes or methods by which a risk is neutralised, reduced, mitigated or eradicated. Through reviewing whether the controls are adequate, any gaps in controls will be identified. Risk evaluation needs to consider whether current controls are reducing risk or harm to its lowest level and moving the risk towards its target risk rating. To improve the effectiveness of controls, additional mitigating actions might need to be undertaken.

Actions; any identified gaps in controls should prompt an action to close the identified gap. Actions should be specific, nominate clear owners, and provide a date for completion. E.g. to develop an policy or a training programme

Review; all risks are to be reviewed and a progress update added in line with current risk score and risk appetite. The standards set are as follows:

Current Risk score	Frequency of review (minimum)	Threshold for compliance reporting
12 and above	Once a month	35 days
8-11	Every 2 months	70 days
4-7	Every 3 months	105 days
1-3	Every 6 months	200 days

Risk Assessor: the risk Assessor is responsible for ensuring that the risk is assessed, and progress updates added to the risk record in line with the requirement for review and that any need to materially amend or upgrade the risk is escalated to the Risk Owner

Risk Owner; the risk owner takes oversight of the accuracy and timely review of the risk record. The risk owner is ultimately responsible for the risk, the control framework, and ongoing management and grading of the risk.

Risk Register; all identified risks are recorded on the Trust risk register. This is a dynamic and responsive collection of risks that the Trust faces across clinical and corporate areas. This is managed on the DATIX system; access to which can be register can be requested through the Quality Governance Team.

Board Assurance framework (BAF) is utilised by the Board of Directors as a planned and systematic approach to the identification, assessment and mitigation of the risks that could hinder the Trust achieving its strategic goals. The assurance framework contains details internal and external assurances that organisational goals are being met. Where risks are identified, mitigations and subsequent action plans are mapped against them.

6. Organisational and Management Arrangements

6.1 The Trust's Governance Structure is set out in the Trust Accountability Framework.

6.2 The following Committees and Groups hold explicit responsibility for the review, challenge, action, and escalation of risks as appropriate:

- The Trust Board
- Trust Quality Committees
- Trust Clinical Governance Group
- Care Group Boards
- Directorate Governance

6.3 The Trust Board: The Trust Board of Directors set the strategic direction of the Trust which includes setting strategic objectives and ensuring that patient and staff safety is prioritised, and that effective and robust risk management systems are in place throughout the organisation.

6.4 The Board of Directors develop, monitor and manage the Board Assurance Framework which records the strategic risks to the Trust that may affect the achievement of the Trust's strategic objectives.

6.5 Part 1 of the Board meets every other month. A Risk Register report on all new and current risks rated 12-25 will be presented to the Part 1 meeting each time.

6.6 **Audit Committee:** The Audit Committee is a committee of the Board of Directors, chaired by a non-executive director, which ensures effective evidence and assurance of internal control, including Risk Management, is in place throughout the Trust. It provides the Board with independent and objective review and monitoring of:

- the effectiveness of the systems in place for the management of risk;
- compliance with the law and regulations covering the NHS
- the internal financial control system
- delivery of the Board Assurance Framework.

The Audit Committee reviews the full Board Assurance Framework quarterly and receives a report on all 12-25 risks at each meeting.

6.7 **Quality Committee:** The Quality Committee is a committee of the board of directors and is chaired by a non-executive director. The committee receives detailed quality, safety and performance reports so that it can ensure that patient safety and quality of services meet registrations and compliance requirements.

The Committee reviews the BAF six monthly (Q2 and Q4) and receives a monthly report on any new or current risks rated 12-25. New risks are presented to the committee by an in-depth report by the executive sponsor or relevant Care Group Director (or designated deputy).

6.8 **Finance and Performance Committee:** The Finance and Performance Committee is a committee of the Trust Board and is chaired by a Non-Executive Director.

The Finance and Performance Committee provides the Board with assurance that there are robust and integrated mechanisms in place to ensure detailed consideration and oversight of the Trust's finance and investments in the context of delivering the Trust's strategy, the underpinning financial plan and associated clinical activity data. The Committee has over-arching responsibility for financial risks, sustainability risks and operational performance risks on behalf of the Board. The Committee receives a report for each meeting on any new or current finance or performance risks rated 12-25.

6.9 **People and Culture Committee:** The People and Culture Committee is a committee of the Trust Board and is chaired by a Non-Executive Director.

The Committee provides the Board with assurance concerning all aspects of strategic and operational workforce and organisational development relating to the provision of care and services. It also provides assurance to the Board that the structures, systems and processes are in place and functioning to support the workforce in the provision and delivery of high quality, safe patient care. The Committee receives a report for each meeting on any new or current workforce risks rated 12-25.

6.10 **Population Health and System Committee** provides the Board with assurance that there are robust and integrated mechanisms in place to ensure detailed consideration and oversight of the Trust's transformation and service improvements in line with the Dorset ICS Long Term Plan. The Committee has over-arching responsibility for health system risks on behalf of the Board.

6.11 **Trust Management Group:** The Trust Management Group (TMG) is the lead operational group for the Trust chaired by the Chief Executive and includes the Executive Directors, and Clinical Directors. It is responsible for the delivering the Trust's strategic objectives, operational management, service planning and delivery and advising the Board of Directors. TMG receives a monthly risk report (12-25 rated risks).

6.12 **Clinical Governance Group (CGG):** The Trust Clinical Governance Group meets monthly. The group will receive a monthly report on all clinical risks rated 8 -25. The Group will receive by exception risk reports from sub-groups and directorate at least quarterly.

7. Responsibilities and Scheme of Delegation for Risk Management

7.1 The Trust's risk management framework requires engagement from all staff throughout the Trust, including contractors and temporary staff. All are expected to participate in the risk management process. Individual staff and groups have specific responsibilities and accountability around risk management which are detailed below.

7.2 The **Chief Executive Officer** has overall responsibility for having an effective risk management system in place within the Trust and for meeting all statutory requirements and adhering to guidance issued by the Department of Health and Social Care and Care Quality Commission in respect of governance.

7.3 The **Chief Medical Officer** and **Chief Nursing Officer** have joint delegated responsibility for managing the strategic development and implementation of organisational risk management and clinical governance. The Chief Nursing Officer has specific responsibility for acting as to the Board lead for monitoring compliance with the Care Quality Commission. The Chief Medical Officer is the Trust Caldicott Guardian.

7.4 The **Chief Finance Officer** has delegated responsibility for ensuring that the Trust complies with NHS England and Monitor's requirements for financial risk management.

7.5 The **Chief People Officer** has delegated responsibility for all aspects of human resource risk management, Health and Safety and for the co-ordination and implementation of the Trust's strategy for occupational health services.

7.6 The **Director of Infection Prevention and Control** has responsibility for advising the Board on all risk issues relating to the prevention, management and control of infection.

7.7 **Executive Directors**: The Trust has identified Executive Director leads for each of the main areas of risk. The Executive Directors with delegated responsibility sit on the Quality Committee with responsibility for risk management.

Executive Directors agreeing (as part of formal escalation process) to act as Lead Executive for risks are responsible for monitoring compliance and supporting the management, progress and further escalation of risks on the Trust's risk register that are relevant to their delegated roles and responsibilities. Executive Director leads are responsible for ensuring that reported risks are updated in accordance with the Trust Risk Management strategy and risk appetite and for ensuring the adequacy of any agreed controls and action plan to mitigate or reduce identified risks.

New risks are presented to the Quality Committee by the executive sponsor or relevant Care Group Director (or designated deputy). New risks are presented to the Board of Directors by the executive sponsor

7.8 **Non-Executive Director Leads:** The Trust has identified Non-Executive Director leads for risk. The Non- Executive Directors with delegated responsibility sit on the Quality Committee.

7.9 **Care Group Directors, Deputies and Heads of Nursing and Professions:** have the following responsibilities in relation to risk management.

- Review with the Directorate Governance Group leads, Directorate Manager and Matrons the directorate risk register, integrated performance report, CQC action plan and other associate quality reports
- Provide a Care Group report to the Quality Committee and escalation of any areas of risk or concern. Provide a report on any mitigating actions, recommendations/ or learning points.
- Ensure quality patient safety, patient outcomes and patient experience is a standard agenda item at all directorate governance and risk meetings and is a core objective for all managers across the Care Group
- Ensure all escalated new risks are consistent with Trust approach to the articulation and assessment of risks and that they have a current action plan

7.10 **Directorate Clinical Governance/Lead Clinician (Clinical Governance Group representative):**

- Directorate leads are responsible for reporting any significant clinical governance or risk issues for CGG attention and for dissemination any important learning points from the directorate review of serious incidents, root cause analysis reports, complaints, clinical audits, mortality reviews or external inspections/reports.
- Responsible for ensuring their directorate retains an effective directorate risk register.
- Ensure all pending or new risks are consistent with Trust approach to the articulation and assessment of risks and that they have a current action plan

7.11 **Directorate Managers, Senior Matrons and Matrons** responsibilities for risk management include:

- To ensure that the directorate has a robust structure for the management of quality, clinical governance and risk, and that this is communicated and applied across all areas of the directorate
- Ensuring that, as appropriate, risks agreed at Directorate Governance are escalated for consideration, review and acceptance at Care Group Board.
- To ensure that lessons learned, and best practice are disseminated across the directorate and Trust
- To ensure that the directorate clinical governance and risk meetings are multidisciplinary and cover directorate wide activity and responsibilities. Ensuring that the risk register is reviewed at each meeting.

7.12 **Managers / Heads of Department / Ward Sisters,** are responsible the management of local risks. This is done by adhering to the following roles and responsibilities:

- Carrying out local risk assessments and escalating these at directorate level
- Ensuring the all learning events are reported, recorded investigated and acted upon within their designated area(s) and scope of responsibility in accordance with Trust policy
- Disseminating information on the Trust's Risk Management Strategy (and associated policies and procedures) within their designated area(s) of responsibility, via local induction, appraisal and mandatory training
- Ensuring that all staff are made aware of the risks and associated risk control plans within their work environment and their individual responsibilities via the processes above
- Ensuring that all staff have appropriate information, instruction and training to enable them to work safely. Those responsibilities extend to anyone affected by the Trust's operations including sub-contractors, members of the public, visitors etc.

7.13 **Staff,** every member of staff (including contractors and agency staff) must be aware of the Trust Risk Management Strategy & Policy and their individual responsibilities with regards to maintaining safety. All staff have a responsibility for risk management and a commitment to identifying and minimising risks. In particular, key responsibilities are to:

- Escalate perceived risks to team leaders and line managers,
- Understand and support the controls in place in work areas to mitigate risks,
- Report Learning Events (including incident, concerns, near misses) in accordance with the Trust's Learning Events policy and bring this to the attention of their line manager
- Act safely in accordance with training, policy guidance, and good practice,
- Comply with Trust policies, procedures and guidelines in place to protect the health, safety and welfare of anyone affected by the Trust activities
- Neither intentionally nor recklessly interfere with or misuse any work equipment provided for the protection of safety and health
- Be aware of emergency procedures (e.g. resuscitation, evacuation, fire and major incident procedures) relevant to their roles and work area(s)
- Attend mandatory training and any other risk management training deemed necessary for their role and/or area of work

- Comply with professional guidelines (as applicable to their role and profession) and acting in accordance with such guidelines and codes of practice

7.14 **Associate Director for Quality Governance and Risk is responsible for;**

- Supporting the Chief Nursing Officer and Chief Medical Officer in the strategic leadership for quality governance and risk management for the Trust ensuring the Trust has a robust framework which meets the requirements of NHS Improvement, NHS England, the Care Quality Commission and the CCG to deliver year on year improvements in patient care.
- Overseeing the Trust Risk Management Strategy and risk register process.
- Working with the Chief Medical Officer and Chief Nursing Officer to ensure that quality and clinical governance systems and processes are integrated across the Trust and appropriately aligned with the Care Group/Directorates

7.14 **Head of Risk Management**, is responsible for;

- The development of strategic plans, policies, procedures and statement of purpose documents with regard to risk management.
- Development, support and oversight of the implementation of the risk functions and of the Risk Management Strategy
- Provision of training, information and support to clinical and corporate teams
- Ensuring relevant risks are reported to external agencies such as commissioners through appropriate oversight groups.
- Responsibility for ensuring systems and processes relating to clinical risk management are embedded throughout the Trust, including clinical incident reporting and investigations; ensuring lessons learnt from LERNS are shared throughout the governance structure; reviewing risk assessments to identify risks which are prevalent across the organisation.
- Ensuring the risk management system and associated processes are maintained and updated in line with Organisational requirements and the Trust Risk Appetite.
- Provide, through oversight, a 'check and challenge' process for all risks on the register with the risk owners through a systematic and documented process.
- Support the Associate Director for Quality Governance and Risk in regard to the Trust Risk Management Strategy and risk register process.

7.15 Risk Management Processes

8.1 The Trust's process for risk management is intended to provide a structured method for the identification, management, and escalation of risks. A toolkit is provided on the Trust intranet and the Quality and Risk Team are a key contact for support.

8.2 The primary tool that the Trust uses for managing its identified risks is the Risk Register. This can be described as a record of all risks identified, both clinical and non-clinical, that might impact on the Trust's delivery of its objectives.

8.3 The Trust Risk Register is accessed through the DATIX system, similarly to the management of incidents.

8.4 **Risk Identification;** Risks will be identified in many ways and prompted by both internal and external events. The Trust aims to be proactive in its identification of risk The Trust has a range of risk assessment tools to identify risk and potential risks associated with its activities. Examples include; risk assessments (clinical and non-clinical), audit (clinical and non-clinical), impact assessments, CQC inspections and monitoring visits, complaints and concerns, LERNs and LERN Reviews, etc.

8.5 Risks should be titled with a brief summary of the risk and can be framed as an '*if … 'then'* statement, for example: If we continue to or fail to do something then the result will be.

8.6 The description of the risk should be succinct and summarises the causes of the risk, and the consequences/outcome if the risk were to occur. Providing this context will help to align controls and actions to specific causes and consequences.

8.7 Consider the risk against the key strategic objectives. Is there impact on the Trust workforce (Our People), Finance (Sustainable Services), Quality (Outcome and Safety), Patient Experience or Reputation and Innovation (Population Health & System). What is the amount of risk being taken on and where is the level of risk when set against the Trust Risk Appetite Statement?

8.8 **Risk Assessment;** The Trust uses a standardised approach to risk assessment that ensures consistency across the organisation. Risks are assessed based on the impact that the risk might have if it were to occur, and the likelihood of the risk occurring. The impact can be based on a variety of factors including; financial implications, the number of service users affected and the severity of harm, or the impact on staff morale and wellbeing.

8.9 The Trust uses a standard 5x5 risk scoring matrix for assessing the impact and likelihood of the risk. The matrix has been adopted as part of a pan-Dorset Risk Management framework.

	Likelihood Score				
	1	**2**	**3**	**4**	**5**
Impact Score	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Figure 2. 5 X 5 risk scoring matrix.

Risk rating 1-4 Very low
4-6 Low
8-12 Moderate
15-25 High

8.10 Each risk will be assessed as below:

- **Initial**, this score reflects the impact and likelihood of the risk, once, and at the point of assessment and articulation of the risk reflecting the prior management/actions that have been undertaken and the reflecting the identified gaps in controls at that time
- **Current**, this score will reflect the progress to delivery of controls and the gaps in controls that may increase or decrease during the life of a risk. This assessment and potential to re-grade will be considered and amended as appropriate at each risk review.
    - Note: at the point of submission to the risk register initial and current risk score will be the same
- **Target**, the risk score that should be achieved through implementing actions, bringing the risk in line with articulated appetite and tolerance. This should include a date by which the target score will be achieved.

8.11 Risk scores are not intended to be precise mathematical measures of risk but are a useful tool to help in the prioritisation of control measures for the treatment of risk. The scoring system allows the levels of risk to be easily identified and therefore prioritised.

8.12 Controls to manage the risk should be described to provide detail on the management systems and processes the Trust have in place to manage its risks. Examples include policy guidance, staff training, appropriate skill mixes and staff numbers, etc.

8.13 Actions should be recorded to provide detail on further work planned to mitigate the risk. These should align to gaps in controls or controls that are understood to be ineffective. Actions should be specific, measurable, achievable, relevant, and time-specific

8.14 An element of the risk assessment process is to agree the course of action. Courses of action can be summarised as either to;

- **Treat** – identify new actions that will, once completed, become controls and further mitigate the risk
- **Tolerate** – agree that the control framework in place is appropriate and reflective of the seriousness of the risk, and that no further action is necessary
- **Transfer** – move the risk away from the organisation through, for example, outsourcing activity.
- **Terminate** – agree that the risk cannot be practically mitigated further, but is in excess of risk appetite, and therefore to consider terminating the activity that produces the risk.

8.15 Risks are recorded onto the Risk Register; a crucial part of the Trust Risk Management Strategy. The register is a management tool that enables the organisation to be aware of its risk profile. The register is a dynamic living document which is populated through the organisations risk assessment and evaluation

processes. This enables risks to be quantified and ranked and shared at the appropriate levels.

8.16 The risk register is primarily an internal management tool to support Care Groups / Directorates in managing their risks, whilst offering an opportunity to escalate particular risks to the Trust Executive and senior management.

8.17 The Trust has one electronic risk register accessed through the risk management system (Datix). Risk assessments can be completed with reference to the Risk Register toolkit found on the intranet.
Link below: https://intranet.rbch.nhs.uk/index.php/quality-and-risk-management/risk-register-toolkit

8.18 **All new risks** must be reviewed and signed off by the relevant Governance, Clinical or Operational Departmental Lead and:

- **Risks rated 8** and above must be signed off by the relevant Directorate Management Team.
- **Risks rated 12** and above require the review and agreement from the Care Group Directors and communication to the relevant Executive Lead.

Evidence of this ensures the consistent escalation of appropriate risks to Quality Committee for sign off and notification to Board of Directors. As below:

Risk Score	Decision to Accept or Close a Risk	Exec Lead	Risk Owner	Risk Assessor
V.Low 1-3	Directorate Governance	If Board Assurance Framework Risk otherwise not applicable	Clinical or Operational Departmental Lead	Departmental /Specialty Lead
Low 4-6	Directorate Governance	If Board Assurance Framework Risk otherwise not applicable	Clinical or Operational Departmental Lead	Departmental /Specialty Lead
Moderate 8-10	Care Group Governance	If Board Assurance Framework Risk otherwise not applicable	Care Group Director	Directorate General Manager/ Senior Matron/ Clinical or Governance Leads
Moderate 12	Reviewed at Quality Committee Agreed at Trust Board	All risks	Care Group Director	Care Group Director/ Operational/ Governance Lead. Or Subject Matter Lead Or Trust Operational Lead
	Reviewed at Quality Committee Agreed at Trust Board	All risks	Care Group Director	Care Group Director/ Operational/ Governance Lead. Or Subject Matter Lead Or Trust Operational Lead

8.19 All new 12 and above risks are presented to the Quality Committee for recommendation for agreement at the Board of Directors

8.20 Whilst all specialties and wards have local level responsibility for reviewing and managing their risks, the Care Groups/Directorates have an overarching responsibility to ensure that all relevant risks within their area are monitored, managed and escalated appropriately. This will include:

- A review of scores, controls, and action plans for risks recorded on the risk register
- A challenge of the risks recorded as an accurate reflection of the area's risk profile
- Agreement of escalation of risks in excess of the Trust's risk appetite.
- A review of mitigated risks with completed action plans, with a view to closing these risks down.

8.21 Directorate and Care Group Leads are responsible for keeping their risk register up to date and for highlighting any risks graded 12 or above for acceptance onto the Trust Risk Register.

Current Risk score	Frequency of review (minimum)	Threshold for compliance reporting
12 and above	Once a month	35 days
8-11	Every 2 months	70 days
4-7	Every 3 months	105 days
1-3	Every 6 months	200 days

8.22 Risk register 'hygiene' will be maintained by ensuring that;

- all risks graded as Very Low and Low that have met their target risk grading are closed,
- all risks currently graded as Moderate that have met their target risk grading are reviewed at Care Group Boards for consideration of closure as a tolerated risk,
- risks graded as Very Low and Low that have not been reviewed for a year are closed unless statutory reason for extended planned review date
- risks designated 'in holding' status are reviewed and become accepted onto the risk register within 60 days or are considered for rejection or closure.

8.23 To ensure effective escalation and management of risks, the risk assessor must inform the Directorate manager and Care Group leads when a new risk exceeding risk appetite (i.e. graded 12 or above) is submitted for acceptance onto the 'live' directorate risk register.

In turn the Care Group Directors must request the relevant Executive Director to confirm that they will act as Executive Lead. This will ensure that the risk narrative and controls identified are agreed and that any action plan can be supported by the

Care Group and by an Executive Lead. The process is not aimed to inhibit directorates raising risks but will ensure risks are clearly articulated, have appropriate Care Group and Board level discussion, approval and support at the earliest opportunity.

9.0 Training

9.1 The Trust Board recognises that training is central to the successful implementation of this strategy and to staff understanding their roles and responsibilities for risk management across the organisation.

9.2 Risk management training not mandatory for all staff. Those in leadership or management positions and those with explicit responsibility for risk management should receive risk management training. This training is provided by the Quality and Risk Team on a bimonthly basis. Full details are available on the Trust intranet.

9.3 It is expected that all staff will familiarise themselves with this Strategy & policy document and be able to identify, communicate, and escalate risks in their areas.

10. Process for Monitoring Compliance with this Policy

Criteria	Method of Monitoring	When	Method of following up non compliance	Follow up of action plan by	Criteria
The Risk Strategy has a process for Board or high-level committee to review the organisation wide risk register	Annual review by Internal Audit of risk Management functions and Assurance Framework	Annually	Results of Audits reviewed and shared with Quality Committee (QC)	Internal Audit	Internal Audit Report –Audit Committee
The Risk Strategy has a process for management of risk locally, which reflects the Trust risk management strategy	Directorate Internal Audit Reports (rotational) Looking at whether risk management processes function appropriately at local level.	Annually	Results of audit reviewed and shared with QC and Audit Committee chairs, action plans to address non-compliance requested	Internal Audit	Internal Audit Report –Audit Committee

	Review of results of Annual Governance Audit tool, identifying whether staff are made aware of processes for risk management.	Annually	Results reviewed by Health and Safety Group and action plans re non-compliance requested	Health and Safety Group	Annual review of results and action plans by Health and Safety Group

11. Approval, Implementation and Review

11.2 Once approved, the strategy will be placed on the Trust intranet.

11.3 The Board is responsible for reviewing the strategy annually and updating it as necessary.

12. References

- Risk Register Toolkit (inc. Escalation and agreement of risks rated 12-25)
- Risk matrix
- Risk Grading descriptors

https://intranet.rbch.nhs.uk/index.php/quality-and-risk-management/risk-register-toolkit

Appendix 1 – Definitions of terms used in the Framework

Term	Definition
Active risk	This is a risk that is on the risk register that has received sponsorship and is in the process of actions being put in to place to mitigate the risk. This is a risk where actions are ongoing.
Assurance	Assurances are evidence showing us whether controls are working. Actions are things we intend to do in future to reduce the risk further – and once we are doing them, they become controls.
Board Assurance Framework (BAF)	An integral part of the system of internal control and sets out the risks to delivering our strategic objectives. It also summarises the controls and assurances that are in place or are planned to mitigate them, and aligns principal risks, key controls, and assurances on controls alongside each objective. Gaps are identified where key controls and assurances are insufficient to reduce the risk of non-delivery of objectives. This enables the Board to develop and subsequently monitor a Board Assurance action plan for closing the gaps. https://www.good-governance.org.uk/wp-content/uploads/2020/05/Board-assurance-framework-diagram_pdf-4.pdf Shown as Appendix 3
Clinical Governance	Clinical Governance is a management systems framework, through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.
Closed risk	This is a risk that has been managed to the point that it is no longer an issue.
Control	Risk control is part of the risk management system, which involves the implementation and application of policies, standards, procedures and physical changes to eliminate or minimise adverse risks. (Mitigation)
Consequence	A measure of the effect that the predicted harm, loss or damage would have on the people, property or objectives affected.
Corporate (Strategic) risk	A significant risk that will impact trust wide and not just a care group or division or a risk that cannot be managed at divisional level without corporate support.
Likelihood	A measure of the probability that the predicted harm, loss or damage will occur.
Hazard	Can be anything whether that is equipment, work methods or practice that has the potential to cause harm.
Learn from Patient Safety Events (LFPSE)	A new national NHS Learn from patient safety events service (previously called the patient safety incident management system – PSIMS – during development) is in the final stages of development as a central service for the recording and

Appendix B 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

Risk Grading	Likelihood x Consequence		Summary Descriptor (reference to patient safety domain only)
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

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

Appendix C: Quality and Risk Group Meeting Toolkits – content and link

https://intranet.uhd.nhs.uk/index.php/quality-risk/quality-governance/toolkits

- Terms of Reference template and meeting documentation templates for the following groups:
- Care Group Quality and Risk Group
- Directorate Quality and Risk Group
- Specialty Quality and Risk Group
- Ward/Department Quality and Risk Group

Appendix D: Risk Register Toolkit - content and link

https://intranet.rbch.nhs.uk/index.php/quality-and-risk-management/risk-register-toolkit

- Trust Risk Appetite & Statement
- Role of the Risk Register
- Acceptance onto the 'Live' Risk Register
- Risk Submission
- 12 + risk escalation
- Reviewing a risk
- Risk Closure
- Running reports
- Appendix A : Flow chart: Escalation and agreement of risks rated 12 and above
- Appendix B : Grading the Risk and Risk Matrix / Descriptors

EQUALITY IMPACT ASSESSMENT (EIA) SCREENING FORM

1. Title of document/service for assessment	Risk Management Strategy
2. Date of assessment	
3. Date for review	
4. Directorate/Service	
5. Approval Committee	

	Yes/No	**Rationale**
6. Does the document/service affect one group less or more favourably than another on the basis of:		
• Race	No	Policy applies to all staff groups and adverse incidents are treated uniformly
• Gender (including transgender)	No	Policy applies to all staff groups and adverse incidents are treated uniformly
• Religion or belief	No	Policy applies to all staff groups and adverse incidents are treated uniformly
• Sexual orientation, to include heterosexual, lesbian, gay and bisexual people	No	Policy applies to all staff groups and adverse incidents are treated uniformly
• Age	No	Policy applies to all staff groups and adverse incidents are treated uniformly
• Disability – learning disabilities, physical disabilities, sensory impairment and mental health issues	No	Policy applies to all staff groups and adverse incidents are treated uniformly
• Marriage and Civil Partnership	No	Policy applies to all staff groups and adverse incidents are treated uniformly
• Pregnancy and Maternity	No	Policy applies to all staff groups and adverse incidents are treated uniformly
7. Does this document affect an individual's human rights?	No	Policy applies to all staff groups and adverse incidents are treated uniformly
8. If you have identified potential discrimination, are the exceptions valid, legal and/or justified?	No	Policy applies to all staff groups and adverse incidents are treated uniformly

9. If the answers to any of the above questions is 'yes' then:	**Tick**	**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		
If neither of the above possible, submit to Diversity Committee for review.		

10. Screener(s)

Print name……

11. Date Policy approved by Committee	

12. Upon completion of the screening and approval by Committee, this document should be uploaded to Papertrail.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 06 March 2024

Agenda item: 8.3

Subject:	Engagement Policy - Board of Directors and Council of Governors
Prepared by:	Klaudia Zwolinska, Corporate Governance Assistant *(cover sheet)* and Yasmin Dossabhoy, Associate Director of Corporate Governance *(cover sheet and revisions to engagement policy)*
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)	Not applicable	
Purpose of paper:	Decision/Approval	
Executive Summary:	The purpose of the Engagement Policy/Statement on Engagement is to set out a policy for establishing effective communication mechanisms between the Board of Directors and Council of Governors. An updated version of the Engagement Policy is attached for consideration, and if thought fit, approval by the Board of Directors (having already been approved by the Council of Governors).	
Background:	**Context: Code of Governance** Under the Code of Governance for NHS Provider Trusts (version effective April 2023): *The council of governors should establish a policy for engagement with the board of directors for those circumstances where they have concerns about the performance of the board of directors, compliance with the provider licence or other matters related to the overall wellbeing of the NHS foundation trust and its collaboration with system partners..* **Context: Trust's Constitution** Annex 6: Governors and Directors: Communication and Conflict of the Trust's Constitution:	

	…describes the processes intended to ensure a successful and constructive relationship between the Council of Governors and the Board of Directors. It emphasises the importance of informal and formal communication and confirms the formal arrangements for communication within the Trust. It suggests an approach to informal and formal communications between the Council of Governors and the Board of Directors. and at section 5 to Annex 6: *The Council of Governors adopts a policy to proactively engage with the Board of Directors in those circumstances where they have concerns. The Council of Governors is encouraged to ensure its interaction and relationship with the Board of Directors is appropriate and effective.* The Engagement Policy/Statement on Engagement with the Board of Directors was last reviewed in 2020.
Key Recommendations:	To consider and if thought fit approve the Engagement Policy/Statement on Engagement with the Board of Directors.
Implications associated with this item:	Council of Governors ☒ Equality and Diversity ☐ Financial ☐ Operational Performance ☐ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☐ Regulatory ☒ Strategy/Transformation ☐ System ☐
CQC Reference:	Safe ☐ Effective ☐ Caring ☐ Responsive ☐ Well Led ☒ Use of Resources ☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Council of Governors	11/02/2024	Approved

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

DRAFT v0.1 – 3 January 2024

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

ENGAGEMENT POLICY:

THE COUNCIL OF GOVERNORS AND THE BOARD OF DIRECTORS

1. INTRODUCTION

1.1 This Engagement Policy has been developed in recognition of the recommendations in the ~~NHS Foundation Trust~~ Code of Governance for NHS Provider Trusts (Appendix B.~~5~~2.6) to address engagement between the Board of Directors and the Council of Governors. The principles in this policy may be applied to engagement between the Council of Governors and committees of the Board of Directors.

1.2 The engagement between the Council of Governors and the Board of Directors is enshrined within the Constitution Annex 6, Section 6: Governors and Directors: Communication and Conflict. This describes the processes intended to ensure a successful and constructive relationship between the Council of Governors and the Board of Directors. It emphasises the importance of informal and formal communication, and confirms the formal arrangements for communication within the Trust. It suggests an approach to informal and formal communications between the Council of Governors and the Board of Directors.

2 Purpose

2.1 This Engagement Policy outlines the mechanisms by which the Council of Governors and Board of Directors will interact and communicate with each other to support ongoing interaction and engagement, ensure compliance with the Regulatory Framework and specifically provide for those circumstances where the Council of Governors has concerns about:

2.1.1 the performance of the Board of Directors;
2.1.2 compliance with the Trust's Provider Licence; or
2.1.3 other matters related to the overall wellbeing of the Trust and its collaboration with system partners.

3 Definitions

3.1 In this Policy the following definitions shall apply:

2006 Act	means the National Health Service Act 2006 (and includes all amendments, replacements or re-enactments made to or any regulations, statutory guidance or directions made under it).
Board of Directors	means the Board of Directors as constituted in accordance with the Constitution
Chair~~man~~	means the chair~~man~~ of the Trust appointed in accordance with the Constitution
Chief Executive	means the Chief Executive (and Accounting Officer) of the Trust appointed in accordance with the Constitution
Company Secretary	means the Company Secretary of the Trust or any other person appointed to perform the duties of the

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	secretary of the Trust
Constitution	means the Constitution of the Trust
Council of Governors	means the Council of Governors of the Trust as constituted in accordance with the Constitution
Director	means a ~~director on~~ member of the Board of Directors
Governor	means a member of the Council of Governors, being either an elected or an appointed Governor
~~Independent Regulator~~	~~he independent regulator of foundation trusts known as Monitor, as provided by Section 61 of the 2012 Act~~
Lead Governor	means one Governor appointed by the Council of Governors to communicate directly with ~~Monitor~~ NHS England in certain circumstances
Provider Licence	means the Trust's provider licence and which forms part of the oversight arrangements for NHS foundation trusts ~~granted by the Independent Regulator under section 87 of the NHS Act 2006~~
Senior Independent Director	means the Non-Executive Director appointed by the Board of Directors in accordance with the Constitution
Trust	means the University Hospitals Dorset NHS Foundation Trust

4 Informal Communications

4.1 Informal and frequent communication between the Governors and the Directors is an essential feature of a positive and constructive relationship designed to benefit the Trust and the services it provides.

4.2 The Chair~~man~~ shall use reasonable endeavours to encourage effective informal methods of communication including:

i) participation of members of the Board of Directors in the induction, orientation and training of Governors;

ii) development of ~~special interest~~ relationships between Non-Executive Directors and Governors such as through Board and Council of Governor Development Sessions;

iii) discussions between Governors and the Chair~~man~~ and/or the Chief Executive and/or Directors through the office of the Chief Executive or a nominated officer;

iv) involvement in membership recruitment and briefings at public events organised by the Trust.

5 Formal Communications

5.1 Some aspects of formal communication are defined by the constitutional roles and responsibilities of the Council of Governors and the Board of Directors respectively.

5.2 Formal communications initiated by the Council of Governors and intended for the Board of Directors will be conducted as follows:

i) specific requests by the Council of Governors will be made through the Chair~~man~~ to the Board of Directors;

ii) any Governor has the right to raise specific issues to be put to the Board of Directors at a duly constituted meeting of the Council of Governors through the Chair~~man~~ but if the Chair~~man~~ declines to raise any such issue the said Governor may nonetheless still raise it provided two thirds of the Governors present approve his request to do so. The Chair~~man~~ shall then raise the matter with the Board of Directors and provide the response to the Council of Governors;

iii) joint meetings will take place between the Council of Governors and the Board of Directors as and when appropriate as determined by the Chair~~man~~ (in his capacity as the Chair~~man~~ of both the Board of Directors and the Council of Governors.

5.3 The Board of Directors may request the Chair~~man~~ to seek the views of the Council of Governors on such matters as the Board of Directors may from time to time determine.

5.4 Communications between the Council of Governors and the Board of Directors may occur with regard to, but shall not be limited to:

i) the Board of Directors' proposals for the strategic direction of the Trust and the annual business plan, including information on ICS plans, decisions and delivery that directly affect the organisation and its patients;

ii) the Board of Directors' proposals for developments;

iii) Trust performance;

iv) involvement in service reviews and evaluation relating to the Trust's services; and

v) proposed changes, plans and developments for the Trust not covered by paragraph 5.4 above.

5.5 Some or all of the Board of Directors shall also present to the Council of Governors the Annual Accounts, the Annual Report including the Quality Account and any report of the Auditors in accordance with the terms of the Constitution and of the 2006 Act.

5.6 The following formal methods of communication may also be used as appropriate ~~with the consent of both the Council of Governors and the Board of Directors~~:

i) attendance by ~~the~~ Directors at a meeting of the Council of Governors;

ii) provision of formal reports or presentations by Executive Directors to a meeting of the Council of Governors;

iii) inclusion of appropriate minutes for information on the agenda of a meeting of the Council of Governors;

iv) reporting the views of the Council of Governors to the Board of Directors though the Chair~~man~~, the Vice Chair~~man~~ or the Senior Independent Director.

6 Other Communication

6.1 The Governors are welcomed to Part 1 meetings of the Board of Directors. There is an item on each Part 1 agenda "Questions from the Governors". These are requested by the Chair~~man~~, enabling individual governors to put questions to the Board of Directors. Verbal responses will be supplied as far as reasonable at the time of the meeting ~~and reported in a subsequent edition of the Governors' newsletter~~. The Chair~~man~~ has discretion to manage this item in the light of other Board of Directors' business. It is also a matter for Governors as to whether the question is for a formal Board of Directors' meeting or can be raised through the informal route. ~~Board time is set aside for informal discussion between individual Governors and Board Members prior to commencement of the Part 1 meetings.~~ Shortly following a Board of Directors' meeting a briefing meeting takes place with the Chair~~man~~ and Governors with the purpose of informing the Governors as far as reasonable about the discussions conducted under the private session of the Board of Directors meetings. ~~Approved Part 2 minutes of the Board of Directors are made available to Governors on a confidential basis. Where able,~~ Executive and Non-executive Directors may exceptionally attend these briefings to support the Chair~~man~~ and impart further information if required. The ~~Chairmen~~ Chairs of the committees of the Board of Directors are also to periodically attend meetings or briefings ~~annually~~ to discuss the work of the committees to assist the Council of Governors in their duty to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors.

6.2 A ~~weekly~~ newsletter ~~from the Chairman, Chief Executive and Company Secretary~~ will also be sent to Governors containing relevant information and updates.

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7 Senior Independent Director

7.1 The Senior Independent Director (SID) can act as an alternative source of advice to Governors from the Chair~~man~~.

7.2 The SID shall be available to Governors if they have concerns that contact through normal channels has failed to resolve any issues which have been raised or for which such contact is inappropriate.

8 Raising Concerns/ Dispute Resolution Procedure

8.1 The Council of Governors adopts a policy to proactively engage with the Board of Directors in those circumstances where they have concerns. The Council of Governors is encouraged to ensure its interaction and relationship with the Board of Directors is appropriate and effective. Governors can raise concerns with the Company Secretary who may in the first instance be able to resolve the matter informally.

8.2 Where the Company Secretary has been unable to resolve the matter, the Lead Governor shall be the first point of contact when Governors wish to seek advice and/or raise issues and who acts as the Council of Governors lead representative to the Chair~~man~~ on Governor matters.

8.3 In the event of a dispute arising between the Council of Governors and the Board of Directors, the Chair~~man~~ (or Vice-Chair~~man~~ if the dispute involves the Chair~~man~~) will endeavour to resolve the dispute informally, through discussions within the Council of Governors.

8.4 Within twenty-eight days of the Council of Governors of the Board of Directors resolving that a dispute exists with the other, the Company Secretary shall call a joint meeting to be held as soon as reasonably practicable within three months of the resolution. The joint meeting shall be held under the Trust's Board of Directors' Standing Orders, but the provisions of the Standing Orders of the Council of Governors in relation to interests shall apply to Governors attending the joint meeting as they apply to a Council of Governors meeting.

8.5 The joint meeting shall be chaired by the Chair~~man~~ and the agenda shall be agreed with the Chief Executive. The joint meeting shall either recommend to each of the constituents the formula for resolving the dispute which each shall receive and consider formally as soon as practicable, or, if possible, shall agree the relevant issues and the possible way forwards.

8.6 If either constituent resolves to refer the issue to mediation, the Lead Governor and a second nominated Governor on behalf of the Council of Governors and the Chief Executive and the Vice-Chair~~ma~~n of the Board of Directors shall meet within twenty-eight days of such resolution to agree a mediator. In default of agreement, either constituent may resolve to refer the dispute for resolution by ~~Monitor~~NHS England.

8.7 On the satisfactory completion of this disputes process the Board of Directors and the Council of Governors, as appropriate, shall implement any agreed actions.

8.8 The existence of the dispute shall not prejudice the duty of the Board of Directors in the exercise of the Trust's powers on its behalf.

8.9 Nothing in this procedure shall prevent the Council of Governors, if it so desires, from informing ~~Monitor~~ NHS England that, in the Council of Governors' opinion, the Board of Directors has not responded constructively to concerns of the Council of Governors and that the Trust is not meeting the conditions of its provider licence. The Lead Governor will act as the conduit between the Council of Governors and ~~Monitor~~NHS England.

9. Supporting Documents or Relevant References

9.1 ~~Monitor~~ NHS England – ~~The NHS Foundation Trust~~ Code of Governance for NHS provider trusts (~~July 2014~~October 2022);
Monitor – Director-governor interactions in NHS foundation trusts: a best practice guide for boards of directors
Monitor – Your Statutory Duties: A Reference Guide for NHS Foundation Trust Governors (August 2013);
NHS England - Addendum to your statutory duties – reference guide for NHS foundation trust governors (October 2022)

UDHFT Code of Conduct for Board of Directors;
UDHFT Code of Conduct for the Council of Governors.

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10. Conclusion

10.1 This policy will be made available to the Board of Directors and the Council of Governors.

Appendix A

The procedure for any such mediation shall be as follows:

1.3.1 A neutral person, being an *accredited mediator, (the "**Mediator**") shall be chosen by agreement between the two parties. Alternatively, either party may within seven days from the date of the proposal to appoint a mediator, or within seven days of notice to any party that the chosen mediator is unable and unwilling to act, apply to the Centre for Dispute Resolution ("**CEDR**") to appoint a Mediator.

1.3.2 The parties shall within seven days of the appointment of the Mediator agree a timetable for the exchange of all relevant and necessary information and the procedure to be adopted for the mediation. If appropriate, the parties may at any stage seek from CEDR guidance on a suitable procedure.

1.3.3 All negotiations and proceedings in the mediation connected with the dispute shall be conducted in strict confidence and shall be without prejudice to the rights of the parties in any future proceedings.

1.3.4 All information (whether oral or in the form of documents, tapes, computer disks etc) produced for, during, or as a result of, the mediation will be without prejudice, privileged and not admissible as evidence or discoverable in any litigation or arbitration relating to the dispute. This does not apply to any information which would in any event have been admissible or discoverable in any such litigation or arbitration.

1.3.5 The Mediator's reasonable fees and other expenses of the mediation will be borne by the Foundation Trust. The Foundation Trust will bear the reasonable costs and expenses of the participation in the mediation.

1.3.6 If the parties reach agreement on the resolution of the dispute that agreement shall be reduced to writing and shall be binding upon the relevant parties.

1.3.7 For a period of ninety days from the date of the appointment of the Mediator, or such other period as the parties may agree, neither party may commence any proceedings in relation to the matters referred to the Mediator.

1.3.8 If the parties are unable to reach a settlement at the mediation and only if both parties so request and the Mediator agrees, the Mediator will produce for the parties a non-binding recommendation on terms of settlement. This will not attempt to anticipate what a court might order but will set out what the Mediator suggests are appropriate settlement terms in all of the circumstances. Such opinion shall be provided on a without prejudice basis.

1.3.9 Subject to Conditions 1.3.6 and 1.3.7, should either party decide to pursue the dispute in a court, the Foundation Trust shall not be liable for any of the costs or expenses in relation to such proceedings.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 06 March 2024

Agenda item: 8.4

Subject:	Objectives for UHD 2024/2025
Prepared by:	Richard Renaut, Chief Strategy and Transformation Officer
Presented by:	Richard Renaut, Chief Strategy and Transformation Officer

Strategic themes that this item supports/impacts:	Systems working and partnership ☒ Our people ☒ Patient experience ☒ Quality: outcomes and safety ☒ Sustainable services ☒ Patient First programme ☒ One Team: patient ready for reconfiguration ☒
BAF/Corporate Risk Register: (if applicable)	Whole BAF for 2024/2025 will be set around this.
Purpose of paper:	Decision/Approval
Executive Summary:	The March Board of Directors should set the objectives for the year ahead. Attached is the final version for 2024-2025. Consistency of objectives over several years is an approach the Board supported last year, as we started the Patient First journey. The attached slides represent significant continuity against our "True North" objectives, with several refinements: • Five strategic themes remain • Breakthrough KPIs updated slightly for 4-hour emergency standard, Referral to treatment (RTT) times, and financial sustainability. • The 8 corporate enabling programmes feature more fully, as these have matured. These will be a focus of effort, and explicitly other major changes will not be progressed. • The Dorset ICS 5 year Forward Plan is referenced, with a driver diagram showing how UHD efforts are aligned and contributing to these long-term improvements.

	• The Patient First improvement system, and the values and behaviours framework summary is included. • The national planning guidance is not yet known, but Dorset's expectation of key deliverables is included. The delay in national planning guidance is much later than normal, reflecting the intense financial and operational pressures across the NHS. The public scrutiny of the NHS, in an election year, is also heightened. However, the proposed objectives for 2024-5 are expected to be broadly in line with the key requirements. The alternative of not planning, and waiting for guidance, is not recommended. The Board is asked to approve these objectives, such that they can inform the Board objectives and BAF and be cascaded for all staff and team objectives in 2024/2025.
Background:	Significant work is underway to complete the detail work for the Annual Plan, which includes sections on: • Finance • Activity • Performance • Workforce • Quality • Narrative sections This detail is vitally important, and key information, including financial settlements, are not yet known. However this does not stop us setting our objectives, and working towards our long term goals. The methodology used for developing the objectives is Patient First The attached slides provide the over-arching narrative and objectives which are considered the right areas of focus, subject to Board discussion and agreement.
Key Recommendations:	1. To approve the attached objectives for 2024-2025 2. To note progress in developing the Annual Plan, key sections on activity, performance, workforce, finance, quality and narrative sections. 3. To prepare for team and individual objective setting, as part of well structured, values-based appraisal.
Implications associated with this item:	Council of Governors ☒ Equality and Diversity ☐ Financial ☒ Operational Performance ☒ People (inc Staff, Patients) ☒

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

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Board of Directors Part 2	27/02/2024	Draft objectives discussed.

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

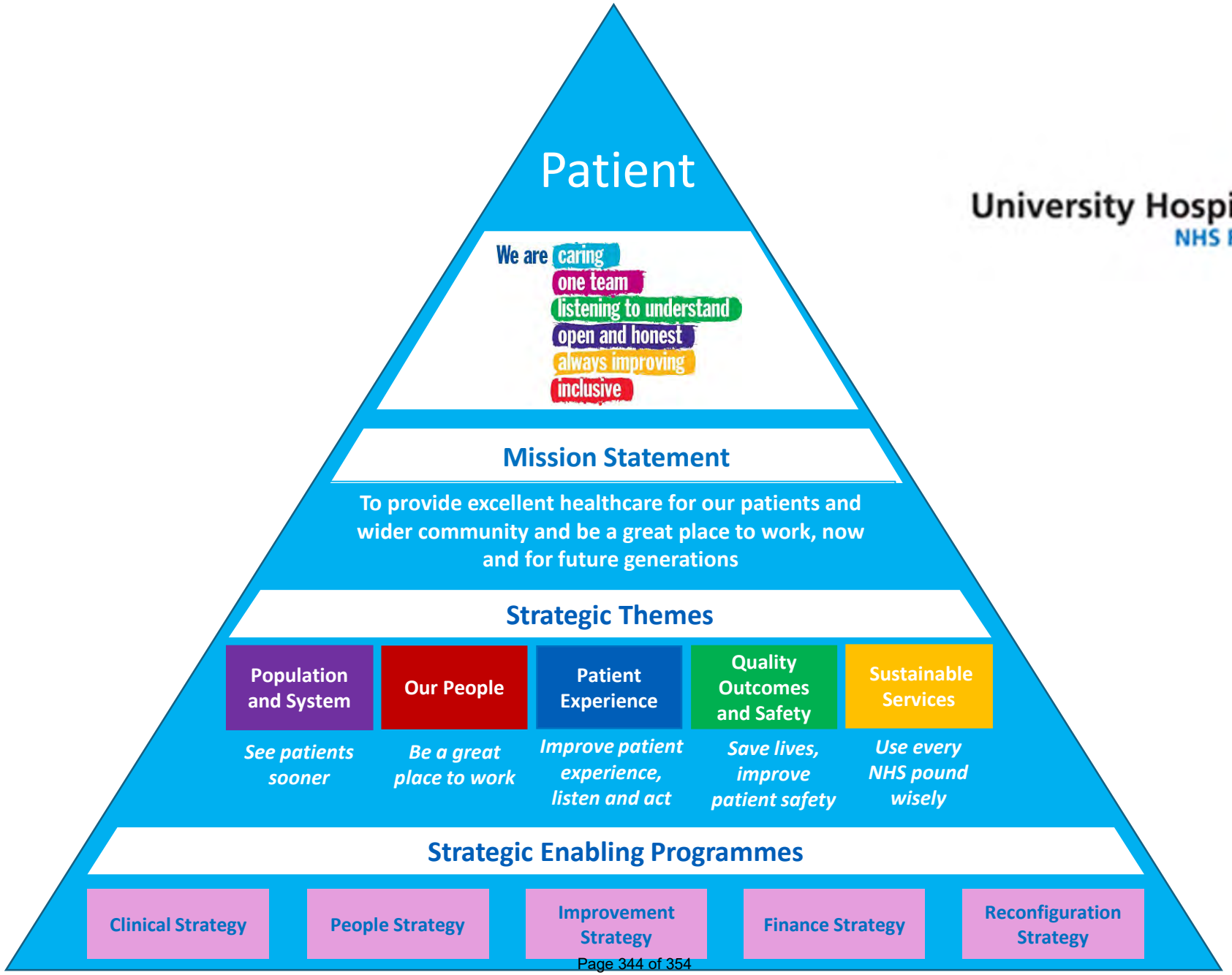
Annual Plan 2024-5

Setting our objectives

& Patient First transition.

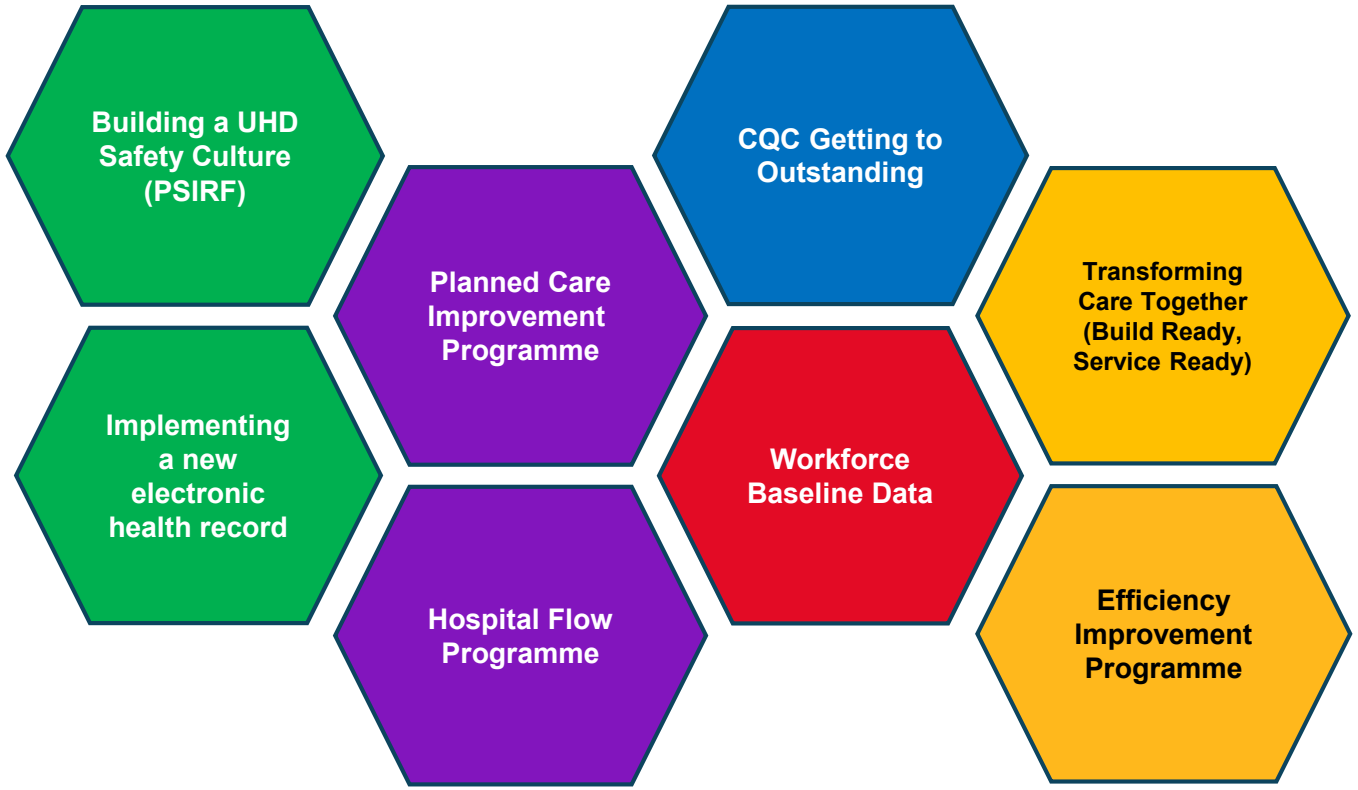
FINAL for approval

University Hospitals Dorset
NHS Foundation Trust



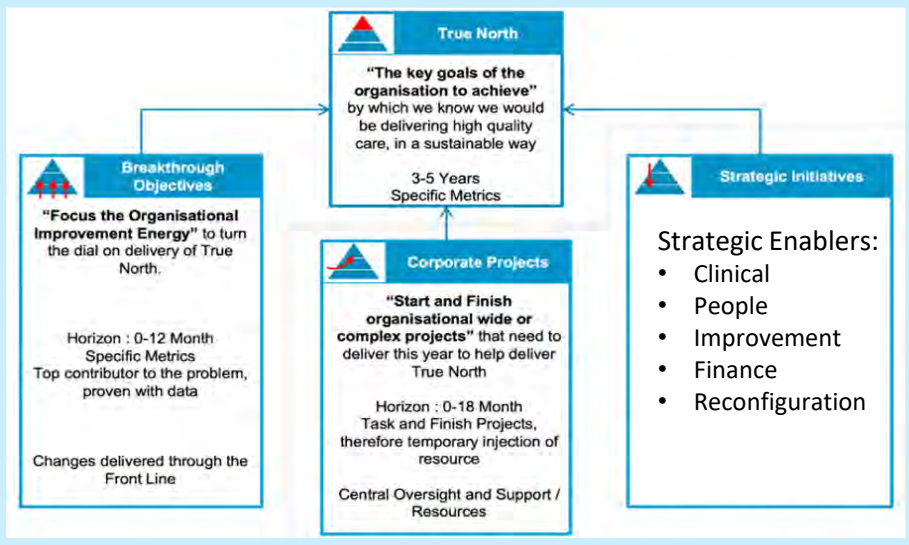
Strategic Theme	Breakthrough Objective SHORT TERM: 2024/5
POPULATION AND SYSTEM	• **Planned Care** - To have no patients waiting in excess of 65 weeks on an RTT pathway to be seen and treated • **Emergency/Urgent Care:** >76% of patients treated within 4 hours through the emergency care pathway
OUR PEOPLE	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 develop and fully deliver **recurrent financial efficiencies** of £33m (4.4%) consistent with the budgeted Cost Improvement Programme target.

8 Corporate projects



Patient First Improvement System

2 Management System



A) UHD has set it's True North five goals and metrics.
B) There are 8 enabling corporate programmes to help
C) SDRs (Strategy Deployment Reviews) keep us on track

3 Improvement Toolkit

A) Training & Skills e.g. A3 problem solving,
B) Cohorts of frontline teams e.g. Stroke
C) Data insights e.g. SPC charts, huddle boards

1 Leadership Behaviours & Culture

A) 'Leaders as coaches' with standard work and personal A3s
B) Behaviours framework
C) Good quality appraisals covering values & behaviours

UHD's Values and 12 Positive Behaviours

Dorset's Joint Forward Plan: UHDs contribution to Five Pillars

Our plan has five areas of focus — our five outcomes are:

- We will **improve** the lives of 100,000 people impacted by poor mental health.
- We will prevent 55,000 children from becoming overweight by 2040.
- We will reduce the gap in healthy life expectancy from 19 years to 15 years by 2043.
- We will increase the percentage of older people living well and independently in Dorset.
- We will add 100,000 healthy life years to the people of Dorset by 2033.

Emergency Flow

- Same Day Emergency Care
- Frailty Pathway
- Virtual Wards
- Falls &Anticipatory Care
- Discharge Pathway

Living Older, Living Well

Day Hospital (Patient First)

Patient Safety
- Reduce HSMR

Elective Recovery
- Reduce Long Waits
- Faster Cancer Access
- Diagnostic Standards

Smoking cessation (Staff & Patients)

Weight Management; Active Dorset Partnership

100,000 extra healthy life years

Other strategy linkages with corporate projects??

- Patient Experience: look at mental illness LD, Older People and Dementia
- EPR to look at anticipatory care for older living well and adding life years
- Clinical Strategy to reflect population health
- Service Ready; enables emergency and Elective Improvements
- Sustainable: Green UHD air quality and Biodiversity; anchor institution role
- Workforce: recruitment from areas of deprivation ?

Elective Access
Reducing variation by age, gender, deprivation and ethnicity (inc maternity pre-term)

Boscombe - Community Diagnostics

North Bournemouth

Reducing Gap in Life Expectancy

Better Births &UNICEF Friendly

Preconception Care (Multi-Agency)

Oral Health

Less Childhood Obesity

Lowering Disabled People Admissions

Dementia Diagnosis & Treatment

Perinatal Care

Addiction Services

Acute Mental Health Admissions to ED

Better Mental Health

CAMHS acute care including eating Disorders

Dorset as the Healthiest Place to Live

Operational Standard Priorities: System Approved 23/01/2024

NHS Dorset

SyRG approved the priorities on the understanding:

- Delivery Groups need to identify where additional resource is required to achieve these.
- Health inequalities and productivity will be a theme throughout the narrative from each Delivery Group.
- More ambition required for Children and Young People metrics, Delivery Groups to be tasked with this.

Headline Summary

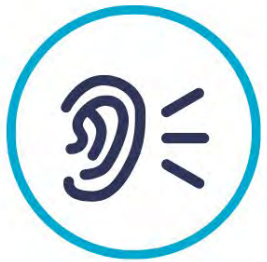
Delivery Group	Plan to Deliver	Plan to Improve Performance	Plan to Maintain Performance
Primary and Community Care	• Primary care access • Urgent community response – 80% • Virtual wards- bed per 100,000 population 40-50, utilisation 80%	• Dental activity. • Community pharmacy referrals • Additional Roles Reimbursement Scheme (ARRS) . • Reduction of community waiting lists. • GP retention	• Children and Young People community services.
Urgent and Emergency Care	• 4-hour emergency department standard- increase ?80% • Handover delays • category 2 response times- improvements towards 18mins	• Reduce G&A bed occupancy to 92% or below.	
Planned Care	• Reducing waiting list and long waiters. • Improving theatre productivity. • Improving outpatient productivity. • All cancer standards- FDS 77% by March 25, 62d combined standard 70% from April with 80% by March 25 • Diagnostic waiting times and reporting turnaround times- 6 week test >90% (95% March 2024 ambition)	• All 52-week patients to have 1st outpatients by end October 2024. • Elective recovery including Children and Young People. • Tooth extractions due to decay for children. Increase % of cancers diagnosed at stages 1 & 2.	• Advice and Guidance.
Mental Health, Learning Disabilities, and Autism	• Eliminating out of area mental health inpatients • Annual Health checks 85% pf DP LDR • Learning disability and autism inpatient rates.	• Access to perinatal mental health.	• Children and Young People's mental health access. • NHS talking therapies recovery. • Overall access community mental health services for adults and older adults. • Dementia diagnosis rate- 66.7%.
Maternity and Neonatal	• Progressing the national safety ambitions. • Increasing maternity establishments.		
Health Inequalities and Population Health		• Patients treated for hypertension • Patients with CVD risk score of greater than 20% on lipid lowering therapies. • Continue to deliver Core20PLUS5.	
Children and Young People Delivery Group		• Children and Young People Core 20PLUS5. • Paediatric virtual wards. • Vaccinations	

NHS
University Hospitals Dorset
NHS Foundation Trust

Team UHD
Our 5 objectives
2024-25

See our patients sooner

Be a great place to work



Improve patient experience, listen and act

Save lives, improve patient safety

Use every NHS pound wisely

Scan here or search 'Patient First' on the intranet to find out more...

Making sense of this for every member of staff...via a meaningful, values-based appraisal.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 06 March 2024

Agenda item: 8.5

Subject:	Register of Use of Seal
Prepared by:	Ewan Gauvin, Acting Deputy Company Secretary
Presented by:	Ewan Gauvin, Acting Deputy Company Secretary

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:	Information	
Executive Summary:	This report contains the register of use of the Trust's seal during 2023-24. During the period, the seal was used on thirteen occasions.	
Background:	The Trust Constitution provides that "an entry of every sealing shall be made and numbered consecutively by the Company Secretary. A report of all sealing shall be made to the Board of Directors annually."	
Key Recommendations:	For information only.	
Implications associated with this item:	Council of Governors Equality and Diversity Financial Operational Performance People (inc Staff, Patients) Public Consultation Quality Regulatory Strategy/Transformation System	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☒ ☐ ☐
CQC Reference:	Safe Effective Caring Responsive	☐ ☐ ☐ ☐

	Well Led	☒
	Use of Resources	☐

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

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

University Hospitals Dorset NHS Foundation Trust

Register of Use of Seal – 1 April 2023 to 28 February 2024

	Company	Transaction	Authorised By	Witnessed By	Date
18	Boots UK Limited	Boots Pharmacy Unit, Poole Hospital	Karen Allman, Chief People Officer	Mark Mould, Chief Operating Officer	05/06/2023
19	Boots UK Limited	Boots Ground Floor Pharmacy Unit, Royal Bournemouth Hospital	Karen Allman, Chief People Officer	Mark Mould, Chief Operating Officer	05/06/2023
20	Northern Care Alliance NHS FT and Lancashire Teaching Hospitals NHS FT	Deed of Novation – ELFS Hosting Arrangements	Paula Shobbrook, Chief Nursing Officer	Richard Renaut, Chief Strategy & Transformation Officer	05/07/2023
21	Integrated Health Projects	Multiple Major Reconfiguration Projects Scheme at the Royal Bournemouth Hospital	Karen Allman, Chief People Officer	Peter Wilson, Chief Medical Officer	13/11/2023
22	Hurleys Solicitors Ltd	Supplemental lease of Ground Floor, Commercial Unit, 1141 Christchurch Road, Bournemouth	Paula Shobbrook, Chief Nursing Officer	Mark Mould, Chief Operating Officer	04/12/2023
23	Tops Day Nursery Ltd	Lease of Tops Nursery forming part of the Royal Bournemouth Hospital	Mark Mould, Chief Operating Officer	Paula Shobbrook, Chief Nursing Officer	04/12/2023
24	Bournemouth, Christchurch and Poole Council	Land at Wessex Fields, Deansleigh Road, Bournemouth – Engrossment TP1 Transfer And Plan annexed to transfer	Siobhan Harrington, Chief Executive Siobhan Harrington, Chief Executive	Peter Wilson, Chief Medical Officer Paula Shobbrook, Chief Nursing Officer	19/12/2023
25	Bournemouth, Christchurch and Poole Council	Lease relating to land on the north side of Deansleigh Road, Bournemouth	Siobhan Harrington, Chief Executive	Paula Shobbrook, Chief Nursing Officer	20/12/2023
26	Dorset County Hospital NHS FT	Deed of Adherence in relation to the	Mark Mould, Chief Operating	Paula Shobbrook,	30/01/2024

	Partnering Solutions (Dorset) Limited DCH Estates Partnership LLP	partnership between Dorset County Hospital NHS FT, Partnering Solutions (Dorset) Limited and DCH Estates Partnership LLP	Officer	Chief Nursing Officer	
27	Partners of Troup Bywaters + Anders (General Partnership) Troup Bywaters + Anders LLP	Deed of Novation relating to the conversion of Troup Bywaters + Anders (General Partnership) to an LLP (Royal Bournemouth Hospital McCann Stage 3 Technical Review)	Paula Shobbrook, Chief Nursing Officer	Mark Mould, Chief Operating Officer	30/01/2024
28	Partners of Troup Bywaters + Anders (General Partnership) Troup Bywaters + Anders LLP	Deed of Novation relating to the conversion of Troup Bywaters + Anders (General Partnership) to an LLP (Poole Hospital Phases C1, D1, D2, D3 and ESL)	Paula Shobbrook, Chief Nursing Officer	Mark Mould, Chief Operating Officer	30/01/2024
29	Partners of Troup Bywaters + Anders (General Partnership) Troup Bywaters + Anders LLP	Deed of Novation relating to the conversion of Troup Bywaters + Anders (General Partnership) to an LLP (Royal Bournemouth Hospital Electrical Infrastructure)	Paula Shobbrook, Chief Nursing Officer	Mark Mould, Chief Operating Officer	30/01/2024
30	Partners of Troup Bywaters + Anders (General Partnership) Troup Bywaters + Anders LLP	Deed of Novation relating to the conversion of Troup Bywaters + Anders (General Partnership) to an LLP (CDC Endoscopy)	Paula Shobbrook, Chief Nursing Officer	Mark Mould, Chief Operating Officer	30/01/2024