University Hospitals Dorset
NHS Foundation Trust

# UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

## BOARD OF DIRECTORS – PART 1 MEETING

**Wednesday 5 March 2025**

**9:30 – 12:15**

**via Microsoft Teams**

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

University Hospitals Dorset
NHS Foundation Trust

**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 5 March 2025 in the Committee Room at Royal Bournemouth 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**

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**9:30 on Wednesday 5 March 2025**

| Time | Item | | Method | Purpose | Lead |
|---|---|---|---|---|---|
| **9:30** | **1** | Welcome, Introductions, Apologies & Quorum | **Verbal** | | **Chair** |
| **9:32** | **2** | Declarations of Interest | **Verbal** | | **Chair** |
| **9:35** | **3** | Patient Story | **Verbal** | **Discussion** | **CNO** |
| **9:55** | **4** | **MINUTES** | | | |
| **9:55** | **4.1** | For Accuracy and to Agree: Minutes of the Board of Directors Meeting held on 5 January 2025 | **Paper** | **Approval** | **Chair** |
| **9:58** | **4.2** | Matters Arising - Action List *(none outstanding)* | **Verbal** | **Review** | **Chair** |
| **10:00** | **5** | **TRUST CHAIR AND CHIEF EXECUTIVE UPDATES** | | | |
| **10:00** | **5.1** | Trust Chair's Update | **Verbal** | **Information** | **Chair** |
| **10:10** | **5.2** | Chief Executive Officer's Report<br>• ICB minutes<br>• Feedback from CQC | **Paper** | **Information** | **CEO** |
| **10:25** | **6** | **STRATEGY, RISK AND PERFORMANCE** | | | |
| **10:25** | **6.1** | Integrated Quality, Performance, Workforce, Finance and Informatics Report<br>*Questions to the Executive Team by exception* | **Paper** | **Assurance** | **Execs** |
| **11:00** | **6.2** | Quality Committee – Chair's Report – January and February 2025 | **Paper** | **Assurance** | **Committee Chair** |

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| | | • Maternity and Neonatal Quality and Safety Report Q3 *(to be presented by Director of Midwifery)*<br>• Mortality Report | **Paper**<br>**Paper** | **Assurance**<br>**Assurance** | |
| **11:10** | **6.3** | Finance and Performance Committee – Chair's Report – January and February 2025 | **Verbal** | **Assurance** | **Committee Chair** |
| **11:15** | **6.4** | People and Culture Committee – Chair's Report – December 2024<br>• Guardian of Safe Working Hours *(to be presented by Guardian of Safe Working Hours)*<br>• Maternity Staffing – June to December 2024<br>• Equality Diversity System<br>• Pay Gap Reports | **Paper**<br>**Paper**<br>**Paper**<br>**Paper**<br>**Paper** | **Assurance**<br>**Assurance**<br>**Assurance**<br>**Approval**<br>**Approval** | **Committee Chair** |
| **11:30** | **6.5** | Transforming Care Together – Chair's Report – February 2025 | **Verbal** | **Assurance** | **Committee Chair** |
| **11:35** | **6.6** | Charitable Funds Committee – Chair's Report – February 2025 | **Verbal** | **Assurance** | **Committee Chair** |
| **11:40** | **6.7** | Population Health and System Committee – Chair's Report – January 2025 | **Paper** | **Assurance** | **Committee Chair** |
| **11:45** | **6.8** | Audit Committee – Chair's Report – January 2025 | **Verbal** | **Assurance** | **Committee Chair** |
| **11:50** | **7** | **ITEMS FOR APPROVAL/INFORMATION** | | | |
| **11:50** | **7.1** | Risk Register: review of significant risks; new risks rated 15 and above | **Paper** | **Information** | **CNO/ Execs** |
| | **7.2** | Membership of Board Committees and Terms of Reference:<br>• Audit Committee *(Terms of Reference)*<br>• Charitable Funds Committee *(membership)*<br>• Finance and Performance Committee *(membership and Terms of Reference)*<br>• People and Culture Committee *(Terms of Reference)*<br>• Population Health and System Committee *(Terms of Reference)*<br>• Quality Committee *(Terms of Reference)*<br>• Transforming Care Together Group *(membership and Terms of Reference)* | **Paper** | **Approval** | **Chair** |
| **12:05** | **8** | Any Other Business | **Verbal** | **Discussion** | **Chair** |
| | **9** | Reflections on the Board Meeting | **Verbal** | **Discussion** | **Chair** |

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| | **10** | Questions from the Council of Governors and Public arising from the agenda.<br><br>Governors and Members of the public are requested to submit questions relating to the agenda by no later than noon on Sunday 2 March 2025 to<br>company.secretary-team@uhd.nhs.uk | | | |
| | **11** | **Date and Time of Next Board of Directors Part 1 Meeting:**<br>Board of Directors Part 1 Meeting on Wednesday 7 May 2025 at 9:30. | | | |
| | **12** | **Resolution Regarding Press, Public and Others:**<br>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** | **13** | **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 Update
- Committee Chair's Key Issues & Assurance Report
- Integrated Performance Report
- Risk Register Report
- Maternity Safety Champions Report

Annual reports

- Staff Survey Report and Action Plan
- Gender Pay Report
- Going Concern Statement
- Key Areas of Judgment and Estimation within the Annual Accounts
- Annual Operational Plan
- Annual certificates: availability of resources; training of governors
- Code of Governance
- Register of compliance with licence conditions
- Independence of Non-Executive Directors
- Seal of Documents Register
- Gifts and Hospitality Register
- Register of Directors' Interests

Bi-annual reports

- Board Assurance Framework

- 7 Day Services Board Assurance Framework
- Freedom to Speak Up Guardian Report (to include Behaviour Charter)

Quarterly Reports

- Guardian of Safe Working Hours Report
- Mortality Report
- Maternity and Neonatal Quality and Safety Report Q4

Ad Hoc Reports

- Patient First
- Accountability Framework

## AGENDA – PART 2 PRIVATE MEETING

**12:30 on Wednesday 5 March 2025**

| Time | Item | | Method | Purpose | Lead |
|---|---|---|---|---|---|
| **12:30** | **14** | Welcome, Introductions, Apologies & Quorum | **Verbal** | | **Chair** |
| | **15** | Declarations of Interest | **Verbal** | | **Chair** |
| **12:32** | **16** | **MINUTES AND ACTIONS** | | | |
| **12:32** | **16.1** | For Accuracy and to Agree: Minutes of the Board of Directors Meeting held on 5 February 2025 | **Paper** | **Approval** | **Chair** |
| **12:33** | **16.2** | Matters Arising – Action List | **Paper** | **Review** | **Chair** |
| **12:35** | **17** | **UPDATES** | | | |
| **12:35** | **17.1** | Chief Executive Officer's Update<br>• One Dorset Provider Collaborative Minutes | **Paper** | **Information** | **CEO** |
| **12:55** | **17.2** | • Feedback/Escalations from Committee Chairs (not already covered in Part 1)<br>• Feedback From Dorset County Hospital Board | **Verbal** | **Information** | **Committee Chairs** |
| **13:05** | **17.3** | Feedback from Service Visits | **Verbal** | **Information** | **All** |

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| **13:15** | **18** | **STRATEGY AND FINANCE** | | | |
| **13:15** | **18.1** | Finance Update | **Paper** | **Review** | **CFO** |
| **13:25** | **18.2** | 2025/26 Operational Planning | **Paper** | **Decision** | **COO** |
| **13:45** | **18.3** | Capital Update | **Verbal** | **Information** | **CSTO** |
| **13:50** | **19** | **QUALITY AND PEOPLE** | | | |
| **13:50** | **19.1** | Patient Safety Event Report | **Paper** | **Review** | **CMO** |
| **14:00** | **20** | **ITEMS FOR APPROVAL/INFORMATION** | | | |
| **14:00** | **20.1** | Shared Services Business Case | **Paper** | **Approval** | **CSTO** |
| | **20.2** | New Hospitals Programme FBC B | **Paper** | **Ratification** | **CSTO** |
| | **20.3** | Wayfinding | **Paper** | **Approval** | **CSTO** |
| | **20.4** | Integrated Neighbourhood Teams Business Case | **Paper** | **Approval** | **DCH/ DHC CSTO** |
| | **20.5** | One Dorset Procurement Business Case | **Paper** | **Approval** | **CFO** |
| | **20.6** | Agency Staff and Locums | **Paper** | **Approval** | **CFO** |
| | **20.7** | Brachytherapy Applications | **Paper** | **Approval** | **CFO** |
| | **20.8** | Routine and Out of Hours Reporting | **Paper** | **Approval** | **CFO** |
| | **20.9** | Private Patients restructuring | **Paper** | **Approval** | **CFO** |
| | **21** | Any Other Business | **Verbal** | | **Chair** |
| | **22** | Reflections on the Board Meeting | **Verbal** | | **Chair** |
| | **23** | **Date and Time of Next Standing Board of Directors Part 2 Meeting:** Board of Directors Part 2 Meeting on Wednesday 5 March 2025 at 12:30. | | | |
| **14:30** | **24** | **Close** | **Verbal** | | **Chair** |

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

**Items for Next Standing Board Part 2 Agenda**

Standing Reports

- Trust Chair's Update
- Chief Executive's Update
- Escalations from Committee Chairs (not already covered in Part 1)
- Patient Safety Event Report

- Recommendation Reports

Annual Report

- Operational Budget (subject to national timeline)
- Draft annual report and accounts

**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

# 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 8 January 2025 at 9:30 via Microsoft Teams.

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| **Present:** | Rob Whiteman | Trust Chair *(Chair)* |
| | Beverley Bryant | Chief Digital Officer |
| | Judy Gillow | Non-Executive Director |
| | Siobhan Harrington | Chief Executive Officer |
| | Sarah Herbert | Chief Nursing Officer |
| | John Lelliott | Non-Executive Director |
| | Femi Macaulay | Non-Executive Director |
| | Helena McKeown | Non-Executive Director |
| | Mark Mould | Chief Operating Officer |
| | Pete Papworth | Chief Finance Officer |
| | Sharath Ranjan | Non-Executive Director |
| | Richard Renaut | Chief Strategy and Transformation Officer |
| | Tina Ricketts | Chief People Officer |
| | Cliff Shearman | Non-Executive Director |
| | Claire Whitaker | Non-Executive Director |
| | Peter Wilson | Chief Medical Officer |
| **In attendance:** | David Broadley | Medical Director, Integrated Care |
| | Stephanie Barnes | Senior Biomedical Scientist |
| | Colin Blebta | Public Governor |
| | Robert Bufton | Public Governor |
| | Sharon Collett | Public Governor |
| | Alahna Cullen | Clinical Specialist |
| | Andrew Doe | Associate Non-Executive Director |
| | Yasmin Dossabhoy | Associate Director of Corporate Governance *(minutes)* |
| | Cllr Bery Ezzard | Appointed Governor, Dorset Council |
| | Paul Hilliard | Appointed Governor, BCP Council |
| | Eiri Jones | Non-Executive Director, Dorset County Hospital |
| | Tracie Langley | Non-Executive Director appointee |
| | Diane Smelt | Public Governor |
| | Lorraine Tonge | Director of Midwifery |
| | Kani Trehorn | Public Governor |
| | Michele Whitehurst | Public Governor |
| | Klaudia Zwolinska | Corporate Governance Assistant |
| | 1 member of the public in attendance | |

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| **BoD 001/25** | **Welcome, Introductions, Apologies & Quorum**<br>Rob Whiteman welcomed everyone to the meeting, in particular Femi Macaulay, Non-Executive Director and Andrew Doe, Associate Non-Executive Director. Tracie Evans would also be joining the Trust as a Non-Executive Director, with onboarding processes being concluded upon which he would update the Council of Governors. Each of them introduced themselves. |

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| | In addition, he extended a welcome to colleagues from NHS England, Neil Cleaver and Kim Jones, who had been invited to observe the meeting.<br><br>Eiri Jones, Non-Executive Director from Dorset County Hospital (DCH) who would be observing Part 1 meetings of the Board was also warmly welcomed and introduced herself. Reciprocal arrangements were in place for Judy Gillow to observe Part 1 meetings of the DCH Board.<br><br>Apologies had been received from Alison Honour, Associate Non-Executive Director from Bournemouth University.<br><br>The meeting was declared quorate. |
| **BoD 002/25** | **Declarations of Interest**<br><br>Rob Whiteman reported that he had joined the Board of National Highways from 1 January 2025.<br><br>Femi Macaulay had reported that he had no interests to declare.<br><br>Andy Doe had made a general declaration by virtue of him having the following interests:<br><br>• Shareholder and director of Gizme Limited, a management consultancy business working with other NHS organisations and providers to the NHS<br>• Shareholder in CognitionHub.com Limited, a provider of AI consultancy and services which also seeks to do business with the NHS<br>• Trustee of the charity Wildscreen (charity number 200450)<br>• Non-Executive Director of Viridi Co2 Limited (company number 13063405).<br>He had also reported being in the process of being appointed as a Non-Executive Director of End Holdco UK Limited.<br>• Four other dormant company directorships: News Telemedia Europe Limited, Make IT Plan Limited, Sports Port Limited and Tweetproof Limited.<br><br>Helena McKeown declared that with effect from 6 January 2025 she had become lead appraiser for clinicalpartners.co.uk, a provider of mental health services. She did not consider this to be a conflict but would remind the Board if it became relevant.<br><br>Rob Whiteman referenced that as a system, work had been commissioned from Newton and reminded the Board that he gave strategic advice to their local government practice but not their health practice.<br><br>Subject to this, no existing interests in the matters to be considered were declared. In addition, no further interests were declared. |
| **BoD 003/25** | **Patient Story: David**<br><br>Sarah Herbert introduced the Patient Story, thanking David for attending the meeting to share his story about his experience at the Trust. David had suffered a stroke while a patient at the Trust, following on from which he had a number of complex health concerns. He was accompanied by Alahna Cullen, a stroke rehabilitation practitioner at the Trust who was supportive of the service provided to David to enable him to get home at pace. The story was representative of the patient centred approach being promoted within the organisation, getting patients home sooner and with a better quality of life. |

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| | Introducing the context, Alahna Cullen outlined that she had been involved in a project during the past year funded by NHS England related to stroke quality in rehabilitation. A small team had been established to focus upon rehabilitating patients at home rather than in an in-patient setting. There had been wide national provision to provide an early supported discharge for stroke; however, historically this had been for patients with fairly mild to moderate strokes. Patients recovered better at home. Through the project the team had wanted to consider expansion of the provision to enable patients who had suffered more severe strokes to receive some of their rehabilitation at home.<br><br>David outlined his background in middle to upper management and he had run his own businesses. He recognised the costing of hospital beds and had planned to complete a doctorate on the human side of enterprise. He referenced some of the health issues he had faced: he had been unable to squeeze toothpaste, unable to sit up in bed, unable to wash himself, had a catheter, a stoma bag and renal failure. When in hospital he had wanted to go home: he and the team had a shared objective for him to get home as soon as appropriately possible. This had been achieved. The team had given him the confidence to return home. He had not expected the service that he received. Within the team's remit had been to visit him within a care home. They visited up to four times a week, with him being taught and progressing to be able to sit up, stand up, walk, get in a wheelchair and get himself mobile. On one occasion, one of the team gave him a walking stick, developing his confidence from there to walk with this. The NHS had saved his life, the team gave him added quality of life.<br><br>He summarised that the team helped him to set goals, which were jointly established and progressed. He had set the goal of coming home and with their help identified how to undertake fundamental daily tasks such as getting to his bedroom and how to sit up there. David shared the mental and emotional challenges he had encountered during this journey. The team identified his mental health support needs and positive support had been arranged. He commented upon the importance of both the physical and mental care.<br><br>Referencing the financial implications of patients remaining within the hospital, David articulated the savings that must have been achieved of a hospital bed not remaining occupied by the rehabilitation being provided in a suitable different setting. He re-emphasised that the progress he had made and quality of life given to him so quickly through the service had been "phenomenal". He was a member of the Heart Club and now exercised there two to three times each week.<br><br>Siobhan Harrington thanked David and also Alahna Cullen. It made her very proud of everything done at the Trust. Noting that David had been full of praise for his journey, she asked what could be even better. He said that he could not think of any improvements for physiotherapy or occupational therapy. However, his experience in relation to his stoma had been different from that with the stroke rehabilitation team. The stoma team had been overrun and his experience had been that it had been short of nurses. Following him having been discharged, there had not been many follow ups and he had to take the initiative to make contact with them. This had slowed his progress by flushing electrolytes and having to have monthly magnesium infusions. As a result, reversal was being considered in the next quarter. Responding to the same question posed by Siobhan Harrington, Alahna Cullen commented that she would like to deliver this service to more patients, with there being potential to expand it further if capacity were extended. Acknowledging this, |

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| | Siobhan Harrington agreed that this was part of the future: seeking to create the resource in the correct part of the system, which was continuing to be worked through.<br><br>As a Non-Executive Director with a clinical background, Judy Gillow thanked David for sharing his experience and asked whether there was anything relating to communication with him during his months within the hospital that could have been improved. It was important to the Board that the Trust continued to learn and to get things right for patients. In response to this, David explained that he had felt somewhat isolated. There had been vagueness about when he could go home and the process for that. He also provided feedback on his experience of the inter-connectivity between services. Currently when he was between cardiology, AMU and stoma and gave the example of food for stoma conflicting with that for the heart. There were conflicts that did not appear to have a joined up approach.<br><br>Also extending his thanks to David, Pete Papworth referred to David's earlier comments about the financial aspects. There would be some difficult conversations in the Board seminar taking place later that day in relation to the operational planning for the coming financial year. However, when the Trust focused on the quality of care and the experience in the organisation, the money followed.<br><br>Concluding, Sarah Herbert reiterated thanks to David, Alahna Cullen and the team. Providing a patient centred approach was very important. There was work within the Dorset provider collaborative about providing parity across stroke services to support people to get home.<br><br>The Board NOTED the Patient Story. |
| **BoD 004/25** | **Update from the Council of Governors**<br><br>Michele Whitehurst, Lead Governor presented the Update from the Council of Governors, including:<br><br>• She expressed thanks for the hard work of the staff and Board of the Trust throughout 2024. Notwithstanding the challenges, the Trust had made significant strides in improving patient care and operational efficiency.<br>• The Council of Governors appreciated the Board's commitment to transparency and collaboration.<br>• She reported that during the past year, the Council of Governors had engaged with members and the wider community extensively. The Council continued to promote Governors' availability to speak with groups about ongoing transformation changes at the Trust.<br>• Showcasing some of the Council's work in 2024, she referenced the successful listening event in Saxon Square, Christchurch. Steve Dickens had received recognition for his presentation at the Ferndown Probus club, with an invitation to present at the Ringwood Veterans Hub. Governors had also attended the Freshers Fair at Bournemouth University Talbot Campus, with significant interest from students in the Trust and the NHS. They had also visited Lansdowne Campus with an information stand and had appreciated the opportunity to address 100 nursing students at the start of the lecture session. Other events had included at the Allendale Centre in Wimborne, a listening event at the Gather in the Dolphin Centre and Asda at Castlepoint. The final public engagement event of the year had been in the Atrium at Royal Bournemouth Hospital where festive cheer and music had been enjoyed by all. |

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| | • Key themes from engagement events had included a sense of apprehension and excitement. Expressions of immense gratitude for the care received and recognition of the hard work and challenges faced by staff were consistent. Questions received included when the new buildings would open, the availability of car parking, which hospital site to attend in future, the availability of workforce for the size of the hospital, ability to attend the urgent treatment centre at Bournemouth hospital when the Emergency Department opened.<br>• Members of the public were consistently pleased to see Governors and grateful for their views being heard.<br>• She had recently shared insight and best practices with Governors from another trust.<br>• The recent Governor training and development session had highlighted a shared warmth, purpose and responsibility among members of the Council.<br>• She outlined the focus upon Staff Governors and exploring ways to expand their visibility within the Trust. Elections for members of the Council of Governors would be taking place during 2025.<br>• The Council of Governors were keen to attend face to face meetings with Board members. Governors observed Board Committees and were keen to participate in key projects to help effectively represent the interests of members and the public.<br><br>Rob Whiteman expressed thanks for the update and commented that in the calendar for 2025, there were more face to face meetings, with the feedback about this having been appreciated. A meeting of the Council of Governors would be taking place the following day.<br><br>The Board NOTED the Update from the Council of Governors |
| **BoD 005/25** | **For Accuracy and to Agree: Minutes of the Board of Directors Meeting held on 6 November 2024**<br><br>Rob Whiteman reported that there had been two comments received on the minutes. The first amendment was the inclusion of "HRH" before Princess Anne; the second identified by the Company Secretary Team had been a typo on page 13 with "ration" instead of "ratio" shown.<br><br>Subject to this, the minutes of the Part 1 meeting of the Board of Directors held on 6 November 2024 were APPROVED as an accurate record. |
| **BoD 006/25** | **Matters Arising – Action List**<br><br>*BoD203/24 – Transition arrangements between paediatric and adult care* – An update was included in the meeting materials. Action CLOSED. |
| **BoD 007/25** | **Trust Chair's Update**<br><br>Rob Whiteman presented his Trust Chair's Update:<br>• It was a busy time across the National Health Service. Being a curious Board, there would likely be a number of questions. However, he expressed thanks to Siobhan Harrington, the Executive Team and all staff for their work. Overall, commendable progress was being made.<br>• Jenny Douglas-Todd would be standing down as Chair of NHS Dorset from the end of March 2025 and would be taking up another role. Thanks were extended to her for being an outstanding ICB Chair and the way she had led during her tenure.<br>• Work continued to progress with the provider collaborative. He, Siobhan Harrington and the Chair and Chief Executive Officer of DCH/Dorset HealthCare (DHC) had been meeting to ensure |

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| | productivity improvement. The Board had requested that effort continued to be made to ensure the pace within the collaborative accelerated in the coming year.<br>• While the Board received a number of papers, it was good for Non-Executive Directors to meet patients and the community. This was important for triangulation. Visits that had taken place since the last meeting of the Board in public had included pre-operative medicine at Poole hospital, cardiology at Bournemouth hospital, clinical research centre at Bournemouth hospital, clinical coding at Poole hospital, main outpatients at Bournemouth hospital, falls prevention at Poole hospital, charity team at Poole hospital and catering at Bournemouth hospital.<br>• Matt Prosser would be moving on from Dorset Council, with thanks being extended to him for his collaborative working.<br><br>The Board NOTED the Trust Chair's Update. |
| **BoD 008/25** | **Chief Executive Officer's Report**<br>Presenting her report, Siobhan Harrington reiterated her thanks to staff, with there having been sustained pressure on urgent and emergency pathways over a number of weeks. She added that:<br>• It had been challenging but compared to previous years, flow was slightly better within the Trust. On Christmas Day, Sarah Herbert had been at Bournemouth hospital and she had been at Poole. They had observed a sense of focus on patient safety and people looking after each other in the organisation. This would continue to be the focus through the winter. Work with all system partners to improve flow and reduce pressure on the Emergency Departments (EDs) could be seen in the reports.<br>• The Trust had been impacted more than planned by the impact of certain infections: there had been more instances of flu among patients and staff. Encouragement continued to be given about having vaccinations. The Board would have a hand washing session, with the basics of nursing care being fundamental.<br>• There were opportunities at the Trust to transform and improve services for patients and staff.<br>• The detail of the national news related to Reforming Elective Care for Patients continued to be considered and would be presented to a Board meeting in future.<br>• Sarah Macklin had taken a two-year commitment at the provider collaborative and would be coming back with a clear strategy and reset for the provider collaborative. This would be important for future work across Dorset.<br>• Although the Trust had a break even plan, the system position was challenged with a deficit of £25m.<br>• She referenced the celebrations of St Mary's currently ongoing, with it having contributed to Poole and the broader area over many years.<br>• Data from the embargoed staff survey results had been received and being analysed. The results would be presented to the Board once the embargo had been lifted. It was important to listen to staff at every opportunity. She asked that Non-Executive Directors encourage staff when visiting services to complete the Pulse survey in January 2025.<br>• While there had been improvement in 65 weeks waits, she recognised that it was not acceptable for patients to be in corridors or to be waiting for extended periods of time. The team were driven to improve this across the Trust and the Dorset system. |

- The COAST building had been erected within six weeks. It was a critical path to the transformation, ambitious but with tight timescales.
- Referencing the traffic issues at Royal Bournemouth Hospital, she explained that some had been within and others outside of the Trust's control. Work with partners was ongoing about the opening of the second road into the Bournemouth site.

Commenting on the extent of change in the current year, Rob Whiteman asked Siobhan Harrington about the capability and resources to deliver the change as well as appropriate risk management strategies being in place. Responding to this, she commended the Executive team, noting the responsibility for public money and working in a system with a financial challenge. It was important to work in the most effective way. A number of people were working on the transformation - a challenge going forward would be reviewing the transformation and change support being in the right place. The Executive team were mapping out the work needed to be completed over the coming 18 months. It would be important to continue to challenge each other about working in the right ways: support throughout this time would be needed at local ICB system, regional and national level. The Executive team was focused on implementing the changes safely. The Trust's risk management systems were being reviewed for improvement. Other organisations who had experienced considerable change had been contacted, with the Trust keen to learn from others. Reflecting on the focus of the Board agenda, she commented upon it covering strategy, culture and performance, these being part of keeping the Trust safe for the remainder of the year. Adding to this, Pete Papworth highlighted the need as well for ongoing focus upon efficiency savings and productivity. Richard Renaut referenced the Transforming Care Together Group overseeing internal changes, with an external Group led by the system focused on partner alignments.

Helena McKeown enquired whether the Trust had sufficient focus upon prevention, reducing demand on healthcare in the future and as an anchor institution for its own staff. Answering this, Siobhan Harrington stated that more could always be done. The People Strategy later on the agenda would give an opportunity to review this. However, it would also be important to prioritise the Trust's focus as part of the Patient First improvement methodology. This methodology had helped the Trust to be more focused upon a smaller number of priorities.

Femi Macaulay applauded the significant work as part of the consultation on the 10 year plan, enquiring how this was progressing. He also asked how well the Trust's strategic plan and priorities matched the three shifts. Thanking him for this question, Siobhan Harrington outlined that this work was being carried out through the planning round. The Trust would be well placed going through the changes – the three shifts aligning with what the Trust needed to do as an organisation. It was in an exciting place to be in a significantly better position for the later stages of the 10 year plan. The upcoming two to three years would be focused on the transformation – physical, digital and cultural. Adding to this, Richard Renaut referenced the 5 to 10 year clinical strategy, being built bottom up at speciality level. He also commented upon the announcement in relation to elective recovery and the national strategy to move care closer to neighbourhoods: the Trust was well positioned with endoscopy and the outpatients service at the Dolphin Centre was a national exemplar, which the Trust was seeking to improve for the future. From a digital perspective, Beverley Bryant outlined the ambition to proceed with the digital transformation but with a need to ensure the sequencing was correct and stepped through safely.

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| | The Board NOTED the Chief Executive Officer's Report. |
| **BoD 009/25** | **Integrated Performance Report**<br>Rob Whiteman introduced the Integrated Performance Report (IPR), inviting Mark Mould, Peter Wilson and Sarah Herbert to present first.<br>Mark Mould reminded the Board that:<br>• The Trust's priority continued to be patient safety, this being the focus through the winter period. The organisation was highly busy, with some days being challenging. However, this was similar nationally, regionally and locally across the NHS. He was aware that as at 45 minutes prior, 12 organisations had declared a critical incident.. The Trust was not in critical incident but was in business continuity and had been for 10 days. A clear definition existed for this, which was different from critical incident. He explained that business continuity was where the Trust put in special arrangements over and above the winter plan because the level of service it was able to provide was not available. Measures that had been implemented during its business continuity were:<br>o Additional escalation capacity. The difficult decision had been made to slow elective work to provide more capacity for emergencies.<br>o There was additional senior support, with Executive Directors leading the site meetings and being part of the day to day operations. 52 weeks each year, the Director on call chaired the meeting in the morning, at lunchtime and at the weekends.<br>o Additional medical support had been put in ED.<br>Distinguishing this, he explained that a critical incident was an incident where temporarily or permanently there was a loss of the ability to deliver critical services, such that the ED could not receive patients, the critical care department did not have capacity, there was not a plan to be able to de-escalate critical care capacity and theatres were not able to operate. He relayed that he was the Director on call Monday, Tuesday, Wednesday and Thursday that week. He had been coming in to a position where it had been busy, wait times to be seen in both EDs was less than 3 ½ hours, there were 30 patients in each department - which was very good - and only two people waiting but cared for well in non-clinical areas, with them quickly being moved out of such areas. Nobody was waiting in ambulances.<br>The pressures were being driven by:<br>o It being winter. As usual for the time of year, the Trust had a winter plan.<br>o There was the additionality of winter flu and respiratory illness. This brought the challenge of testing at the front door, with an impact upon flow. It impacted upon infection prevention control (IPC) and cleaning of spaces to safely accommodate patients into the capacity. It also impacted upon sickness of staff.<br>He provided an example of the agility of the Trust: a point of care test was being tested that day, providing additional resilience against the capacity in the laboratories.<br>o Pressures on discharging patients. Usually, going into Christmas there were 220 beds across both sites; however, there had been circa 80 beds available to move through the winter period. |

Going through the winter period, length of stay had been 0.6 different than the same period in the previous year, giving more capacity.

At the same time last year, there had 100 plus beds in escalation open. Currently, there were 20 beds open, with 10 beds being day case open overnight. This was a significant improvement.

Virtual ward capacity at the same time last year had been no more to 40-50; there were now routinely 70 plus patients on the virtual ward. He thanked DHC noting the pathway 2 patients in complex discharge who had experienced care through community hospitals.

- He was proud of what the teams had achieved, while also recognising that the Trust was not where it wanted to be with people delayed in the ED. The Trust was in a better position than last year.

Referencing no criteria to reside (NCtR) as an area of ongoing focus and also the NHS Dorset minutes of 5 September 2024 noting a meeting with BCP Council, John Lelliott asked whether the pressures during the Christmas period had helped or hindered NCtR and about the benefits from the Newton work. Responding to this, Mark Mould reported that as at that day, there were 197 patients ready to be discharged. Through the winter plan agreed as part of the system, it had been anticipated that the Trust would be 47 better than the current position. The avoiding admissions workstream would commence the following day, with there being four other workstreams. A trajectory and plan were in place for the coming 12 months.

Also commending the achievements, Judy Gillow asked whether the escalation beds that were open were in the plan or if they would have to be funded additionally and impact upon the year end position. Mark Mould confirmed that they were not currently in the plan. Once safe to do so, the Trust would de-escalate out from that, commencing with same day emergency care (SDEC) being back up and running.

Continuing, Mark Mould:

- Highlighted that the IPR related to November 2024, but during both November and December, activity expected to be delivered had been maintained.
- The number of patients waiting over 65 weeks was 16, predominantly due to corneal grafts and mesh, with this having been maintained in December 2024.
- Reductions in patients waiting over 52 weeks was expected to continue in December 2024.

Sarah Herbert presented highlights from the Quality, Safety and Patient Experience reporting that:

- Some of the impact of the improvements in place was starting to be seen. Considerable work had been undertaken with the implementation and embedding of the Purpose-T tool. Pressure ulcers were starting to reduce, with continued focus to upskill staff. PSIRF was also feeding into this, with a deep dive of thematic understanding progressing.
- The falls team, whom Judy Gillow had visited, were providing impressive data. This had been presented to the Clinical Leaders Group. Improvements were being seen in the older patients' assessment areas who were developing prevention approaches in conjunction with their PSIRF work.

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| | • IPCs were holding or reducing, showing improvements in fundamental approaches to infection prevention. However, there was a mindfulness that hand hygiene and bare below the elbows was regarded as an area of improvement. While the data showed hand hygiene compliance of 89%, this was not always the case when covert monitoring had been carried out. Focused work in the area had been undertaken and was continuing with improvement in practice. Flu was at a peak nationally - within the Trust it had been relatively consistent during the past two to three weeks, with it being controlled, managed and contained well.<br>• Long-outstanding complaints had taken the average wait time up. However, response rates were generally much quicker. Complaints were being addressed at a PALS level, with early resolution.<br><br>Peter Wilson presented the Mortality reporting from the IPR.<br><br>Applauding the overall performance, including maintenance of the position on fractured neck of femur, he asked about room for improvement on flow. Peter Wilson confirmed that there was further work to do, including a refocusing of efforts on criteria led discharge. Having SDECs operating seven days a week would be key but it was important to approach these efforts sequentially.<br><br>Judy Gillow reinforced and supported the importance of IPC and the basics being right. In parts of the organisation, there had been a relaxation in adhering to these essential practices. She commented that Board members were role models and needed to follow the guidelines when conducting service visits. Following on from this, there was discussion about cultural aspects, including having a multi-professional approach to empowering staff to have a voice, support staff and raise appropriate challenge.<br><br>Andrew Doe introduced questions he had in relation to digital:<br>• Noting the shift in sending text reminders from three and 10 days to four and 14 days was referenced in the materials, he asked whether this had been AB tested before the change being made or whether there was another best practice source.<br>• There was a reference to 55.4% communications by digital letter; the target and actions being taken to increase it were unclear.<br>• 17.4% telemedicine versus 25% target did not appear to be changing. He enquired about the action plan to get this on track.<br>• Further detail about the booking process issues would be beneficial.<br>• He asked about the plan to expand virtual wards.<br><br>Beverley Bryant explained that she had inherited the IPR scorecard for digital, which was in the process of being refreshed to make it more meaningful. Summarising, she confirmed that the position on the technical infrastructure was encouraging and safe. She would work with Andrew Doe on how the IPR could be made more meaningful and linked to the business objectives. Adding to this, Mark Mould thanked Andrew Doe for the questions, referencing that as an Executive team, the decision had been made to move outpatients into the corporate team. Greater effort, resource, capacity and capability was needed into outpatients. In relation to the question about text messaging, considerable work had been undertaken on data mining to work through five or six key interventions to significantly improve contact with patients and ability to fill the slots. The Trust had a strong evidence base for the change rationale. He also explained the context behind the commissioning for the virtual ward capacity and plans to increase such capacity as well as the challenges. |

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| | Siobhan Harrington commented upon the importance of the digital conversation, with there being large-scale changes specifically related to outpatients.<br>In relation to AB testing, Beverley Bryant proposed discussing with Andrew Doe the current levels of digital maturity within the Trust and target state.<br>In relation to the move from 61% to 72% in one year on the four hour organisational standard, Femi Macaulay commented upon the significant improvement and enquired about its sustainability. Responding, Mark Mould explained that only actions that were sustainable had been undertaken to support embedding into day to day working. The Trust could do better and the aim was for 78% in March 2025, but it would be challenging. Adding to this, Peter Wilson outlined that the organisation had not had the four hour standard for a number of years; consequently there had been cultural issues during the past year to be addressed upon which Mark Mould in particular had delivered.<br>Pete Papworth presented the Finance aspects, adding that:<br>• Following confirmation of the forecast adverse variance of £25m across the system, the system had been placed in Tier 4 and there were ongoing discussions about the additional support or intervention that may be required recognising the work already in progress.<br>• As part of the revised forecast outturn, the Trust had agreed to go further than the original Board approved financial plan, with a planned contribution of an additional £6.7m to the system financial recovery. While on trajectory, the plan was challenging and volatile.<br>• The response on the capital slippage reprofiling requests remained pending. If an outcome had not been not received by the following week, he would escalate to the regional chief finance officer; the Trust did not have a plan to mitigate that scale of slippage.<br>Tina Ricketts presented the Workforce aspects adding:<br>• There had been challenges achieving the workforce plan in the current year. A target had originally been set of 347 whole time equivalent reduction, which had been stretched to 397. The Trust had been on plan for the first five months but had been off plan for the past three months, predominantly driven by improved recruitment in the domestic marketplace and an increase in staff being utilised for escalation areas. Additional controls had been put in place with every post being scrutinised. A live Mutually Agreed Resignation Scheme was also live.<br>Rob Whiteman asked what the likely workforce year end position would be, with Tina Ricketts confirming that the Trust was likely to be off plan because of the unplanned use of staff escalation and specialing.<br>Adding to this, Siobhan Harrington commented on the risk with amounts missed in the current year being added to the future year figures, exacerbating the challenge, while also reiterating the importance of the focus upon safety.<br>The Board NOTED the Integrated Performance Report. |
| **BoD 010/25** | **Quality Committee – Chair's Report – November and December 2024**<br>Cliff Shearman presented the Quality Committee – Chair's Report for November and December 2024. Adding to the report, he referenced that:<br>• There had been a change in the work of the Committee. As Patient First had influenced how work was being done, the change in the care being delivered to patients was being seen. Reports from the teams were being seen to cover not only data from retrospective collection but also actions being taken to improve outcomes for patients. |

- Considerable evidence and experience had been seen of how PSIRF was being used, the benefits it was bringing and the preparation and work being put into it. The Committee had been assured about how this was working.
- The Committee had moved to all of its meetings to now being face to face.
- Ophthalmology services had been on the risk register for some time, particularly the treatment of macular degeneration. The team had presented to the Committee on the challenges being faced, the work currently being undertaken and planned. It had been a powerful presentation to receive, similar to the previous presentation given in relation to fractured neck of femur. This provided considerable reassurance and understanding of the mitigations on the risk register.
- The Maternity Safety Champions Report had been discussed in detail, this being an area of significant focus on the Committee agenda. Tremendous changes for the better had been coming through the reports.
- The Maternity Incentive Scheme had been considered with depth, including the report from BDO, with the Committee having been assured by what it had received.
- There had been a marked improvement in the response time for complaints.

<u>Maternity Incentive Scheme</u>

Inviting Lorraine Tonge to present the Maternity Incentive Scheme (MIS), Rob Whiteman noted that the Quality Committee had endorsed it with a recommendation to the Board to approve signature by the Chief Executive Officer prior to submission to NHS Resolution.

Lorraine Tonge presented the report, highlighting that:

- The report had been prepared in December 2024. Since then, there had been further additions to the evidence bundle.
- The evidence bundle had been reviewed by BDO and NHS Dorset to give assurance that the evidence, should it be required by NHS Resolution, was sufficient and above to demonstrate compliance with all 10 safety standards.
- In the previous year, the Trust had not achieved MIS for three areas: training, medical workforce and the Saving Babies Lives bundle. She thanked the Safety Champions, Peter Wilson, Judy Gillow and Sarah Herbert for their support in making the changes to achieve the safety actions.
- MIS was continuous; ongoing monitoring of compliance and safety standards would be undertaken throughout the year. This would take place in the Oversight and Assurance Group, led from the Strategy Deployment Reviews and Patient First methodology. This took place monthly with Siobhan Harrington and the Executive Team. Good governance and processes were in place for continuous improvement. This would be particularly important with the move in 2025 to the new building, with safety remaining the priority.

Sarah Herbert offered congratulations to Lorraine Tonge and the Maternity Team, which were also echoed by Pete Papworth and who noted the financial incentive associated with the achievement.

The Board NOTED the Quality Committee – Chair's Report – November and December 2024.

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| | Having considered the evidence provided and the requirements of the Year 6 Board Declaration Form, the Board APPROVED the Chief Executive Officer signing the Board Declaration Form and the submission to NHS Resolution. |
| **BoD 011/25** | **Finance and Performance Committee – Chair's Report – November and December 2024**<br>John Lelliott presented the Finance and Performance Committee – Chair's Report, reporting that:<br>• The Committee focused at all its meetings on the capital and revenue position and not only the Trust's own position but also that of the ICB, which impacted upon the Trust.<br>• The Committee had received a report on an alternative valuation which could impact on the year end financial position and accounts.<br>• Mark Mould had already updated earlier in the meeting on most aspects of the operational performance. In addition, an area of focus at the November and December 2024 meetings of the Committee had been the Sterile Services Department which had an impact on cost and capital.<br>• Another focus had been on IT and on the Electronic Patient Record.<br>• At the last meeting a sustainability deep dive had been conducted, with interest in the opportunity for geothermal.<br>The Board NOTED the Finance and Performance Committee – Chair's Report – November and December 2024. |
| **BoD 012/25** | **People and Culture Committee – Chair's Report – December 2024**<br>Sharath Ranjan presented the People and Culture Committee Chair's Report – December 2024, adding that:<br>• In relation to the Annual In-Patient Establishment Review, the recommendations had financial implications. Following the meeting, Sarah Herbert had highlighted some of these. From the report, the assurance received had been that the staffing was not deemed unsafe.<br><u>Guardian of Safe Working Hours</u><br>With the Guardian of Safe Working Hours not in attendance at the meeting, Peter Wilson presented the Guardian of Safe Working Hours Report<br><u>2024/25 Annual In-Patient Establishment Review</u><br>Sarah Herbert presented the 2024/25 Annual In-Patient Establishment Review, adding that:<br>• While this was a statutory report that needed to be presented to the Board annually, the data was considered twice a year by the Trust, going through a formal data collection process using the nationally recognised Shelford Safer Nursing Care Tool.<br>• The Trust's maturity in this area had grown, with ward leaders having been incorporated into the process as well as matrons.<br>• The Shelford Tool had changed since the previous year and she outlined key changes.<br>• Investment historically made into nursing had made a significant difference. Twice a day staffing across the organisation was reviewed by a senior matron. Safe staffing was continually reviewed to ensure its appropriateness across all clinical areas.<br>In addition, she explained the RAG rating at the end of the report.<br>In relation to the Guardian of Safe Working Hours report, Cliff Shearman referenced having asked previously about the escalation policy. Additionally, while noting the helpful In-Patient Establishment Review, he asked how safety was assessed as pressures mounted, particularly in the red areas. |

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| | Adding to this, Judy Gillow expressed concern about the red areas and enquired about the process of feeding back to the Board on whether or not they were funded and if not funded, the mitigations.<br>Peter Wilson confirmed that there were processes in place in retrospect where people had concerns on a shift. He commented on cultural elements of people speaking up in real time and proposed further discussion at the Quality Committee about escalation processes as part of daily business. From a nursing perspective, Sarah Herbert gave assurance that on a daily basis there was regular review and scrutiny of staffing together with clear lines of sight from matrons, who conducted walkarounds. A red flag system was used, into which each of the clinical areas fed twice a day. Where there was red flagging, specific details of the concerns were available. In addition to referencing the twice daily staffing meeting led by a senior matron, she reported upon the corporate nursing team's attendance to have oversight of acuity across the organisation and action taken where needed. Data would continue to be reviewed on a monthly basis – including but not only care hours per day. Discussions in relation to the red areas would be integral to budget discussions about safety and prioritisation.<br>Adding to this, Pete Papworth reported upon the decisions related to investment being brought back to the Board as part of budget setting. He also outlined the budget held by the Care Groups and the Board decision made in the previous year to invest £6.6m into nursing templates. The opportunity of the moves to consider different ways of working was also noted.<br>The Board NOTED:<br>• The People and Culture Committee – Chair's Report – December 2024;<br>• The Guardian of Safe Working Hours Report; and<br>• The 2024/25 Annual In-Patient Establishment Review. |
| **BoD 013/25** | **Transforming Care Together – Chair's Report – December 2024**<br>Rob Whiteman presented the Transforming Care Together – Chair's Report – December 2024 reporting:<br>• The meeting held in December 2024 had covered, as usual, Build Ready, Service Ready and People Ready.<br>• There had been deep dives on engagement, seven day working and workforce planning.<br>Adding to this, John Lelliott summarised that:<br>• Office accommodation had been noted as an issue as well as financial pressures.<br>• Further assurance had been required in relation to the IT systems and infrastructure. Beverley Bryant had been asked to provide an IT ready report.<br>Claire Whitaker proposed that there be discussion about flexibility of staff moves as part of the People & Culture Strategy item.<br>The Board NOTED the Transforming Care Together – Chair's Report – December 2025. |
| **BoD 014/25** | **People & Culture Strategy**<br>Tina Ricketts presented the People & Culture Strategy, which had been discussed at the People & Culture Committee where it had been endorsed with a recommendation to the Board to approve.<br>Claire Whitaker noted the glass ceiling for global majority colleagues which Tina Ricketts had highlighted but also raised the absence of a set percentage of personal development plans required to be completed for them. |

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| | Responding to this, Tina Ricketts outlined that personal development plans were part of appraisal. She reported that she was currently awaiting the validated data of percentage complete. The talent management of global majority was being prioritised in the first 18 months of the Strategy, with leadership programmes established to support progression. She also outlined the plans in relation to recruitment.<br><br>Adding to this, Sarah Herbert commented upon the high proportion of the global majority being within the nursing workforce. She was becoming the Executive Lead for the DEN network. The Internationally Educated Nurses Network would also be re-established to provide support to address career progression needs.<br><br>Agreeing that further positive action was needed, Siobhan Harrington welcomed the comments but added that it was important to consider the metrics. She invited Tina Ricketts to outline the approach she had taken to construct the Strategy linked to the Patient First methodology. This had included a reduction in meetings by 60% and a reduction from 222 projects to 19 programmes, with clear lines of accountability.<br><br>Commending the document, Helena McKeown referenced the staff absences in the IPR. She commented upon the opportunities to consider cultural needs as well as access to health and wellbeing needs.<br><br>Echoing the very positive feedback in relation to the Strategy, Judy Gillow raised whether the percentage of middle managers being taken through leadership training within 18 months was sufficiently high. Tina Ricketts explained that this had been limited by the resources available.<br><br>In relation to digital skills, Andrew Doe commented that within the timeframe of the Strategy, digital skills would become increasingly important. He enquired about thinking in relation to this, with Tina Ricketts proposing that this be captured within the Digital Strategy and confirmed that she had been working with Beverley Bryant on how to take that forward.<br><br>Sharath Ranjan raised an observation in relation to proactivity rather than waiting for statutory requirements, citing ethnicity pay gap reporting. Agreeing with this principle, Tina Ricketts proposed that this be discussed further at a future Board Development Session.<br><br>In response to a question from Femi Macaulay about staff engagement and morale between the Trust sites, Tina Ricketts commented on the heatmap she had developed and the triangulation of relevant data. Targeted interventions were implemented where it was known that cultural change or leadership enhancement was needed. She also outlined the positive benchmarking from previous staff surveys in relation to staff engagement and recommending the Trust as a place to work. Sarah Herbert commented upon the variability depending upon the pressures within the organisation. She and Siobhan Harrington emphasised the importance of engaging, listening and creating an improvement culture.<br><br>The Board APPROVED the People & Culture Strategy. |
| **BoD 015/25** | **Annual Equality Diversity and Inclusion Report**<br><br>Tina Ricketts presented the Annual Equality Diversity and Inclusion Report. A user-friendly version would be developed. While some improvement had been shown, there was more work to do, through the People & Culture Strategy.<br><br>Commenting upon her passion for this work, Claire Whitaker noted that there was no reference to the Trust playing a civic role of getting a broader anti-racism message into the community, with it being focused upon the internal culture. Siobhan Harrington considered that there was an opportunity across |

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| | the system and more that could be done but referencing also prioritisation; she would take this forward within the system conversations. In this context, Helena McKeown commented upon the anchor institution role of the Population Health and System Committee and the ICB's Prevention, Equity and Outcomes Committee that she attended.<br>The Board APPROVED the Annual Equality, Diversity and Inclusion report for publication. |
| **BoD 016/25** | **Risk Register**<br>Sarah Herbert presented the Risk Register highlighting the total number of risks and those which were new. While there was regular review at a local level and at Board Committees, a more robust stance was needed at times, particularly in relation to risk appetite and risk tolerance.<br>An Audit Committee Development Session would be taking place the following week, which would include focus upon this.<br>Judy Gillow referenced the six risks that had exceeded the risk tolerance. It would be beneficial to have comment in the Risk Register report about this, with an opportunity for more robustness in risk discussions going forward. Sarah Herbert confirmed that she and Jo Sims had commenced work on how to give the Board better assurance.<br>The Board NOTED the Risk Register. |
| **BoD 017/25** | **Any Other Business**<br>Rob Whiteman requested that the Board approve the following Committee membership:<br>• Femi Macaulay to become a member of the People & Culture Committee, Quality Committee and Appointments & Remuneration Committee.<br>• Following satisfactory completion of her onboarding, Tracie Langley to become a member of the Finance & Performance Committee, Audit Committee and Appointments & Remuneration Committee.<br>In addition, Andrew Doe joining Finance & Performance Committee and Population Health & System Committee.<br>The Board APPROVED the Committee membership and the Terms of Reference of the Committees being updated accordingly. |
| **BoD 018/24** | **Questions from the Council of Governors and Public arising from the agenda**<br>A question had been received from Jerry Scrivens, Public Governor:<br>*I notice from Staff Bulletins that masks are required to be worn in a number of circumstances due to the significant rise in flu admissions.*<br>*However, there is no requirement on staff to have vaccinations for flu, Covid or RSV. From the meeting papers, I note that only 20% of staff have been vaccinated for both flu and Covid.*<br>*Surely if staff can be instructed to wear masks, they can be instructed to be vaccinated. It seems inconceivable that 100% of medical staff caring for vulnerable patients are not vaccinated unless there are health or religious grounds. Please explain why frontline staff are not instructed to be vaccinated.*<br>Answering this question, Tina Ricketts explained that vaccinations for colleagues could not be mandated. There had been Vaccination as a Condition of Deployment regulations in place in 2022 but these had been revoked by the Government at the time because of the response from trade unions and other representative organisations and that it should be personal choice. She confirmed that the Trust was compliant with national NHS |

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| | England guidance. The Trust ensured that it made vaccinations available, that people were informed about the vaccinations, it had peer champions and peer vaccinators in all areas. Regular communication was provided about the importance of individuals protecting themselves and patients.<br>Rob Whiteman enquired how the Trust benchmarked against other organisations. Responding to this, she outlined that most trusts were now finding the take up of vaccinations challenging. There had been a decrease in uptake of both Covid and flu vaccinations in recent years. There was potentially further work to be carried out internally to promote it. Sarah Herbert outlined the national data and regional data which had been considered, with the Trust being within normal standards for flu vaccination rates. There had been an increase in uptake since Christmas, with vaccines continuing to be offered on a regular basis.<br>Thanking Jerry Scrivens for the question, Rob Whiteman offered to discuss it further at the Council of Governors meeting the following day. |
| **BoD 019/25** | **Reflections on the Board Meeting**<br>Rob Whiteman commented that it had been a positive meeting with a good IPR, balance of asking appropriate questions while recognising overall improvement. The following year would be critical and it had been reassuring to hear plans for the budget.<br>He commented on the positive blend between strategy and operational questions. |
| **BoD 020/25** | **Resolution Regarding Press, Public and Others**<br>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.<br>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 5 March 2025 at 12:30 via Microsoft Teams.** |

**MARCH 2025 TRUST BOARD**
**CHIEF EXECUTIVE UPDATE**

## 1 INTRODUCTION

Thank you to all our teams who continue to look after our patients and are focused on reducing waiting times whether on our emergency pathways or planned care pathways. Alongside this we are excited to inform everyone that the BEACH building has now been handed over to us; staff are now using the space to orientate themselves and test out our pathways before services start to move in.

March always represents the beginning of spring; longer brighter Dorset days. Daffodils always signify this time of year to me and we've arranged for some daffodils to be shared with staff in the first week of the month to bring spring into UHD.

We underwent a CQC unannounced Inspection of Surgical Services on 28 & 29 January where patient pathways from our Emergency Departments through to wards, theatres and discharge lounges were followed. We recently received initial high-level feedback from the inspectors (letter attached). There were some areas identified for improvement and we will be working through those issues over the coming period. The verbal feedback to myself and Sarah Herbert, our Chief Nursing Officer, highlighted these areas but also described some great patient and staff feedback. I'd like to thank all our teams for their support of the inspectors and in providing the data and information that supports these visits.

International Women's Day is on 8 March and again UHD's Women's Network is arranging activities to celebrate women with sessions on both of our main hospital sites on 6 March. 77% of staff in the NHS are women. I would encourage everyone to celebrate the women in UHD, staff and patients, and also the women in their lives. March also hosts National No Smoking Day which will coincide with UHD going smokefree on 12 March. We have ensured that staff and patients have access to ongoing support around this change in policy.

### 1.1 Planning Guidance for 2025-26

On 30 January, NHS England published the 2025/26 Priorities and Operational Planning Guidance, together with the detailed financial allocations for each Integrated Care System.

This confirms the national priorities for 2025/26 which are:

- Reduce the time people wait for elective care.
- Improve A&E waiting times and ambulance response times.
- Improve patients' access to general practice and improve access to urgent dental care.
- Improve patient flow through mental health crisis and acute pathways and improve access to children and young people's mental health services.

In delivering the national priorities systems are expected to:

- Drive the reform that will support delivery of the immediate priorities and ensure the NHS is fit for the future.
- Live within the budget allocated, reducing waste and improving productivity.
- Maintain collective focus on the overall quality and safety of services.

Dorset Integrated Care Board (ICB) has received allocations with a headline uplift/growth of 4.37% and has a deficit control total of £13.9 million.

Detailed planning is underway both internally and across the Dorset ICS.

### 1.2 Experience of Care Improvement Framework

On 18 February 2025, NHS England published the Experience of Care Improvement Framework. This can be used by trusts as a tool to improve outcomes and experiences. A review is currently underway of the Trust's current Experience of Care strategy and we will ensure that the latest guidance is reflected in this work.

### 1.3 Neighbourhood Health Guidelines 2025/26

NHS England recently published Neighbourhood Health Guidelines 2025/26 to help integrated care boards, local authorities and health and care providers to continue to progress neighbourhood health. Neighbourhood health aims to create healthier communities through better connectivity and optimisation of health and care resource including:

- From hospital to community – providing better care close to, or in people's homes, with hospitals only used when clinically necessary for care
- From treatment to prevention – promoting health literacy and an increased focus on prevention and proactive care
- From analogue to digital – greater use of digital infrastructure and solutions to improve care.

We have been working collaboratively with colleagues across the Dorset health and care system on plans for an integrated community healthcare service. There is a strong commitment that this is the right thing for the community we serve and that it is progresses at pace. Further updates will be provided on this programme as it develops.

### 1.4 NHS England Chief Executive

NHS England Chief Executive Officer, Amanda Pritchard, will be stepping down from the role at the end of March 2025. Sir James Mackey will be taking over as Transition CEO of NHS England, formally taking up the post on 1 April.

## 2 DORSET UPDATES

2.1 Dorset ICB is concluding its process to recruit a new Chair.

### 2.2 Our Dorset Provider Collaborative (ODPC)

An update is provided below on the work of the Our Dorset Provider Collaborative (the partnership between Dorset HealthCare University Hospital (DHC), Dorset County Hospital (DCH), UHD and the GP Alliance).

**Strategic Direction**

- The ODPC Board is currently considering its priorities for 2025/26, and how they can align, complement and add value to the Medium-Term Financial Plan, trusts' priorities and the future Long Term plan.

**CANDo (Clinical Acute Networks Dorset)**

- The clinical networks in place are completing a stock-take of progress to date and successes within the networks for review by the Board. There are 11 networks in operation at present, their scope varies from networking of clinical teams and best practice discussions to changes in service delivery to single-provider led services to support fragile services.

- Shared Oversight of Waiting Times. Good progress is being made with Access Managers developing shared Patient Tracking processes.

- Dermatology. A joint Collaborative and Commissioning event took place in early January 2025 to engage clinical teams in design of new pathways for commissioning to ensure the commissioning arrangements and model of care meet the population needs. A Local Network is in place, with 2 network meetings held. There is an emerging (but not full) consensus around a pre-referral A.I. pathway. This could change the scope of PCN triage, but it is likely that roll out beyond the current 2 PCNs would still be required.

- Other Networks. Urology, and orthopaedics functioning well, and the ENT and Gastro networks are currently embedding. Gynaecology leads established a network-likely first date middle of November, and the team has received a request from the ICB to align gynaecology work with their commissioning reviews

- Dorset Acute Networked Services Board has considered deep dives from Orthodontics (in transition to single service), Neurology and Oncology. The Board offers services delivered on an all-Dorset footprint the opportunity to consider issues of fairness and escalate problems and seek Provider Collaborative support for shared solutions.

**Procurement and shared services**

- The three Trusts agreed to work towards the development of a new Procurement Target Operating Model; a business case was considered by the ODPC Leadership Board and is subsequently being considered by individual Trust boards.

**Governance**

- The first Trust Chairs/Non-Executive Directors ODPC Informal steering group was held on 22 November 2024. This will enhance the ODPC's governance framework and provide additional challenge/scrutiny. Subsequent regular meetings are being scheduled.

- The dedicated ODPC Programme Director who commenced their position in December 2024 is reviewing the strategy and work programmes of the Provider Collaborative in order to set direction for 2025/26.

## 3 Our People

### 3.1 UHD Staff Awards 2025

Our staff awards 2025 have now opened for nominations. It is so important for us to recognise and appreciate that our staff are one of our most valuable assets and we will continue to pause, reflect and acknowledge the difference they make to people's lives, both patients, the public and colleagues. Two new categories have been created this year: the first is our Digital Improvement Award and our Non-Clinical Support Staff Member of the Year Award. The public also have the opportunity to nominate staff with our Patient Choice Award. Nominations close at 12 noon on 17 March 2025.

### 3.2 UHD reaccredited as Veteran Aware

UHD has received approval of its Veteran Aware Accreditation for a further three years, endorsing its commitment to improving NHS care for veterans, reservists, and members of the armed forces and their families.

### 3.3 Chief People Officer recruitment

Tina Ricketts our current Chief People Officer will be leaving the Trust on 30 April 2025. The recruitment process for Tina's replacement has commenced. Our thanks go to Tina for her significant contribution to UHD.

### 3.4 Deputy chief nurse

Matthew Hodson, Deputy Chief Nurse, leaves the Trust on 14 March moving to a Chief Nursing Officer role at the North Middlesex. Thank you from all of us and all best wishes in your new role.

Vivian Alividza will take up the position of Deputy Chief Nurse on 10 March and we warmly welcome her to Team UHD at this time.

## 4 PERFORMANCE HEADLINES

During January 2025, there was some improvement in terms of the impacts of seasonal variation, though outbreaks of norovirus and flu continued to be challenging in the first half of the month across both sites resulting in bay/ward restrictions additional cleaning and additional testing. This meant patients who were awaiting test results were held in the Emergency Department as per Infection Prevention & Control best practice but added an additional pressure on the department.

Performance against the organisational four-hour safety standard in January 2025 delivered 70.6% against an internal trajectory of 74% which is a recovery of 6.6% from December. Ambulance handover duration has also started to see an improvement and continues to be well below the regional average.

Ongoing challenges remain with occupancy and flow as a result of the number of beds continuing to be occupied by patients with No Criteria to Reside (NCtR). The average number of patients with NCtR has increased from an average of 192 in December to 226 in January 2025. This is a significant increase and significant deviation from the winter plan, with the impact being felt across the Trust as a significant inhibitor to patient flow.

We have continued to deliver an increase in planned operations, procedures and appointments for patients compared to the 2019/20 baseline period. The Trust delivered 111.4% elective activity year to date, exceeding the Trust's operational planning trajectory of 108.6%.

The progress was maintained in January 2025 on eliminating waits for elective treatment above 65 weeks, with only 16 patients remaining with a wait greater than 65 weeks. Further progress was hampered by essential works impacting our access to the sterile service department which limited theatre activity. Waits above 52 weeks are below the Trust's operational plan.

Alongside this we have seen some important improvement against the cancer standards - Cancer 28 Day Faster Diagnosis Standard (FDS) was achieved in December 2024. Performance against the 62 day - time to first treatment standard, also improved and achieved the operational plan.

## 5 FINANCE

At the end of January the Trust has reported a deficit of £6 million against a planned deficit of £4 million, resulting in an adverse variance of £2.0 million. This variance reflects a delay in the timing of planned savings as compared to the original budget. Importantly, at the end of January, the Trust remains on trajectory to deliver the break-even forecast outturn.

The capital programme has progressed well however there remain two risks to delivery in the current financial year; firstly in relation to our reprofiling request for the New Hospitals Programme funding for which we have yet to receive written confirmation; and secondly, in relation to the purchase of Wessex Fields by the end of March.

## 6 STRATEGY AND TRANSFORMATION

### 6.1 Key Service Moves & Progress at the BEACH

The BEACH Building is in its final stages of preparation, with key services set to relocate over the coming months:

- 4 March – Radiology ED Hub
- 25 March – Bournemouth Critical Care Unit
- 29 March – 2 April – Maternity, Neonatal & Obstetric Theatres
- 14 May – Bournemouth Emergency Department

Over 700 staff have now taken part in simulation and orientation training in the BEACH.

Volunteer-led tours have started to allow all staff to familiarise themselves with the new space.

The CQC will be coming to visit and assess our building at the beginning of this month.

### 6.2 Capital Estates & Major Projects

The opening of the new road from Wessex Way is planned. This will improve access for ambulances, staff, deliveries and construction. Patients will continue to use the main road in.

Parking continues to be a challenge especially during peak hours and especially Tuesday and Wednesdays. The new car park operator has started and will be installing new systems and equipment that will improve how we use the spaces we have. This includes a new, better permit portal. Work is also underway to ensure any temporary car parking on Wessex Fields is used to best effect, to allow patients and visitors to park nearer the hospital. Long-term a multi-storey carpark will be needed. New cycle lanes, storage and changing facilities are opening, along with improved support for non-car alternatives.

The hospital continues to make good progress in reducing estates backlog across all sites, with further development planned for Poole, Christchurch, Alderney, and Bournemouth throughout 2025.

Work is also underway for the new Endoscopy Unit at Poole, due to open by the end of the year. This is a large development and will ensure the service is set up for a successful future.

### 6.3 Transforming Care Together Update

The communications and engagement strategy is progressing well, including a short animation showcasing transformation benefits—such as Poole's shift to a planned care hospital and the introduction of the 'barn' theatre model.

Key updates:

- The 2025 transformation timetable has been released.
- Phase 3 of transformation creates the planned and emergency separation. This is set to begin in January 2026.
- Plans are underway for exclusive previews of the BEACH Building for external stakeholders.

Meanwhile, the 'Born at the BEACH' campaign is celebrating maternity and neonatal services' relocation, featuring the Bump to Baby series, which follows an expectant mother's journey. The 'Farewell to St. Mary's' campaign continues, sharing memories from Consultant Gynaecologist Tim Hillard and Theatres Recovery Nurse Gemma Sweetapple.

### 6.4 Inter-Site Shuttle Bus

The tender for the inter-site shuttle bus has been completed and the new service will start from 17 March. This will be for staff, and free to use. The first year of operation will allow us to flex to best

meet demand.

## 7 STRATEGIC ELECTRONIC HEALTH RECORD (EHR) SYSTEM

Our Outline Business Case for the Strategic EHR is still working its way through the approval process. Whilst we iterate and respond to queries, our teams across Dorset and Somerset have led a successful 'pre-market engagement' exercise with suppliers. The engagement has built confidence that, when we issue the tender to the market in the summer, we will receive some high-quality responses that meet our collective requirements. A replanning exercise has also been undertaken to make sure that we focus now on those decisions that will be required for our full business case to be completed. Examples include:

- how we will handle legacy data, our approach to clinical design authority,
- our approach to sufficient public and patient engagement
- learning from others on Business Intelligence
- reporting and technical readiness planning.

## 8 TRUST MANAGEMENT GROUP

Our Trust Management Group continues to meet bi-monthly. Key issues discussed at its January and February meetings included:

- Transformation agenda updates;
    - Phase 3 Ward Move Plan Timeline
    - Beales Outpatient Assessment Expansion
    - Space Allocation for Reconfiguration Critical Path

**People & Culture**

- Recognition of Internationally Educated Nurses Prior Experience
- Rate Cap Compliance for AHP and STT
- Medical Locum Rates and Timesheet Approval Process
- Pay Gap Reports 2025
- Education Learning and Development Report
- Equality Delivery System
- Staff Survey 2024 Update Report

**Updates**

- Hospital at Home
- nhs.net migration

**Strategies**

- Arts Strategy

**Business Cases**

- Interventional Radiology
- Dermatology Expansion
- Lottery Proposal
- Capital Cleaning Equipment

In addition, various policies were presented to the Group.

9 **UHD EXCELLENCE AWARDS**

Thank you to the following staff to whom I have awarded Excellence Awards following their nominations:

Chris Senior - Matron, Cancer Care, Poole

Gary Cupin – Housekeeping ED, RBH

Head & Neck Theatre Staff, Free Flap Service, Poole

**10 INTEGRATED CARE BOARD JANUARY 2025**

I attended the NHS Dorset ICB Board Meeting on 16 January 2025 where the minutes of the meeting held in November 2024 were ratified. I attach a copy of the ratified minutes of the meeting at appendix one.

**Minutes of the meeting of the Part 1 Public ICB (ICB) Board of NHS Dorset**
**Thursday 7 November 2024 at 10am**
**In the Boardroom, Vespasian House, NHS Dorset, Barrack Road, Dorchester, Dorset DT1 1TS and via MS Team**

| | | |
|---|---|---|
| **Members Present:** | | |
| | Jenni Douglas-Todd (JDT) | ICB Chair |
| | Rhiannon Beaumont-Wood (RBW) | ICB Non-Executive Member |
| | Matthew Bryant (MB) | Joint Chief Executive Dorset County Hospital and Dorset HealthCare NHS Foundation Trusts and ICB Board NHS Provider Trust Partner Member |
| | Siobhan Harrington (SH) (virtual) | Chief Executive University Hospitals Dorset NHS Foundation Trust and ICB NHS Provider Trust Partner Member |
| | Leesa Harwood (LH) | ICB Non-Executive Member |
| | Nick Ireland (NI) (part) | Leader Dorset Council and ICB Local Authority Partner Member |
| | Paul Johnson (PJ) | ICB Chief Medical Officer |
| | Jillian Kay (JK) | Corporate Director for Wellbeing, BCP Council and ICB Local Authority Partner Member |
| | Patricia Miller (PM) | ICB Chief Executive |
| | Rob Morgan (RM) | ICB Chief Finance Officer |
| | Pam O'Shea (POS) | Interim ICB Chief Nursing Officer |
| | Kay Taylor (KT) (virtual) | ICB Non-Executive Member |
| | Forbes Watson (FW) | GP Alliance Chair, Primary Care Partner Member |
| | Dan Worsley (DW) | ICB Non-Executive Member |
| **Invited Participants Present:** | | |
| | Louise Bate (LBa) (virtual) | Manager, Dorset Healthwatch |
| | Cecilia Bufton (CB) | Integrated Care Partnership Chair |
| | David Freeman (DF) | ICB Deputy Chief Executive Officer |
| | Charlottee Green (CG) (virtual) | Chair of the Governance Board, Dorset VCSA |
| | Dawn Harvey (DH) | ICB Chief People Officer |
| | Matt Prosser (MP) | Chief Executive, Dorset Council |
| | Andrew Rosser (AR) | Chief Finance Officer, SWASFT |
| | Dean Spencer (DSp) | ICB Chief Operating Officer |
| | | |
| **In attendance:** | | |
| | Jane Ellis (JE) | ICB Chief of Staff |
| | Kirsty Hillier (KH) | ICB Deputy Director of Communications and Engagement |
| | Steph Lower (SL) | ICB Deputy Head of Corporate Governance |
| | Rob Payne (RP) (item ICBB24/147) (virtual) | ICB Head of Primary and Community Integration |
| | Rachel Pearce (RP) | Managing Director (System Commissioning Development), NHS England South West |
| | Ben Sharland (BS) (virtual) | GP Alliance Deputy Chair |
| | Mark Smith (MS) (item ICBB24/149) | ICB Principal Commissioning Lead, Adult Mental Health |
| | Sue Sutton (SS) (item ICBB24/141) | ICB Deputy Chief Operating Officer |
| | Louise Trent (LT) (minutes) | ICB Governance Support Officer |

| | | |
|---|---|---|
| | Julie Walker (JW) (item ICBB24/149) | ICB Senior Lead (BCP Place) |
| | Paul Wyman (PW) (item ICBB24/141) | ICB Automation Architect |
| **Public:** | | |
| | 1 member of the public was present in the room. The meeting was also available via livestream. | |
| **Apologies:** | | |
| | Sam Crowe (SC) | Director of Public Health for Dorset and BCP Councils |
| | Keith Phalp (KP) | Pro Vice Chancellor for Education and Quality, Bournemouth University |

**ICBB24/137 Welcome, apologies and quorum**

The Chair declared the meeting open and quorate and welcomed Charlotte Green, Chair of the Governance Board for Dorset Voluntary and Community Sector Assembly (VCSA) to her first meeting as an ICB participant. There were apologies from Sam Crowe and Keith Phalp.

**ICBB24/138 Conflicts of Interest**

There were no declarations of interest made.

**ICBB24/139 Minutes of the Part One meeting held on 5 September 2024**

The minutes of the Part One meeting held on 5 September 2024 were agreed as a true and accurate record.

**Resolved: the minutes of the meeting held on 5 September 2024 were approved.**

**ICBB24/140 Action Log from the Part 1 meeting held on 5 September 2024**

The action log was considered, and approval was given for the removal of completed items.

ICBB24/126 No Criteria To Reside (NCTR) regular reporting via the Integrated Performance Report (IPR). The data in relation to NCTR had not yet been included in the IPR. A set of monitoring had been agreed across the system as part of the Winter Plan with work progressing on additional metrics in the Local Authorities (LAs) to understand the position of individuals in the assessment process. It was clarified that this work had been undertaken in Bournemouth, Christchurch and Poole Council (BCP) only at this stage and once in place, would be widened to include Dorset Council (DC).

The consistent implementation across the LA areas with the consideration of both mental and physical health to ensure parity was recognised, and the action would remain open with the timescale for completion updated.

**Resolved: the action log was received, updates noted, and approval was given for the removal of completed actions.**

**<u>Standing Items</u>**

**ICBB24/141 Board Story and Deep Dive: Enhance Productivity and Value for Money**

The Chief Finance Officer introduced the Enhance Productivity and Value for Money Board Story and Deep Dive supported by the ICB Deputy Chief Operating Officer and the ICB Automation Architect. The Board received a staff story video about the South Walks House Outpatient Assessment Centre, which included a 'one stop approach' to undertake review

from different professionals in the same place, a central clinicians hub and a Livewell offer with access from the high street which supported a reduction in waiting times and timely appropriate treatment.

*P Johnson and F Watson joined the meeting.*

The Board discussed the previously circulated deep dive paper on productivity and value for money. Key points discussed were the links between productivity and value for money, the impact of COVID, the Darzi report recommendations, pressures on productivity, productivity reporting and metrics, improvements and digital automation.

The Board welcomed the South Walks House centralisation of outpatient appointments, which had been established following a successful pilot. However there was concern that this could impact provision in existing community based services in the wider Dorset rurality. It was confirmed that the importance of the community clinics provision would be part of the Integrated Neighbourhood Team (INT) work and the South Walks House intent was not centralisation but provision of a single access point across several specialities. This would improve community access and attendance with a wider provision for patients during a single visit.

Productivity required focus across the whole system and would benefit from replication of measures from the Darzi review to understand spend across areas. NHS productivity currently had a focus on acute hospitals and it would be beneficial to develop local productivity measures and to ensure that potential improvements in one area would not negatively impact other parts of the system and with progression through investment in prevention to reduce long-term activity. In line with the conversation with the Board, the Chief Operating Officer offered to develop the Integrated Performance Report to include productivity data, as this would be particularly beneficial for the Productivity and Performance Committee.

**Action: DSp**

The Board noted that continuous improvement would address operational efficiencies and productivity improvements, however root cause issues would require further work for transformation of business and delivery models and culture to connect continuous improvement with strategic change. There was a requirement to be more ambitious about defining and tracking productivity with consideration to connect to the wider system for prevention.

**Resolved: the Board noted the Enhance Productivity and Value for Money Board Story and Deep Dive.**

**ICBB24/142 Board Assurance Framework**

The ICB Chief Finance Officer introduced the Board Assurance Framework (BAF).

Work continued to mature the BAF to ensure that this captured the key strategic risks, which were articulated consistently and coherently with appropriate actions tracked.

Feedback had been provided from the ICB committees including a request for clarity in the mitigating actions to track how the progress was improving the risk score or risk tolerance. The covering report for committees would be enhanced to highlight the key issues.

The Board noted that the BAF did not appear to provide focus on assurance, control measures or gaps in controls. It was confirmed that a workshop session for the ICB Board

to support development and understanding of the BAF had been scheduled with Internal Audit to be undertaken early in the new year. The BAF had been mapped to the four core aims however it would be beneficial to determine whether this remained the appropriate focus or whether this should be the longer term aims in the medium term plan and the priorities.

**Resolved: the Board noted the Board Assurance Framework.**

**ICBB24/143 Chief Executive Officer's Report**

The ICB Chief Executive Officer (CEO) introduced the CEO's Report.

Key messages included:

- The Darzi report had been published with an overview on the current position for the NHS and provided a baseline for the work in the 10 Year Health Plan.
- Work had commenced on the 10 Year Health Plan with four working groups who would report to the Department of Health by mid-December for the Secretary of State consideration. It was anticipated that the final version would inform the comprehensive spending review.
- Forthcoming collective action was progressing within General Practice with a range of engagement options and work was underway to mitigate impact. The importance of support to Primary Care sustainability in the Medium Term Financial Plan (MTFP) was recognised.
- A workshop had been undertaken on the MTFP which had been positive. This would be a large-scale work programme to deliver on ambitions to bring Dorset health and care to a sustainable position alongside prevention work. Challenges included the UEC transformation work, INT strengthening and progression, place work, prevention and the New Hospitals Programme. Priorities included access and wellbeing for Mental Health Transformation, an all-age neurodiversity programme and a new End of Life (EOL) service.
- Parity between physical and mental health was acknowledged as a significant area.

It was clarified that the Dorset Medium Term Plan had a predominantly NHS focus as required for submittal to NHS England. The narrative Business Plan had a broader focus and a workshop was planned to include the local authorities and voluntary and community sector. The System Executive Group (SEG) included system wide representation with consideration underway to structure the agenda to provide focus for joint priorities and decision-making.

The Board noted the reference in the report to the establishment of 30-40 INTs by March 2025 and queried progress towards readiness. The programme was developing well, and it was anticipated that the place leadership teams would be set by that date however all INTs would not be in place and a roll out programme had been established to progress. The Board was concerned as this was a key transformation work programme with a requirement to accelerate local conversations to progress. INTs would now be a standing agenda item on the Prevention, Equity and Outcomes Committee (PEOC) and regular updates would be provided to the Board through the PEOC Chair's report.

The 10 Year Health Plan would be supported by the reviews currently underway and would assist with the shift into out of hospital work and prevention with recognition that there would be elements of double running towards achievement. There would be potential opportunities with providing a collective system response to the plan.

**Resolved: the Board noted the Chief Executive Officer's Report.**

**ICBB24/144 Integrated Performance - Committee Escalation Reports**

The committee escalation reports from the October meetings were presented. All issues discussed were included in the previously circulated reports.

Key issues included:

**Integrated Care Partnership –** Executive lead support would be provided by the ICB Deputy Chief Executive Officer and had been welcomed. Strong representation was provided at the meeting from both Local Authority areas, who shared robust examples of joint working at pace to support the ICP work and strategy. Update areas included data driven targeted winter support for the vulnerable, housing, Cardiovascular Disease (CVD), respiratory, and falls and frailty. Update on the success of the SmokeFree 2030 programme had prompted agreement for the requirement for a system wide discussion on vaping to include the issues corresponding to Chief Medical Officer (CMO) advice and the wider issues on criminality, unregulated unlicenced products and uptake by children.

**People, Engagement and Culture Committee** – A cross-committee referred action from the Risk and Audit Committee on staff wellbeing support during challenging times had remained open with a full update requested for the next meeting. Discussions included risk, system supply, workforce and the impact on the Medium Term Recovery Plan, and a presentation was received from Dorset Healthcare and Dorset County Hospital on staff wellbeing and retention.

Although not discussed at the Committee, the ICB Chief People Officer shared that Dorset was an accelerator pilot for coastal navigator work to address deprivation. It was anticipated that the focus for the 10 Year Health Plan would provide attention for Dorset to progress the accelerator opportunity which would be taken through the Committee. The other pilot areas would be shared outside the meeting.

**Action: DH**

**Prevention, Equity and Outcomes Committee** –Specialised Commissioning had been discussed with the recommendation to the Board for approval, with recognition that this was a requirement and with the importance for clarity on the potential risks. Update areas included the progress and plans with INTs and robust discussion on the sustainability of General Practice. GP access, women's health hub and the Individual Patient Treatment reporting had been received.

**Productivity and Performance Committee** – The IPR section of the escalation report had been expanded to include additional detail on the system's operational performance. The current financial position and discussions on Personal Health Commissioning (PHC) would be undertaken during the Part 2 meeting. The Winter Plan would be discussed later during this meeting.

**Quality, Experience and Safety Committee** – The updated Terms of Reference had been approved with a wider discussion on the opportunities to expand the membership. Updates included Patient Safety and Incident Response Framework (PSIRF), an MRSA Deep Dive, CQC system assessment, child and adolescent mental health and the Cass review. Medicines Quality and Safety had raised concerns of shared-care prescribing on high risk drugs and the impact of potential GP collective action and this had been escalated to the Senior Leadership Team (SLT).

**Risk and Audit Committee** – The work and contribution of the outgoing Chair had been recognised and acknowledged. The updated ToR had been approved. Updates included the financial ledger replacement and a request for supplementary information as part of the Award of Contract without Competition reporting. External Audit had raised the potential requirement for future reporting for the Task Force for Climate Related Disclosures for awareness and advanced preparedness. An update on the Finance Governance Review was received and would be taken in Part 2. It had been requested that the outstanding Internal Audit cyber security actions be expedited.

**Strategic Objectives Committee** – The updated ToR had been approved. The inward investment update discussion had widened to follow up on the discussion on the Investment Strategy from the September Board meeting . Updates included research, risks and BAF. A deep dive was received on CVD which had been engaging, informative and welcomed by the Committee, particularly with the focus on outcomes rather than process.

The Board noted the update on CVD as one of the main priorities with the potential for an update at a forthcoming Board meeting on the three priority programmes of CVD, Falls and Frailty and Respiratory, with a focus on outcomes.

**Action: PJ/LB**

**Resolved: the Board noted the Committee Escalation Reports.**

**Items for Decision**

*N Ireland left the meeting.*

**ICBB24/145 Committee Terms of Reference and Governance Update**

The Deputy Chief Executive Officer introduced the Committee Terms of Reference and Governance Update.

These had been taken across each committee both as part of the annual review process and to provide updates to the membership following the Chief Officer team restructure. Each had been recommended to the Board for approval.

The changes had been set out in the report which included the revised membership, amendments to the SOC ToRs that had been previously applied across all committee ToRs but omitted from the SOC, punctuation alterations and changes requested from NHSE following amendments to the model constitution.

Discussions undertaken at the committees had included membership considerations with the possibility of widening to strengthen both representation and contribution. There was potential for consideration through the provider collaborative for possible team-based provider representation due to the demands on individuals time constraints.

**Action: DF**

**Resolved: the Board approved the Committee Terms of Reference.**

**Items for Noting/Assurance/Discussion**

**ICBB24/146 Winter Plan**

The ICB Chief Operating Officer introduced the Winter Plan.

The plan assisted with the system approach for determining capacity, the processes for day to day management and escalation procedures in place and the individual plans for each organisation had been received at the UEC Delivery Group. There had been a 10% rise in emergency admissions however the metrics across areas of UEC, including A&E four hour standard, ambulance handover times and category 2 response times, had demonstrated positive performance with the expectation to maintain during winter. There would be no additional funding provision to assist winter planning for this year.

Capacity management was dependent on the delivery of the NCTR reduction plan which was not currently on track. All organisations had committed to the NCTR plan which included admission prevention, with diversion to same day emergency care units, virtual wards utilisation and ambulance diversions.

New ways of identifying risk factors before discharge had been introduced with escalation processes in place for complex patients. Metrics set during the year included weekly discharge targets, place based improvement teams and improvement in weekend discharges.

The plan had commitment across all organisations. Key risks to delivery of the Winter Plan included GP collective action and non-delivery of the NCTR plan. The risk of harm increased during winter and conversations remained live with monitoring and early tracking.

Improvements had been seen in mental health which included a reduction in both inappropriate out of area placements and inpatient care waits.

The Board noted the plan had been signed off at NHS provider boards and there had been clinical engagement with emphasis on the importance of not opening additional capacity. Live conversations would be required on risk, risk appetite and the enhanced risk share approach. It was confirmed that the weekly improvement group undertook review of discharge metrics and approaches for providing visibility to leadership colleagues would be assessed as senior level discussions ahead of escalation would be beneficial.

Prevention, including the vaccination programme, was recognised as an important area. The Board recognised the strong communications and engagement work undertaken which included the stay well website, information on warm spaces and vaccinations. Dorset remained a strong performer with the vaccination rate however this had declined since the Covid-19 pandemic.

Work was being undertaken by Newton focused on UEC and improved outcomes and this would be brought to the Board once complete to provide sight of the anticipated impact.

**Resolved: the Board noted the Winter Plan.**

**ICBB24/147 Next Steps on Delivery Plan for Recovering Access to Primary Care**

The ICB Chief Medical Officer introduced the Next Steps on Delivery Plan for Recovering Access to Primary Care report.

This had been reviewed at the ICB's Prevention, Equity and Outcomes Committee and was brought to the Board for assurance in-line with the NHSE requirement for an update in public. Positive progress had been demonstrated which was testament to the work undertaken in GP practices despite the challenging position.

**Resolved: the Board noted the Next Steps on Delivery Plan for Recovering Access to Primary Care report.**

**ICBB24/148 CQC – Dorset ICS Pilot Assessment Report**

The Interim Chief Nursing Officer introduced the CQC – Dorset ICS Pilot Assessment report.

This linked to the recent national headlines that the CQC was pausing inspections of Integrated Care Systems. Participation By NHS Dorset in the pilot had been beneficial as this would assist with preparation and preparedness for when the assessments restarted with awareness of the framework and key lines of enquiry that would be anticipated.

**Resolved: the Board noted the CQC – Dorset ICS Pilot Assessment report.**

**ICBB24/149 Intensive and Assertive Community Mental Health Service Review**

The Chief Operating Officer introduced the Intensive and Assertive Community Mental Health Service Review report.

The work had been undertaken as a requirement from NHS England (NHSE) to ensure that appropriate intensive and assertive mental health care was available, particularly for individuals who had severe mental health issues and who experienced difficulties with engagement with services.

NHSE had provided guidance which had been used to review policies and practices. Seventeen site visits had been undertaken which involved talking to patients, carers and staff and the assertive outreach was fully assured. Community mental health service review had demonstrated a requirement for further work to be undertaken to improve. An action plan would be developed and it was proposed that the ICB's Quality, Experience and Safety Committee would have oversight and assurance of the action plan

This had been a fast paced review due to a tight NHSE deadline and was the first step in a longer term process. The action plan would be co-developed with partners as support provision to the cohort of individuals was wider than NHS services with involvement from police, probation, prison, local authorities, and drug and alcohol services.

The oversight from the QESC was welcomed and it was noted that Dorset was one of only a small amount of areas that provided assertive outreach.

It was confirmed that the 'no wrong door' approach was dependent on each part of the system working in a different way culturally. The overlap with the Right Person, Right Place police programme work being undertaken had been recognised during the review and work was underway to ensure this was aligned.

The Board noted the importance of language used within the update as the statement that individuals did not engage with services was not appropriate. Work was required with the creation of the suitable environment and with understanding the requirements of individuals to allow for engagement and support provision to those with capacity difficulties to engage.

The Board requested an update from the Mental Health Delivery Board to reflect the breadth of mental health service provision and the work being undertaken to support individuals with mental health needs.

**Action: MB**

**Resolved: the Board noted the Intensive and Assertive Community Mental Health Service Review report.**

**ICBB24/150 Dorset ICS Engagement Plans to support the National Programme – Change NHS**

The Chief People Officer introduced the Dorset ICS Engagement Plans to support the national programme – Change NHS report.

A broad approach was being undertaken to support using collective assets across networks with strong links to the communities and to encourage input. Approach included continuation of conversations to ensure that the Dorset voices would be heard in the engagement and there had been involvement with designing the national engagement exercise. Population health data would be used to inform specific workshops with groups and this would be a coordinated approach across the south west region. This would be wider than digital participation to gather views with focus groups and specific workshops with cohorts of the community and taking the opportunity to attend wellbeing events to collect views.

The Board noted the potential for a system response to the 10 Year Health Plan consultation and it would be beneficial to undertake a session with the Board for a collective response.

**Action: KH/LB**

Collective responses from groups and networks would be welcomed. Collation of themes and key messages, for instance the importance of the prevention agenda would be beneficial. It was confirmed that the public-facing messaging to individuals engaging with the response had included clarity that this was a national directive and was not directly informing local services. Work was underway to gather the data for Dorset and the south west for the potential of utilisation to inform the next iteration of the Joint Forward Plan.

**Resolved: the Board noted the Dorset ICS Engagement Plans to support the National Programme – Change NHS report.**

**ICBB24/151 <u>Items for Consent</u>**

There were no items for consent.

**ICBB24/152 Questions from the Public**

There were no questions received from members of the public.

**ICBB24/153 Any Other Business**

The Dorset Hydration project had won the Nursing Times National Award for Infection Control. The Pharmacy Team had been nominated for HSJ awards for the Check Before You Order Campaign and the Structured Medication Reviews. The Teams would be invited to join the Board for lunch at the next meeting to acknowledge their achievements and to provide the opportunity to discuss the work further.

**Action: LB**

There was a reminder for the forthcoming Health Inequalities Conference to be held in Bournemouth on 14 November and attendance would be welcomed.

**ICBB24/154 Key Messages and review of the Part 1 meeting**

Key messages:

- Welcomed the Board story and the need to be more ambitious around defining and tracking productivity, wider system involvement and the need to look at the prevention/out of hospital work and how to connect this with improving productivity.
- Board Assurance Framework (BAF) – noted the further work to understand the use of the BAF with the need to focus on the control/assurance agenda.
- CEO report – noted the requirement to build on the response to the Darzi report which would be the basis for current 10 Year Health Plan work. A positive workshop had been held with system colleagues on Medium Term Plan with consensus over next 3 years to deliver what was needed. There was recognition that INTs were a key transformation programme of work with the requirement for acceleration of local conversations.
- Integrated Performance Reporting Committee Escalation Reports – noted the requirement for better forecasting to enable more effective mitigation of risks earlier, the impactful CVD presentation at the SOC, particularly in relation to the focus on outcomes. The main three programmes of CVD, frailty and falls and respiratory would be brought to a future Board meeting.
- The Board approved the committee ToRs noting the revised executive membership and the conversations to revisit provider representation on the committees.
- Winter plan – noted the continued challenges around NCTR and the need to deliver the plan by this winter, with recognition that there would be no financial flexibility over the winter. Admission prevention and consideration of how to manage risk appetite and risk sharing ahead of escalation to senior colleagues was required. An update to the Board on the Newton work programme was required. The work undertaken by the Communications and Engagement Team for prevention awareness was recognised. Parity on mental and physical health was required as part of the winter plan.
- Noted the good progress in terms of the Primary Care Access Recovery Plan.
- Noted the proposed approach in response to the CQC Dorset ICS Pilot Assessment which included the oversight and assurance role of the QES Committee.
- Intensive and Assertive Community Mental Health Review - noted the development of an action plan and that actions and progress would be monitored through the QES Committee. There was recognition of the complexity around service provision and an update would be brought to a future Board meeting. There was a requirement to create right environment to enable people to engage with health and care.
- Dorset ICS engagement plans - Noted the co-ordinated approach being taken to support engagement with the government's 10 Year Health Plan and the importance of comprehensive engagement to ensure inclusivity. A collective response would be considered at a future Board meeting.
- The Teams nominated for awards for the Check Before you Order, Structured Medications Review and Dorset Hydration Programme were congratulated and would be invited to the next business meeting for lunch.
- Coastal navigation would be brought back to the Board.

Review of the meeting:

The requirement for further work on the IPR was recognised with a forthcoming meeting scheduled with Chief Officers and Chairs of relevant committees to create improvements for the committees which would benefit updates for the Board. The larger IPR update had been added to the P&PC Chair report but not to the QESC or the PECC reports. This would require consistency in terms of content and presentation, and this would be considered outside the meeting.

**Action: LB**

The Board discussed the possibility of more detailed discussion of the IPR at Board meetings without replicating the discussion at the committees, with recognition that this would be NHS focused.

**ICBB24/155 Date and Time of Next Meeting**

The next meeting of the ICB Board would be held on Thursday 16 January 2025 at 10am in the Boardroom at the offices of NHS Dorset ICB, Vespasian House, Barrack Road, Dorchester, Dorset, DT1 1TS.

**ICBB24/156 Exclusion of the Public**

The Board resolved that representatives of the press and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest.

Signed by:

Jenni Douglas-Todd, ICB Chair

Date: 16/01/25

Care Quality Commission
Citygate
Gallowgate
Newcastle-Upon-Tyne
NE1 4PA

Siobhan Harrington
Chief Executive
University Hospitals Dorset NHS Foundation Trust

17 February 2025

**Post inspection feedback**

Dear Siobhan,

Following your feedback meeting with Debbie Nugent on 28 & 29 January and with Gina Pickering on 29 January 2024, please find below confirmation of the high level feedback shared during the meeting. This letter does not replace the draft report we will send to you, but simply confirms the feedback we provided on the day.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report.

| | |
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| Provider Name: | University Hospitals Dorset NHS Foundation Trust |
| Location(s) inspected: | Royal Bournemouth Hospital, surgical services and Poole Hospital, Surgical Services. |
| Inspection lead: | Debbie Nugent (Royal Bournemouth Hospital & Gina Pickering (Poole Hospital) |
| Dates of Inspection: | 28 & 29 January 2025 |
| CQC representatives present at the feedback session: | Royal Bournemouth Hospital – Debbie Nugent, Keith Morris, Chris Butler, Julie Romano<br>Poole Hospital – Gina Pickering, Jeena Sherpa, Sheo Tibrewal, Lisa Tiereny |
| Initial feedback | Areas for improvement |
| | Royal Bournemouth Hospital<br>• Suction equipment not readily available by bed spaces.<br>• Provision of equipment, including medication, to treat malignant hyperthermia in theatres. |

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| | • Low level environmental infection prevention and control concerns across the surgical services.<br>• Staff on ward 16 reported a lack of consultant input into the treatment plans for patients at weekends, with no consultant ward rounds, only registrar ward rounds.<br>• General oversight of the environment.<br><br><u>Poole Hospital</u><br><br>• Concerns had been raised to the inspection team by some staff about the safety of the elective gynaecology services once the emergency gyneacology services moved to Royal Bournemouth Hospital in April 2025.<br>• Lack of hostesses across some wards resulted in care staff fulfilling hostess roles and therefore having reduced time to care for patients.<br>• We were told by staff that the staffing template, based on the acuity tool, did not accurately reflect the acuity and required nursing input for patients on B2 ward. |
| | Positive findings |
| | <u>Royal Bournemouth Hospital</u><br>• Internationally trained staff gave positive feedback about working at the trust.<br>• Positive feedback from patients about the care they received.<br>• Nurse in discharge lounge supported patient discharge by working collaboratively with wards and teams.<br><br><u>Poole Hospital</u><br>• Improvements with the timeliness of the fractured neck of femur pathway.<br>• Overall, staff were caring and responsive to their patients.<br>• Generally, the environment was clean and free from clutter. |

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

Write to:

CQC
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely

Gina Pickering

Assessor

Team 2- South Network

**BOARD OF DIRECTORS - PART 1 MEETING**

**Meeting Date: 05 March 2025**

**Agenda item: 6.1**

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| **Subject:** | Integrated Performance Report (Safety, quality, experience, workforce and operational performance) |
| **Prepared by:** | Executive Directors, Leanna Rathbone, Mark Major, Judith May, David Mills, Dr. Matthew Hodson, Irene Mardon, Jo Sims, Adrian Tron, Madeleine Seeley, and Tracy Moran |
| **Presented by:** | UHD Chief Officers |

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| **Strategic themes that this item supports/impacts:** | Population & System ☒<br>Our People ☒<br>Patient Experience ☒<br>Quality Outcomes & Safety ☒<br>Sustainable Services ☒ |
| **BAF/Corporate Risk Register: (if applicable)** | BAF Risks 1-7<br><br>Trust Integrated Performance report for January 2025 - Appendix A |
| **Purpose of paper:** | Assurance |
| **Executive Summary:** | At the end of January 2025, the Trust has reported a deficit of £5.963 million against a planned deficit of £3.940 million, resulting in an adverse variance of £2.0 million. The variance is due to the phasing of the recovery actions compared to the original plan<br><br>There was some improvement in January in terms of impacts of seasonal variation though outbreaks of norovirus and flu continued to be challenging in the first half of the month across both sites resulting in bay/ward restrictions additional cleaning and patient testing in the emergency portals. Performance against the organisational 4-hour Safety Standard delivered 70.6% against an internal trajectory of 74% which is a recovery of 6.6% from December.<br><br>The average number of patients with No Criteria to Reside (NCtR) has increased from an average of 192 in December to 226 in January 2024. This is a significant increase and being felt in compromised flow across the organisation.<br><br>Highlights of Operational delivery for our patients:<br>• *A further increase in Elective value weighted activity* at 111.4% year to date compared to the same period in 2019/20 which enabled additional patients to be treated.<br>• *The Trust has maintained its position on waits for elective care greater than 65 weeks* in January and waits above 52 weeks are remaining below the trust's operational plan. |

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| | • *Diagnostic waits are maintaining strong performance* across the majority of modalities, and additional capacity is due to come online in February to support the recovery in neurophysiology performance.<br>• *Cancer 28 Day Faster Diagnosis Standard (FDS) was achieved in December 2024.* Performance against the 62 day - time to first treatment standard, also improved and achieved the operational plan.<br>• *Ambulance handover performance showed an improvement and* remains significantly stronger than the regional average at 30-36 minutes (vs regional average 60-70 mins).<br><br>In line with our operating plan submission we are making good progress to achieve the national 3.2% agency use target as a percentage of our annual pay bill and reducing our reliance on the temporary workforce. However, due to the unplanned opening of escalation areas, increased use of healthcare support workers for specialing, and successful recruitment we are over our workforce plan for the substantive workforce. We are working to enhanced vacancy controls and have launched a mutually agreed resignation scheme to address this underperformance.<br><br>UHD transitioned to Learn from Patient Safety Events (LFPSE) in November 2023 meaning the adoption of a completely different taxonomy for reporting a patient safety event was introduced. However overall reporting remains high (positive).<br><br>From 1 April 2024 the Trust has adopted the Patient Safety Incident Response framework (PSIRF) which means the language of "Serious Incident" is no longer used. Patient Safety Incident Investigations (PSIIs) will be undertaken in accordance with the Trust PSIR Plan. The Trust has trained over 30 staff in PSII methodology and appointed 2 experienced (part-time) Patient Safety investigators. |
| **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.<br><br>As part of our commitment against the CQC Well-Led Framework we continue to develop the format and content of the IPR by:<br>• Extending best practice use of Statistical Process Control (SPC) Charts.<br>• Greater focus on key indicators as part of our Patient First roll-out programme linked to the Trust Strategic priorities and the Trust refreshed Strategy Deployment Review process.<br>• Providing SPC training to operational leads who compile the narrative against the data included within the report.<br><br>***We recognise as a Trust Board that behind every single metric discussed in this paper there is a patient.*** |
| **Urgent & Emergency Care**<br><br>**(1 Advise)** | **Strategic goal: To meet the patient national constitutional standards for Planned and Emergency care supporting reducing inequalities in outcome and access and improving productivity and value.** |

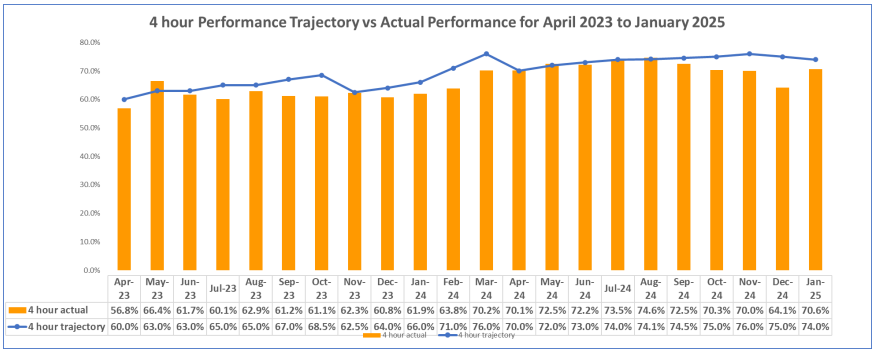
**Advise (1): The 4-hour standard performance for January delivered 70.6% an improvement compared to December against an internal trajectory of 74%.** The target increases in February to 76% to support an improvement at the end of the financial year in March at 78%.

- **Type 1 Patients**
  - Non-admitted performance for January met the trajectory at 73% which is a significant improvement from December at 64.1% and 66.13% in January 2023 respectively.
  - Admitted performance for January saw some improvement to 33% against a trajectory of 36% vs 21% in December.
  - An increase in patients waiting more than 12 hours before admission continues to impact the number of patients cared for in non-clinical areas and the Emergency Departments ability to treat patients in an appropriate clinical space.
  - Wait to be seen reduced by an hour across both sites with Minors seeing the best performance of any month in 2024.

- **Type 3 Patients (UTC)**
  - All patients were seen within 4 hours.
  - There was a further drop in MIU delivered activity- this has been an on-going risk since September. The shift in attendance from MIU (type 3) to Type 1, impacts negatively on the 4-hour standard performance, and is not optimal for patient access or experience.

- **Ambulance Performance**:
  - Average handover duration has started to see improvement- Poole has dropped back from 39 minutes to under 30 minutes, and the RBH site has dropped from 44 minutes to 36. This continues to be lower than the regional average which remains at circa 60-70 minutes.
  - Ambulance handover volumes remained static whilst the percentage (of the total) who waited longer than 60 minutes, decreased from 12% to 11%
  - PH is still currently performing in the context of the region. For January, Poole was 5th of 18 Trusts and RBH continues to hold at number 7. Again, Trust's 1-4 all saw far less conveyances than RBH and PH, with peer Trusts placing 15+ in the region.

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




| | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4 hour actual | 56.8% | 66.4% | 61.7% | 60.1% | 62.9% | 61.2% | 61.1% | 62.3% | 60.8% | 61.9% | 63.8% | 70.2% | 70.1% | 72.5% | 72.2% | 73.5% | 74.6% | 72.5% | 70.3% | 70.0% | 64.1% | 70.6% |
| 4 hour trajectory | 60.0% | 63.0% | 63.0% | 65.0% | 65.0% | 67.0% | 68.5% | 62.5% | 64.0% | 66.0% | 71.0% | 76.0% | 70.0% | 72.0% | 73.0% | 74.0% | 74.1% | 74.5% | 75.0% | 76.0% | 75.0% | 74.0% |

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| | **Improvement Areas:**<br>The Trust continues to update/monitor the 4 Hour organisational counter measure summaries, the project charters and the team improvement plans. Areas of focus include:<br>○ **Non-Admitted Performance:** Focus on ambulatory pathways and driving a reduction in average wait to be seen including piloting a GP overnight across both sites- for January this delivered an improved performance of patients 'Seen in 60 minutes' by 8.8% as well as reduced time to triage to 15 minutes.<br>○ **Admitted Performance**: ED focus on reducing decision to admit time; some improvement made but need to reduce this earlier in the pathway as well as overnight.<br>○ **Season Planning**: winter plan in place with actuals vs plan monitored and reported to the Operational Delivery Group.<br>○ **SDEC:** Specialty SDEC meetings conducted re current provision, future pathways, hours, access points and opportunities. Stage 1 Expansion plan to increase medical SDEC service at RBH site in place, providing additional resilience at weekends with Neurovascular, Stage 2 plan been developed to extend time of day and across 7 day period. SDEC due to go live on the 5th March 2025.<br>○ **Length of Stay:** work towards delivery of future bed allocation plan within the planned core bed capacity that delivers an occupancy level to manage variation in demand. Length of stay improvements have been sustained in January across Older Peoples Services and Orthopedic wards.<br>○ **UEC system Mobilisation:** (FutureCare) Dorset/Newton team assembled and establishing work programme to ensure focus supports UEC delivery over the next 18 months. Meetings progressed for the 6 programme focused areas with 1st Stage 'Inform sessions established):<br>▪ Preventing Admission<br>▪ Transfers of Care<br>▪ Bed Based Intermediate Care<br>▪ Home Based Intermediate Care<br>▪ Change Capability<br>▪ System Visibility + Active Leadership<br><br>Trust is currently on trajectory to finish the year within the top 10 'Most Improved 4 Hour Performance.' As of M9 the Trust is placing 5th nationally. |
| **Occupancy, Flow & Discharge**<br><br>**(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.**<br><br>**Advise (1) Ongoing challenges with occupancy and flow as a result of the number of beds continuing to be occupied by patients with No Criteria to Reside.**<br><br>In January the NCTR numbers remained on an upward trajectory, and a recovery akin to the 2024 figures has not been seen. The number of patients with 'No Criteria to Reside (NCtR),' remains a |

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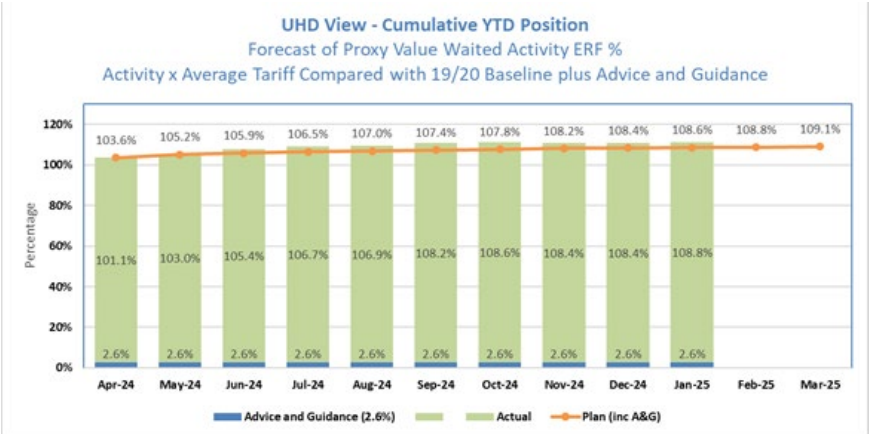
| | significant risk to the winter plan and the site reconfiguration plans. A reduction of 55 was required in January to deliver a balanced bed state, however numbers increased by 34.<br><br>An overall length of stay (LOS) improvement of 0.7 days for Q4 2024/25 has nevertheless been delivered, compared to the same reporting period last year.<br><br>**Improvement Areas:**<br><br>○ Restructured Transfer of Care Hubs with use of the Estimated Date Ready (EDR) as a proactive planning tool to anticipate and bring forward discharge dates.<br>○ My Care Needs tool went live Dec 4th, 2024, this has seen 25% of all referrals across both sites using the new format. Further engagement with stakeholders internally and externally is required to embed the use of the tool.<br>○ Increased focus on patients waiting over 21 days with a criteria to reside, to make sure that we have optimised the patient pathway.<br>○ Engagement through the UEC diagnostic report (FutureCare) and the mobilisation plan. |
| **Referral to Treatment (RTT)**<br><br>**(2 Advise, 2 Assure)** | **Strategic goal: To meet the patient national constitutional standards for Planned and Emergency care supporting reducing inequalities in outcome and access and improving productivity and value.**<br><br>**Assure (1): The Trust delivered 111.4% (value weighted activity year to date) in January compared to the 2019/20 baseline period. The Trust is also achieving its operational plan year to date trajectory.**<br><br>Activity levels year to date exceed the Trust's operational planning trajectory (108.6%).<br><br>  <br><br><br>**Advise (1) 18 week Referral to Treatment (RTT) performance was 60.6% in January 2025.** This is an increase of 0.3% compared to January2024. The Trust has been set a national target to achieve 66.1% by March 2026.<br><br>**Advise (2) RTT Waits >65 weeks increased in January with the Trust reporting 29 breaches at the end of the month.** |

- 29 >65-week RTT waits were reported at the end of January; this rise was forecasted and due to urgent and essential works that took place in the Sterile Services department (SSD) that saw a loss of 20 theatre sessions over the period of work. The month end breaches include 8 patients waiting material for corneal graft transplants to be made available, with long waits occurring nationwide. Plans are in place to recover the position in February.
- There was a small increase in >52 week waits as they were also impacted by the works in SSD, however the Trust's operational plan trajectory to reduce RTT waits >52 weeks has been met this month.

| Planning requirement | Dec24 | January 25 | |
|---|---|---|---|
| Referral to treatment 18-week performance | 60.5% | 60.6% ↑ | National Target 92% |
| Eliminate >78 week waits | 0 | 0 | Plan Trajectory 0 |
| Eliminate >65 week waits | 16 | 29 ↑ | Plan trajectory 0 September 2024 |
| Reduce >52+ weeks | 2,044 | 2,167 ↑ | Plan Trajectory 2,592 by January 2025 |
| Stabilise Waiting List size | 68,079 | 67,553 ↓ | Plan Trajectory 66,982 January 2025 |

The Planned Care Improvement Group is using the Patient First methodology to deliver improvements and reports to the Trust Management Group.

**Key areas of focus**

Maintaining elective activity rates above the 2019/20 baseline by:

- Prioritised booking for all patients in the February and March 65 week cohort into capacity in February for outpatient slots and theatre capacity to deliver 0 65 week waits by end February (except for corneal grafts).
- Utilising UHD & ICB contract capacity with independent sector providers for treatment of long waiters.
- Increasing productivity within core capacity, including reducing missed appointments (DNAs) and improving theatre and outpatient session utilisation rates.
- Continued validation of the waiting list to achieve 90% of all pathways validated every 12 weeks.
- Minimising the impact of urgent care demand and patients with 'no criteria to reside' on elective care beds.

**Theatre productivity**

- Capped theatre utilisation (main and day) in January reported 80% utilisation.
- The Trust remains within the process control limits for theatre case opportunity and continues to deliver the target (<15%).
- The SSD emergency works required January, limited the improvement opportunity in month and consequently performance was below the operational plan trajectory of 82.09%.
- Day case surgery rates (86%) continue to be above the national target (85%).

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| | **Outpatient productivity**<br>• The Trust is maintaining an overall reduction in missed appointments rates (Did not attends) in 2024/25. The DNA rate in January showed improvement again to 5.1% against the target of 5%. Current initiatives include:<br>  • A Basic Rescheduling tool in Dr Doctor has been switched on, which allows patients to cancel their appointments digitally rather than needing to call the department.<br>  • A six-month pilot using a DNA AI predictor tool has commenced in the Trust and is demonstrating beneficial impact in Diabetes Services; the tool identifies people with a high likelihood of a DNA and enables teams to intervene before the appointment date. Specialties in each care group have been identified to participate in the further roll out programme.<br><br>**Assure (2): Time to theatre for fractured neck of femur (# NoF) patients - 74% operated on within 36 hours from admission.**<br>• January performance for time to theatre for fractured neck of femur (#NoF) patients was 87% achieving surgery within 36 hours of being fit for surgery and 74% operated on within 36 hours from admission.<br>• Performance remains above the process mean for the fifth consecutive month and the target is within the upper and lower process control limits.<br>• In January trauma admissions were stable with the challenges of the SSD shutdown being mitigated with mutual aid from Salisbury. |
| **Cancer Standards**<br><br>**(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.**<br><br>**Assure (1) The Cancer 28 Day Faster Diagnosis Standard (FDS) was achieved at 78.1%; with further improvement delivered in cancer 62 day performance.**<br>• FDS performance in December 2024 increased by 2.8% to 78.1% compared with 75.4% in November 2024. Both the national standard and internal trajectory were achieved.<br>• Performance against the 31 Day Standard for December 2024 decreased by 0.6% to 94.5% compared with 95.1% in November 2024. The main breach reasons were due to Skin surgical capacity<br>• Performance against the 62 Day Standard in December 2024 increased by 2.4% to 70.6% achieving the operational plan.<br><br>Improvement actions are detailed within the IPR. |
| ***DM01 (Diagnostics report)***<br>***(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.**<br><br>**Advise (1) The DM01 (Diagnostic) standard performance moved to 14.5% of patients waiting more than 6 weeks for a diagnostic test.**<br><br>Standard: No more than 1% of patients should wait more than 6 weeks for a diagnostic test. |

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| | <table><tr><th>January 2025</th><th>Total Waiting List</th><th>< 6weeks</th><th>> 6 weeks</th><th>Performance</th></tr><tr><td>UHD</td><td>13,197</td><td>11,285</td><td>1,912</td><td>14.5%</td></tr></table><br>• The total diagnostic waiting list increased in January.<br>• Furthest away from the standard are waits for Neurophysiology tests. Performance moved from to 63.4% (from 55.6% in December). Outsourcing to support recovery has now commenced, at a rate of 4 lists per week (20 patients). A new physiologist also commenced in the Trust in December.<br>• Radiology performance has improved to 4.1% in January (from 4.8% in December<br><br>Improvement actions are being delivered as detailed within the IPR. |
| ***Health Inequalities (1 Advise)*** | **Waiting list by Index of Multiple Deprivation (IMD):** The average weeks waiting at the point of treatment for people in IMD 1-2 shows no variation compared to people from IMD 3-10, demonstrating a return to Q1 performance and reduction in variation. Analysing the same data by age band identifies a 1 week variation for children (<18 yrs) remains. This is an improvement from the beginning of quarter 3, which previously showed a variation of 5 weeks.<br><br>**Waiting list by ethnicity:** An analysis of the average weeks waiting by ethnicity grouping identifies no variation between patients within community minority groups and white British populations in Q4. A slight variation is seen in patients with an unknown ethnic group, who on average are waiting 1 week less than those who's ethnicity is recorded. |
| ***Maternity (1 Advise)*** | **Advise (1) There are 4 areas currently flagging as red RAG rated:**<br>• PPH >1.5 litres- ongoing action plan<br>• Apgar <7 at 5 minutes-normal variation<br>• Term admissions to NICU-showing a special cause variation.<br>• Quarterly stillbirth number >2.6<br><br>Improvement actions are detailed within the IPR. |
| ***Infection Prevention and Control: (3 Alert, 6 Advise)*** | **Quality, Safety, & Patient Experience Key Points**<br><br>**Strategic goals: To achieve top 20% of Trusts in the country for mortality (HSMR)**<br>**To reduce moderate/severe harm patient safety events by 30% through the development of an outstanding learning culture**<br><br>• **Alert (1): MRSA bacteraemia:** One case of hospital onset/ hospital acquired (HOHA) MRSA bacteraemia was identified in January 2025. A second case was identified however this was community onset-community acquired (COCA). Both identified cases were in the Surgical Care Group.<br><br>• **Alert (2): Outbreaks/cohort of infectious disease**<br>January saw a decrease in the number of active cohort areas as the month progressed, with activity decreasing on the RBH site. 5 ward areas were confirmed outbreaks where onward transmission occurred within the hospital setting. All identified |

on the PGH site with 3 influenza outbreaks, one Covid and one Norovirus.

- **Alert (3): Gram-negative bacteraemia:** It is noted that all gram-negative bacteraemia increased in January 2025, IPC are carrying out case investigations to understand themes and identify any areas where improvements can be made alongside ongoing case reviews from previous peaks in 2024. Reporting upwardly to ICB and sharing learning internally to UHD. Detail in Advise 1 – 3.

- **Advise (1) *E.coli* bacteraemia:** Cases of *Escherichia coli* bacteraemia increased in January 2025 in comparison to December 2024, whilst case numbers are just within special cause variation there is a marked steady incline. IPC have commenced case investigations to identify any common themes.

- **Advise (2) *Klebsiella* bacteraemia**: Case numbers of *Klebsiella* increased in January, remaining within special cause variation. Investigation into previous peak remains ongoing

- **Advise (3) *Pseudomonas* bacteraemia*:*** Cases of *Pseudomonas* increased in January 2025 compared to December 2024

- **Advise (4) MSSA bacteraemia:** The number of Methicillin-sensitive *Staphylococcus aureus (*MSSA) decreased in January 2025 compared to December 2024, falling below the median level.

- **Advise (5) Clostridioides *difficile* cases**: Case numbers decreased in January 2025

- **Advise (6) Hospital Associated cases trend**

| Organism | Feb-24 | Mar-24 | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MRSA | 0 | 1 | 1 | 2 | 0 | 2 | 2 | 0 | 0 | 0 | 3 | 1 |
| MSSA | 6 | 6 | 4 | 1 | 4 | 8 | 8 | 5 | 5 | 3 | 5 | 3 |
| C Diff | 9 | 13 | 3 | 10 | 8 | 7 | 11 | 11 | 11 | 10 | 14 | 4 |
| E Coli | 8 | 8 | 7 | 14 | 9 | 14 | 13 | 7 | 9 | 12 | 14 | 18 |
| Kleb | 6 | 6 | 4 | 3 | 1 | 3 | 12 | 8 | 8 | 3 | 7 | 8 |
| Pseudo | 3 | 2 | 2 | 1 | 1 | 3 | 1 | 0 | 5 | 2 | 3 | 4 |
| Outbreaks | | | 2 | 0 | 4 | 1 | 2 | 1 | 0 | 0 | 4 | 5 |

***Clinical Practice Team***

***(4 Advise)***

**Clinical Practice Team:**

**Advise (1) Moving and Handling - Essential Core Skills**
The opportunities for increasing provision of face-to-face level two training requirements for clinical staff have been identified. The risk register entry remains at 10 (moderate).

**Falls prevention & management**:
**Advise (2)** Our current UHD Falls (all harm) per 1,000 bed days is 5.3 in January 2025, a slight increase on previous month and slightly below compared to last year December 2023 (5.3).

**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. The referral process is being reviewed across UHD.

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|---|---|
| | **Advise (4) Pressure Ulcers:** *Note* as previously agreed with the CNO Pressure Ulcer Data reported within this IPR is 8-weeks in arrears, therefore December 2024 data is presented in this IPR report. There have been 10 hospital acquired Category 3 pressure ulcers reported during December 2024 and zero Category 4 damage (data reported 4-8 weeks in arrears). Data remains within usual variation control limits.<br>Purpose T Pressure Ulcer Risk Assessment is now 'live' within the electronic nursing assessment application<br>Educational sessions for pressure ulcer preventative care are ongoing<br>A workshop has been scheduled for February focus on pressure ulcer improvement. |
| ***Patient Experience***<br><br>***(4 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.**<br><br>**Patient Experience and Engagement Team Overview:**<br><br>**PALS and Complaints numbers for January 2025**<br><br>**Advise (1) The number of open complaints over 55 days** is currently at 21. They continue to be prioritised within the complaints team and care groups and are decreasing, with further measures to reduce the number of outstanding complaints in place.<br>**Advise (2) Average complaint response timescale** January 2025 was 42 working day average for a final response.<br>**Advise (3) Friends and Family Test (FFT)** The volume of FFT being received has been maintained and UHD has seen a sustained high satisfaction score. The Trust's overall positive score remains above the upper control limit.<br>**Advise (4) Mixed Sex Accommodation Breaches**<br>There were 9 occurrences of MSA in January 2025 in critical care. These occurred as a result of delays of transfers out to ward beds, and capacity pressures. |
| ***Nurse Staffing: (2 Advise, 2 Assure)*** | **Care Hours per Patient Day (CHPPD):**<br><br>**Advise (1)** January 2025 CHPPD remained stable at 4.5 for Registered Nurses/Midwives combined.<br><br>**Red Flag Reporting:**<br>**Assure (1)** The Red Flag data for January was 51 in month. 41% (21) were raised due to challenges in the provision of enhanced care for patients, 20% (10) were attributed to an RN shortfall of more than 8 hours on a shift and 18% (9) reported delays in delivering fundamental care. There were 3 (6%) of the red flags raised respectively for delays in medicine administration, recording vital signs and time critical activity in Maternity. No critical staffing incidents were reported indicating that overall safe staffing was maintained.<br><br>**Workforce Controls:**<br>**Advise (2)** Red flag data is triangulated with other quality and safety information in preparation for unannounced assurance visits to in-patient wards.<br>**Assure (2)** Ongoing review shows no impact on care delivery or safety due to the current workforce controls. |

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| ***Workforce Performance:*** | **Strategic goal: To significantly improve staff experience, engagement, and retention.** |
| ***CPO Headlines*** | Our workforce plan remains challenging to achieve this year. Enhanced controls are in place for the remainder of the year including a mutually agreed resignation scheme. Our agency usage continues to be ahead of plan and remains well below the 3.2% national cap.<br>Our staff turnover rate remains stable, and we are making progress with hard to fill vacancies. Our vacancy rate now stands at 5.1%.<br>Non medical appraisal compliance has improved to 83%. |
| ***HR Operations***<br><br>***(1 Assure, 3 Advise)*** | **Assure - Policies** - In partnership with trade unions, good progress is being made on the review and development of employment policies. Two policies were ratified by the Staff Partnership Forum in January 2025. Work continues on the remaining 20 policies, of which 13 are currently within the ratification process.<br><br>**Advise – Consultant Pay Progression Policy** – Work remains ongoing to develop and implement a policy following agreement nationally, in partnership with trade unions, with an anticipated implementation date of 1 April 2025.<br><br>**Advise – April Resident Doctor Rotation** - 96.6% of Resident Doctor template rotas were circulated in line with the contractual requirement to do so eight weeks prior to commencement in post.<br><br>**Advise - Mutually Agreed Resignation Scheme (MARS**) - The Mutually Agreed Resignation Scheme (MARS) opened on 6th January and closed on 24th January 2024. The Executive MARS panel reviewed 17 applications that had been supported by local management and from these 12 have been agreed. A further three applications are in the pipeline. |
| ***Workforce Systems***<br><br>***(1 Assure, 2 Advise,)*** | **Assure** – **People Ready Group** – All Phase 2 areas moving to the BEACH are progressing with their new staffing templates and any amendments to ESR. Housekeeping remains the most challenging area due to the size of the changes required.<br><br>**Advise** – **Medical and Dental Rostering Project** – Job planning progress reports are being run weekly until the 28 February 2025 where it will be expected that all job plans are completed for 25/26 round. Rostering roll out progress reports are being generated by Care Group in the form of pie charts.<br><br>**Advise** – **Fixed Term Contract (FTC) review -** Bi-weekly meetings are being held between Workforce and HR Operations to support the review of the FTC data. A new robust process for the management of FTC's will be in place by the 31 March 2025. |
| ***Resourcing***<br><br>***(1 Advise)*** | **Advise** - In January the Provider Workforce Return includes new requirements, one of which is Time to Hire data by staff group for both medical and non-medical staff. This is the next stage of an NHS England pilot project, which aims to achieve the Time to Hire target set out in the Long-Term NHS Plan, of 6 weeks. |

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| ***Temporary Staffing (2 Advise, 1 Alert)*** | **Advise –** In line with the People and Culture Strategy, project work continues for the business case review of the Temporary Staffing Service model.<br>**Advise –** The Bank and Agency Locum Standing Operating Procedure has been launched to provide governance around escalated rates and agency use for locums.<br>**Alert–** The draft internal audit report has been received to ensure ward ID checks for temporary workers are fit for purpose. An updated agency worker ID checks standing operating procedure is being implemented. |
| ***Occupational Health (1 Advise)*** | **Advise - Upgrade to OH IT system -** The OH service is now live with the new computer system G2. Initial feedback is very positive from across the Trust.<br>There is currently no meaningful data this month due to the change over of systems. We expect to be able to generate up-to-date data from the beginning of March 2025. |
| ***Organisational Development***<br><br>***( 4 Advise,)*** | **Advise – Leadership and Talent –** A cohort of Leadership in Action and Leadership Fundamentals, programmes commence in March. Applications for the Bournemouth University Senior Leader Apprenticeship close on 14th February 2025.<br>**Advise - Equality Diversity and Inclusion -** Pay Gap reports for Gender, Ethnicity and Disability produced. Gender Pay Gap reduced to 2.3% from 3.53% (2024), the Ethnicity Pay Gap is -1.13% and the Disability Pay Gap 12.29%.<br>**Advise – Freedom to Speak Up -** 455 staff have raised a concern with the FTSU team (April 2024 to end Jan 2025). This is an increase of 41% from the same period last year. The greatest theme relates to behaviours (166 staff; 37%) followed by policy and procedures (138 staff; 30%). Forty per cent of behaviours are relating to incivility and 31% relating to toxic working environments. 55 referrals (12%) were made anonymously and 84 referrals (18%) by staff from our global majorities.<br>Learning includes leadership and management (186 staff; 41%), developing a civil and respective culture (107 staff; 23%), wellbeing support (62 staff; 14%) and merger and team integration (41 staff; 9%).<br>**Advise - Culture and Engagement -** Recruitment to the 2025 People & Culture Champions commenced on 2nd February 2025.<br>Since the promotion of the Thank you app during January's executive brief on 15/01/25 390 thank you's have been shared totalling 490 since the soft launch on 17/12/2024. Initial feedback has been positive. |
| ***Trust Finance Position***<br><br>***(1 Alert, 2 Advise, 2 Assure)*** | **Strategic goal: To return to recurrent financial surplus from 2026/27**<br><br>The Trust now produces a monthly forecast as detailed in the report. At the end of January, the revised forecast financial trajectory for the year end position is still forecast as break-even, noting the risk in relation to winter pressures.<br><br>**Advise (1): Efficiency Improvement Programme**<br>Efficiency savings of £33.977 million have been achieved against a target £33.556 million. As of 31 January 2025, EIP (Efficiency Improvement Plans) are reporting a forecast risk adjusted saving of |

£41.4 million, non-risk adjusted is in line with the target of £42 million including the trust-wide cross cutting schemes.

**Advise (2): Revenue Position**

At the end of January 2025 the Trust has reported a deficit of £5.963 million against a planned deficit of £3.940 million, resulting in an adverse variance of £2.0 million. The variance is due to the phasing of the recovery actions compared to the original plan.

Income is £3.780 million favourable to plan year to date. Income is £3.485 million favourable to plan year to date. Included within this is a £3.862 million favourable position against Dorset ICB related to ERF delivery. NHSE income is £1.872 million favourable and Hampshire and Isle of Wight ICB £1.042 million adverse due to ERF performance. Other Non-NHS patient care income is £111,000 favourable due to RTA income (£198,000 favourable), LVA income (£145,000 favourable) and overseas patient income (£36,000 favourable), partially offset by a shortfall in private patient income of £271,000. The favourable income flows in respect of ERF aligns to recovery actions required to deliver the full year plan.

Operating expenditure is £58.219 million adverse to plan year to date. This includes a £46.772 million impairment which is adjusted for when calculating the Trust's overall year to date performance against control total. Pay is £6.442 million adverse to plan year to date, primarily due to premium nursing agency expenditure and non-delivery of recurring pay EIP. Clinical supplies expenditure is £2.057m adverse to plan year to date mainly due to additional activity in the Surgical care group. Drugs expenditure is £4.274 million adverse to plan year to date mainly due to Dorset ICS and Hampshire ICS block contract drugs. Purchase of healthcare is £3.531 million adverse to plan year to date mainly due to CDC costs (offset by income).

Premises and fixed plant expenditure is £3.930 million favourable to plan year to date due to energy costs.

Agency spend in month is £0.788 million and is under the cap value equating to 3.2% of total pay expenditure. This is a significant reduction when set against the expenditure in March.

**Assure (1): Public Sector Payment Policy**
In relation to the Public Sector Payment Performance the Trust is currently delivering performance of 94.9% against the national standard of 95%.

**Alert (1): Capital Programme**
The Trust has reported capital expenditure of £119.9 million against a plan of £127.6 million. The underspend is due to slippage on committed schemes due to phasing delays, primarily NHP (New Hospital Programme). The forecast shows a balanced position on the basis that a re-profile of CDC national funding of £6m has been agreed.

**Assure (2): Cash**
As at 31 January 2025 the Trust is holding a consolidated cash balance of £115.1 million which is fully committed against the future Capital Programme.

| | | |
|---|---|---|
| **Key Recommendations:** | Members are asked to note the content of the report. | |
| **Implications associated with this item:** | Council of Governors<br>Equality, Equity, Diversity & Inclusion<br>Financial<br>Health Inequalities<br>Operational Performance<br>People (inc Staff, Patients)<br>Public Consultation<br>Quality<br>Regulatory<br>Strategy/Transformation<br>System | ☐<br>☒<br>☒<br>☒<br>☒<br>☒<br>☐<br>☒<br>☒<br>☒<br>☒ |
| **CQC Reference:** | Safe<br>Effective<br>Caring<br>Responsive<br>Well Led<br>Use of Resources | ☒<br>☒<br>☒<br>☒<br>☒<br>☒ |

| **Report History: Committees/Meetings at which the item has been considered:** | **Date** | **Outcome** |
|---|---|---|
| Finance & Performance Committee (Operational / Finance Performance) | 24/02/2025 | Pending |
| Trust Management Group | 18/02/2025 | Pending |
| Quality Committee | 26/02/2025 | Pending |

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

University Hospitals Dorset
NHS Foundation Trust



# Integrated Performance Report

Reporting month: January 2025

# Contents


| | |
|---|---|
| Achievements | 3 |
| Performance – Matrix 1 | 4 |
| Performance – Matrix 2 | 5 |
| Statistical Process Control (SPC) | 6 |
| Quality – Safe (1) | 8 |
| Quality – Safe (2) | 9 |
| Quality – Safe (3) | 10 |
| Quality – Safe (4) | 11 |
| Quality – Caring (5) | 12 |
| Quality – Effective & Mortality (6) | 13 |
| Quality – Well Led (7) | 14 |
| Performance – Quality KPI | 15 |
| Maternity (1) | 16 |
| Maternity (2) | 17 |
| Maternity (3) | 18 |
| Workforce – Well Led (1) | 20 |
| Workforce – Well Led (2) | 21 |
| Workforce – Well Led (3) | 22 |
| Workforce – Well Led (4) | 23 |
| Workforce – (Well Led) KPI | 24 |
| Responsive (Elective) RTT | 26 |
| Responsive (Elective) Diagnostic Waits | 27 |
| Responsive (Elective) Cancer FDS 62 day standard | 28 |
| Responsive (Elective) Cancer over 62 day breaches | 29 |
| Responsive (Elective) Theatre Utilisation | 30 |
| Responsive (Elective) Outpatients | 31 |
| Responsive (Elective) Screening Programmes | 32 |
| Health Inequalities | 33 |
| Performance Responsive (Elective) KPI | 34 |
| Responsive (Emergency) Ambulance Handovers | 35 |
| Responsive (Emergency) Care Standards | 36 |
| Responsive (Emergency) Trauma & Orthopaedics | 37 |
| Responsive (Emergency) Patient Flow | 38 |
| Responsive (Emergency/Elective) Length of Stay & Discharges | 39 |
| Performance (Emergency) KPI | 40 |
| Finance – Use of Resources | 42 |
| Well Led – Information Technology (1) | 44 |
| Well Led – Information Technology (2) | 45 |
| Well Led – Information Technology (3) | 46 |

# Achievements

## In 2024/25 the achievements to date have been :

- Friends and Family Test (FFT) : We are seeing a sustained increase in the number of Family and Friends Tests (FFT) responses being received. The Trust overall positive score remains above the average.
- Waits for elective treatment greater than 78 weeks have been eliminated in line with the national ambition to reduce long waiters, along with decreasing numbers of pathways exceeding 65 weeks.
- UHD has achieved the 28 day faster diagnosis cancer standard consistently between October and December 2024 and a month on month improvement against the 62 day cancer standard over the same period.
- The Trust is delivering over 111.4% elective activity compared to the 2019/20 baseline year, resulting in more patients being seen and treated.
- Percentage of patients seen by clinician within 60 minutes in Emergency Department exceeded 40%. Highest % in 24/25, and since 2021.
- Reductions in both bank and agency usage are now evident, and both metrics are within plan . Agency usage is alsio flagging as special cause variation improvement.

# Performance at a Glance Indicators (1)

| | | | Jan-24 | Feb-24 | Mar-24 | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **SAFE** | | | | | | | | | | | | | | | |
| Quality | Presure Ulcers (Hospital Acquired Cat 3 & 4) | | 15 | 10 | 11 | 12 | 11 | 9 | 15 | 10 | 13 | 14 | 9 | 10 | |
| | Inpatient Falls (Moderate +) | | 2 | 13 | 7 | 4 | 8 | 2 | 6 | 8 | 7 | 11 | 8 | 6 | 10 |
| | Medication Incidents (All) | | 140 | 156 | 163 | 166 | 193 | 177 | 168 | 156 | 179 | 164 | 129 | 157 | 159 |
| | Patient Safety Incidents (All) | | 1260 | 1187 | 1230 | 1176 | 1254 | 1092 | 1211 | 1173 | 1178 | 1334 | 1107 | 1219 | 1261 |
| | Hospital Acquired Infections | MRSA | 1 | 0 | 1 | 1 | 2 | 0 | 2 | 2 | 0 | 0 | 0 | 3 | 1 |
| | | MSSA | 3 | 6 | 6 | 4 | 1 | 4 | 8 | 8 | 5 | 5 | 3 | 5 | 3 |
| | | C Diff | 6 | 9 | 13 | 4 | 10 | 8 | 7 | 11 | 11 | 11 | 10 | 14 | 18 |
| | | E. coli | 17 | 8 | 8 | 14 | 14 | 9 | 14 | 13 | 7 | 9 | 12 | 14 | 18 |
| | | Kleb | 4 | 6 | 6 | 4 | 3 | 1 | 3 | 12 | 8 | 8 | 3 | 7 | 8 |
| | | Pseudo | 2 | 3 | 2 | 2 | 1 | 1 | 3 | 1 | 0 | 5 | 2 | 3 | 4 |
| | Hand Hygiene Compliance | | 96.0% | 95.7% | 95.9% | 95.1% | 96.2% | 95.9% | 96.0% | 94.7% | 95.6% | 96.6% | 96.2% | 96.2% | 96.2% |
| | Infection Control Mandatory Training Compliance | | 87.6% | 88.4% | 88.3% | 89.4% | 89.2% | 89.0% | 89.4% | 90.1% | 90.0% | 89.9% | 89.6% | 89.6% | 89.5% |
| **EFFECTIVE** | | | | | | | | | | | | | | | |
| Mortality | HSMR In Month (UHD) | Latest Oct 24 (source HED) | 104.1 | 119 | 96.1 | 101.2 | 103.2 | 113.5 | 98.9 | 92.3 | 109.1 | 92.4 | | | |
| | Deaths within 36hrs of Admission | | 23 | 38 | 32 | 30 | 24 | 39 | 32 | 18 | 28 | 22 | 33 | 44 | 41 |
| | Deaths within 5 day readmission spell | | 14 | 19 | 21 | 18 | 19 | 20 | 15 | 16 | 23 | 21 | 18 | 22 | 22 |
| **CARING** | | | | | | | | | | | | | | | |
| | Complaints Received | | 62 | 60 | 66 | 78 | 90 | 68 | 64 | 58 | 76 | 75 | 63 | 54 | 65 |
| | Complaint Response Rate (Grade based target) | | 56.2% | 38.8% | 38.8% | 40.5% | 58.6% | 54.9% | 59.3% | 48.6% | 56.6% | 64.7% | 42.2% | 33.9% | 41.3% |
| | Friends & Family Test | | 94.1% | 94.2% | 94.0% | 94.7% | 94.6% | 95.0% | 94.5% | 94.9% | 99.5% | 94.3% | 94.2% | 93.5% | 93.9% |
| **WELL LED** | | | | | | | | | | | | | | | |
| Safety | Risks 12 and above on Register | | 48 | 43 | 40 | 36 | 38 | 45 | 45 | 56 | 58 | 62 | 62 | 63 | 61 |
| | Risks 15 and above on Register | | 20 | 18 | 19 | 18 | 18 | 21 | 20 | 16 | 16 | 18 | 20 | 23 | 19 |
| | Red Flags Raised | | 28 | 13 | 14 | 13 | 11 | 9 | 20 | 13 | 26 | 31 | 15 | 21 | 51 |
| People | Turnover | | 11.1% | 11.1% | 11.1% | 10.9% | 10.7% | 10.6% | 10.5% | 10.6% | 10.7% | 10.6% | 10.6% | 10.5% | 10.6% |
| | Vacancy Rate | Reported 1 month in ar | 7.1% | 9.4% | 7.7% | 9.6% | 8.9% | 8.3% | 8.8% | 8.6% | 8.1% | 6.5% | 5.0% | 5.1% | |
| | Sickness Rate (rolling 12 month) | | 4.5% | 4.4% | 4.4% | 4.4% | 4.4% | 4.5% | 4.6% | 4.6% | 4.6% | 4.6% | 4.6% | 4.7% | 4.7% |
| | Statutory and Mandatory Training | | 88.91% | 89.43% | 89.0% | 89.5% | 90.1% | 90.2% | 90.5% | 90.9% | 89.8% | 90.1% | 89.9% | 90.2% | 90.2% |
| | Appraisal Compliance - Values Based | | 62.18% | 62.00% | 62.3% | 61.8% | 59.4% | 55.1% | 55.8% | 63.2% | 71.5% | 78.2% | 81.2% | 82.6% | 83.4% |
| | Appraisal Compliance - Medical & Dental | | 75.96% | 76.10% | 75.7% | 79.0% | 78.6% | 78.1% | 79.7% | 80.8% | 77.9% | 81.0% | 82.8% | 82.7% | 84.8% |
| | Temporary Hours Filled by Bank | | 53.5% | 55.6% | 57.6% | 57.8% | 57.7% | 61.3% | 61.4% | 62.1% | 62.4% | 60.7% | 61.8% | 57.5% | 62.3% |
| | Temporary Hours Filled by Agency | | 24.6% | 22.9% | 23.2% | 22.8% | 22.0% | 19.2% | 18.5% | 19.0% | 19.4% | 18.7% | 18.2% | 18.1% | 15.6% |
| | Agency Pay as Proportion of Total Pay | | 5.3% | 5.2% | 4.4% | 3.7% | 3.5% | 3.0% | 3.0% | 2.6% | 2.7% | 1.9% | 2.0% | 1.9% | 1.7% |

# Performance at a Glance Indicators (2)

| | | standard | Jan-24 | Feb-24 | Mar-24 | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **RESPONSIVE** | | | | | | | | | | | | | | | | |
| RTT | 18 week performance % | 92% | 60.3% | 62.2% | 62.0% | 63.0% | 62.4% | 61.1% | 61.2% | 61.1% | 61.4% | 60.8% | 61.1% | 60.5% | 60.6% | |
| RTT | Waiting list size | 66,982 January 2025) | 67,983 | 66,909 | 68,398 | 70,012 | 68,343 | 67,977 | 68,825 | 68,760 | 68,039 | 67,993 | 67,413 | 68,079 | 67,553 | RAG rated based on trajectory |
| RTT | No. patients waiting 52+ weeks | 2,592 (January 2025) | 3,722 | 2,967 | 2,767 | 2,813 | 2,960 | 2,999 | 2,841 | 2,532 | 2,226 | 2,177 | 2,172 | 2,044 | 2,167 | RAG rated based on trajectory |
| RTT | No. patients waiting 65+ weeks | | 1,220 | 840 | 328 | 335 | 393 | 471 | 459 | 351 | 65 | 48 | 16 | 16 | 29 | |
| RTT | No. patients waiting 78+ weeks | 0 | 86 | 45 | 29 | 22 | 11 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | RAG rated based on trajectory |
| Theat | Theatre utilisation (capped) - main | 85% | 80% | 82% | 82% | 83% | 82% | 82% | 81% | 84% | 80% | 81% | 82% | 80% | 81% | |
| Theat | NOFs (Within 36hrs of admission rom ED - NHFD) | 85% | 73% | 62% | 64% | 63% | 51% | 50% | 47% | 32% | 80% | 73% | 72% | 62% | 74% | |
| Outpatients | **Outpatient metrics** | | | | | | | | | | | | | | | |
| Outpatients | Overdue Follow up Appts | | 26,506 | 25,844 | 26,075 | 26,161 | 26,046 | 25,642 | 25,492 | 25,407 | 25,706 | 25,658 | 25,982 | 27,881 | 28,813 | |
| Outpatients | % DNA Rate | 5% | 5.9% | 5.6% | 5.3% | 5.3% | 5.3% | 5.1% | 5.1% | 5.7% | 5.5% | 5.3% | 5.6% | 5.7% | 5.1% | |
| Outpatients | Patient cancellation rate | | 11.3% | 11.1% | 10.6% | 11.0% | 11.4% | 11.6% | 11.3% | 11.2% | 11.5% | 11.2% | 9.9% | 11.4% | 10.5% | |
| Outpatients | % non face to face (telemedicine) attendances | 25% | 17.5% | 17.1% | 17.2% | 17.0% | 17.3% | 17.1% | 17.2% | 16.6% | 17.7% | 17.3% | 17.4% | 18.0% | 17.8% | |
| DM 01 | **Diagnostic Performance (DM01)** | | | | | | | | | | | | | | | |
| DM 01 | % of >6 week performance | 1% | 11.8% | 8.7% | 10.7% | 11.8% | 12.9% | 11.6% | 12.5% | 14.7% | 13.2% | 9.8% | 10.6% | 12.6% | 14.5% | |
| Cancer | 28 day faster diagnosis standard | 75% | 72.5% | 77.8% | 75.2% | 66.3% | 73.5% | 73.1% | 73.4% | 65.5% | 69.0% | 75.6% | 75.3% | 78.1% | *75.8%* | *January cancer position provisional* |
| Cancer | 62 day standard | 85% | 62.7% | 65.0% | 68.9% | 68.4% | 66.8% | 69.0% | 67.7% | 69.4% | 68.7% | 67.0% | 68.2% | 70.6% | *57.9%* | |
| Emergency Dept | 4 hour care standard | | 61.9% | 63.8% | 70.2% | 70.1% | 72.5% | 72.2% | 73.5% | 74.6% | 72.5% | 70.3% | 70.0% | 64.1% | 70.6% | RAG rated based on trajectory |
| Emergency Dept | Arrival time to initial assessment | 15 | 20.0 | 20.0 | 20.0 | 19.0 | 19.0 | 20.0 | 20.0 | 17.0 | 18.0 | 17.0 | 18.0 | 18.0 | 15.0 | |
| Emergency Dept | Clinician seen <60 mins % | | 31.3% | 33.0% | 32.0% | 29.0% | 30.0% | 29.0% | 28.7% | 34.0% | 30.6% | 30.0% | 31.6% | 27.8% | 43.4% | |
| Emergency Dept | Patients >12hrs from DTA to admission | 0 | 483 | 202 | 207 | 145 | 214 | 171 | 140 | 39 | 139 | 227 | 136 | 428 | 510 | |
| Emergency Dept | Patients >12hrs in dept | | 1681 | 927 | 979 | 745 | 801 | 785 | 702 | 400 | 705 | 924 | 652 | 1312 | 1163 | |
| SWAST | Ambulance handovers | | 4385 | 3993 | 4332 | 4060 | 4336 | 4082 | 4052 | 4165 | 4087 | 4250 | 4151 | 4318 | 4048 | |
| SWAST | Ambulance handovers - average hours lost UHD | | 45 | 30 | 32 | 28 | 30 | 31 | 28 | 24 | 30 | 32 | 27 | 40 | 36 | |
| SCAST | Ambulance handovers - average hours lost RBH | | 48 | 33 | 35 | 32 | 33 | 36 | 33 | 26 | 31 | 36 | 28 | 45 | 39 | |
| SCAST | Ambulance handovers - average hours lost Poole | | 43 | 27 | 29 | 24 | 26 | 27 | 24 | 23 | 28 | 27 | 25 | 35 | 33 | |
| SCAST | Ambulance handover >60mins breaches | | 779 | 299 | 365 | 263 | 312 | 357 | 269 | 156 | 287 | 368 | 188 | 1072 | 476 | |
| Patient Flow | Bed Occupancy (capcity incl escalation) | 85% | 96.4% | 92.4% | 93.0% | 94.0% | 93.7% | 92.7% | 93.6% | 89.0% | 91.6% | 92.3% | 92.0% | 93.6% | 94.5% | |
| Patient Flow | Stranded patients: | | | | | | | | | | | | | | | |
| Patient Flow | Length of stay 7 days | | 566 | 551 | 528 | 527 | 512 | 510 | 545 | 507 | 529 | 518 | 505 | 532 | 571 | |
| Patient Flow | Length of stay 14 days | | 370 | 363 | 336 | 339 | 324 | 327 | 343 | 329 | 337 | 324 | 320 | 322 | 369 | |
| Patient Flow | Length of stay 21 days | 108 | 266 | 255 | 235 | 241 | 230 | 229 | 237 | 234 | 236 | 222 | 225 | 218 | 252 | |
| Patient Flow | Non-elective admissions | | 6538 | 6135 | 6718 | 6494 | 7030 | 6365 | 6668 | 6458 | 6161 | 6737 | 6823 | 6648 | 6573 | |
| Patient Flow | > 1 day non-elective admissions | | 3981 | 3673 | 4175 | 3973 | 4193 | 3957 | 4086 | 4011 | 3926 | 4179 | 4238 | 4202 | 4079 | |
| Patient Flow | Same Day Emergency Care (SDEC) | | 2391 | 2295 | 2395 | 2365 | 2629 | 2384 | 2581 | 2446 | 2234 | 2558 | 2584 | 2444 | 2492 | |
| Patient Flow | Conversion rate (admitted from ED) | 30% | 28.47% | 29.30% | 30.70% | 31.10% | 30.30% | 29.90% | 31.20% | 31.80% | 30.00% | 30.70% | 32.50% | 31.14% | 32.00% | |

# Statistical Process Control (SPC) – Explanation of Rankings


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

# Quality Outcomes & Safety Patient Experience

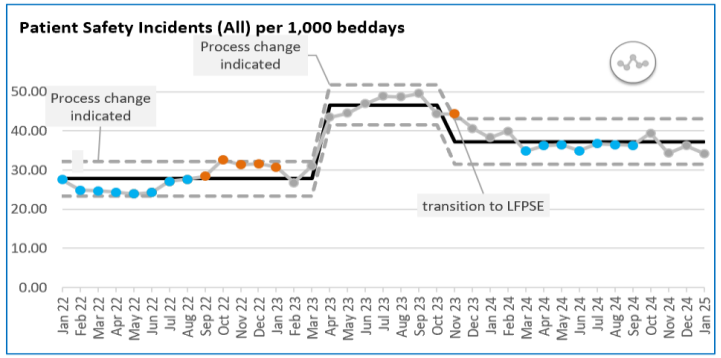
University Hospitals Dorset
NHS Foundation Trust

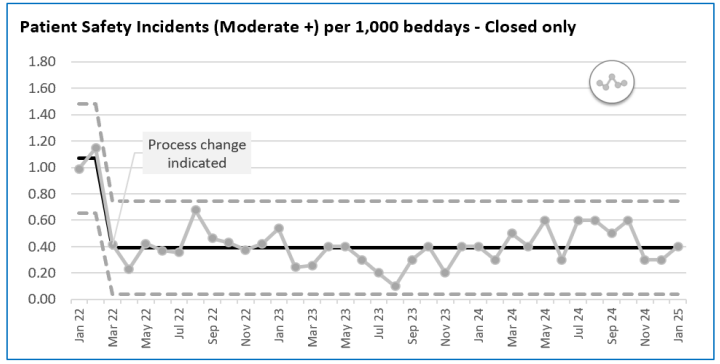

**Sarah Herbert**
Chief Nursing Officer
**Dr Peter Wilson**
Chief Medical Officer

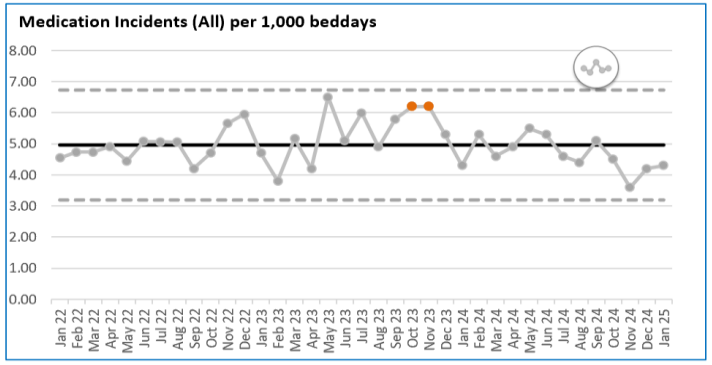
**Operational Leads:**
Matthew Hodson – Deputy Chief Nursing Officer (IPC, Workforce, Education and Research)
Madeleine Seeley – Interim Deputy Chief Nursing Officer (Clinical Practice, Patient Experience, Safeguarding)
Sean Weaver– Medical Director for Quality & Safety
Jo Sims – Associate Director Quality, Governance and Risk
Lorraine Tonge – Director of Midwifery
Mr Alex Taylor – Clinical Director
Darren Jose – Interim Care Group Director of Operations, Women's, Children, Cancer and Support Services

**Committees:**
Quality Committee

# Quality (1) – Safe




## Background/target description

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

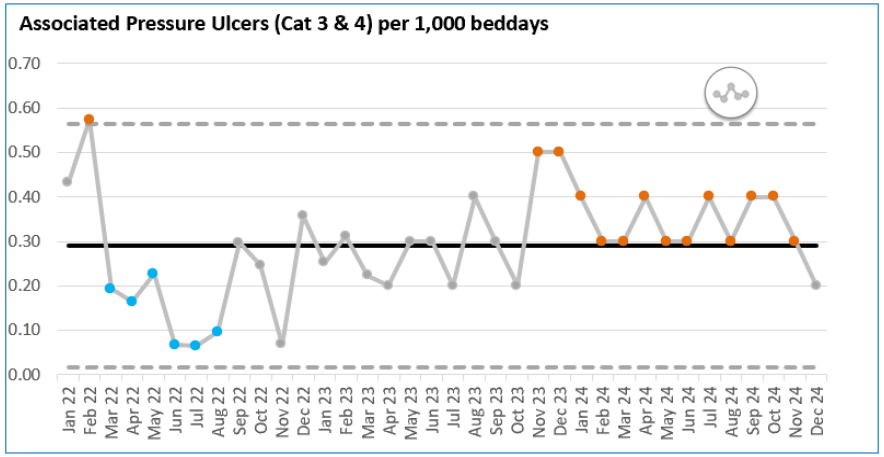
## Performance

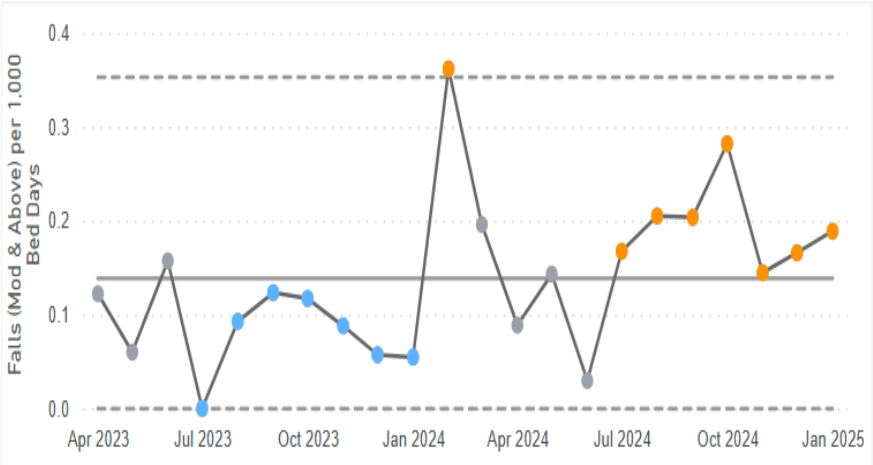
- The Trust transitioned to LFPSE in November 2023 meaning the adoption of a completely different taxonomy for reporting a patient safety event was introduced. The definition change significantly reduced the number of incidents reportable to LFPSE as a Patient Safety Incident.
- From 1 April 2024 the Trust has adopted the Patient Safety Incident Response Framework (PSIRF) and in October 2024 the new PSIRF/LERN Policy was approved. PSIRF investigation response tools are available on the Quality and Risk pages of the intranet.
- No new trends noted in month.

## Key Areas of Focus

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

# Quality (2) – Safe




## Background/target description

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

## Performance

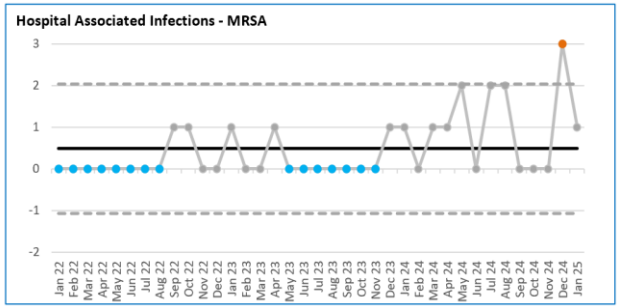
**Clinical practice:**

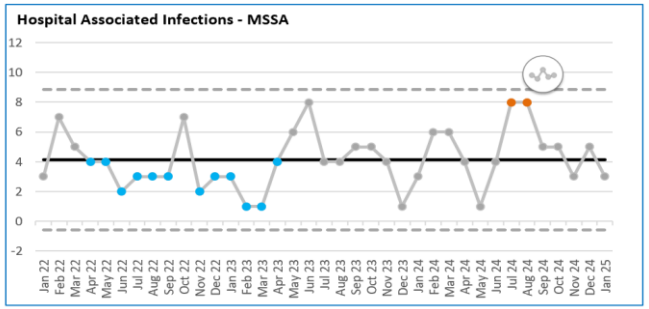
- There have been 10 hospital acquired Category 3 pressure ulcers reported during December 2024 and zero Category 4 damage (data reported 4-8 weeks in arrears). Pressure damage was located on the sacrum/ buttocks (n=8), hip (n=1) and heel (n=1)
- Appropriate patient safety investigation follow up has been completed and local learning shared within clinical teams; namely importance of effective change of position.
- Our current UHD Falls (all harm) per 1,000 Bed Days is 5.3 in January 2025, within expected range and below the average 5.5.
- The seven consecutive above-average data points for moderate and above harm per 1000 bed days are concerning, indicating an increase in falls leading to injuries like fractures and head trauma.
- Individual learning reviews show that patients had baseline conditions that increased their fracture risk in the event of a fall. Patient Safety Team plans to conduct a thematic analysis of falls to identify any further underlying patterns and risk factors.

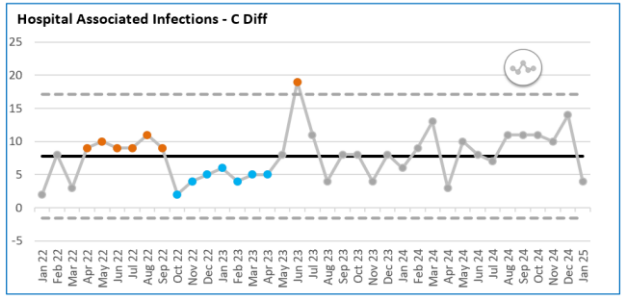
## Key Areas of Focus

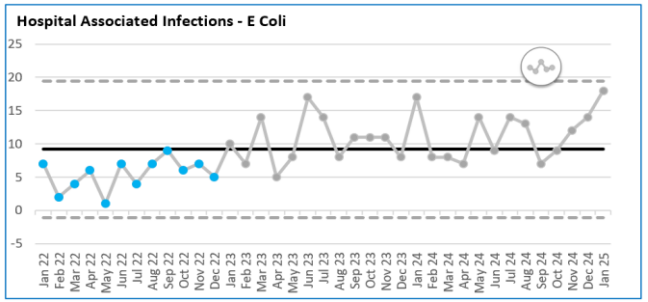
- Themes from Falls Information Tool within January 2025 remain same: Lying and standing BP non-compliance, pain relief administration post injury and consideration of appropriate bed rail positioning.
- There is mild data inconsistency in harm levels due to incorrect incident report forms being submitted and harm grading not being properly corrected in the LPSFE section of the LERN form.
- Purpose T Pressure Ulcer Risk Assessment is now 'live' within the electronic nursing assessment application
- Educational sessions for pressure ulcer preventative care are ongoing
- A workshop has been scheduled for February focus on pressure ulcer improvement

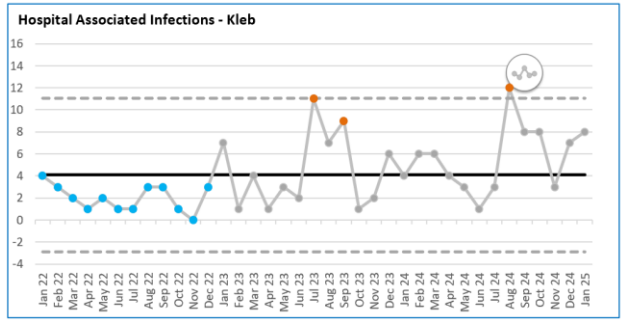
# Quality (3) – Safe

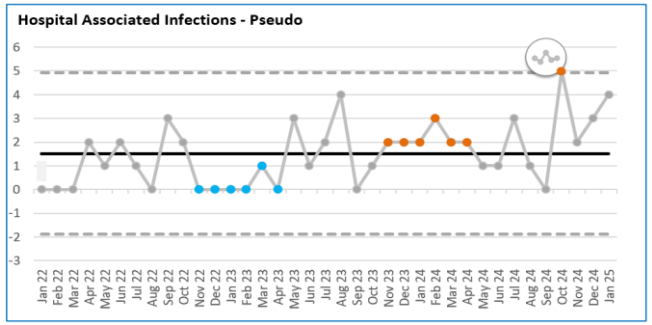



## Background/target description

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

## Performance

**Infection Prevention and Control (IPC)**:

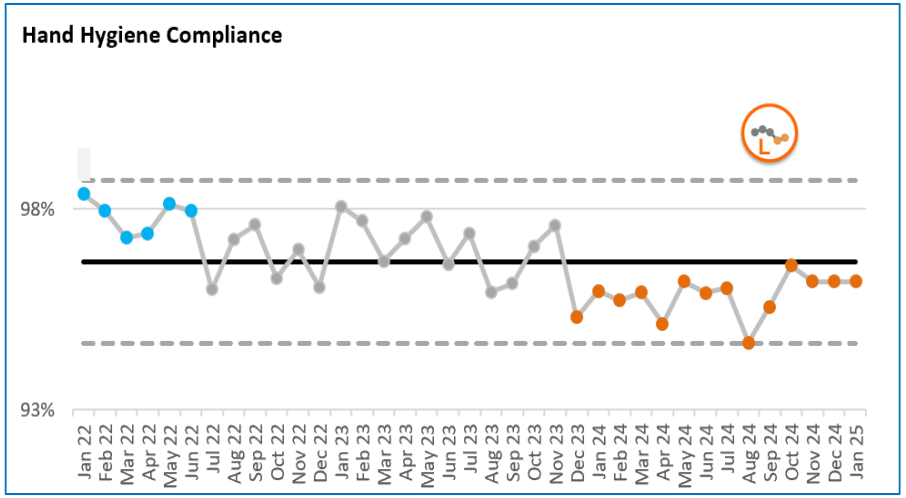
- Two cases of MRSA bacteraemia were identified in January 2025, placing UHD back within special cause variation. One case was community acquired, one case was hospital acquired, both in the Surgical Care Group
- There was decrease in cases of MSSA compared to December 24.
- Cases of *Escherichia coli* bacteraemia increased in January 2025 in comparison to December, a steady incline has been noted towards the upper level of special cause variation. IPC are investigating cases.
- *Clostridioides difficile* cases decreased in January 2025, falling below the median level.
- Total number of cases of *Klebsiella* increased in January 2025 remaining within special cause variation
- Cases of *Pseudomonas* increased in January 2025 compared to December 2024

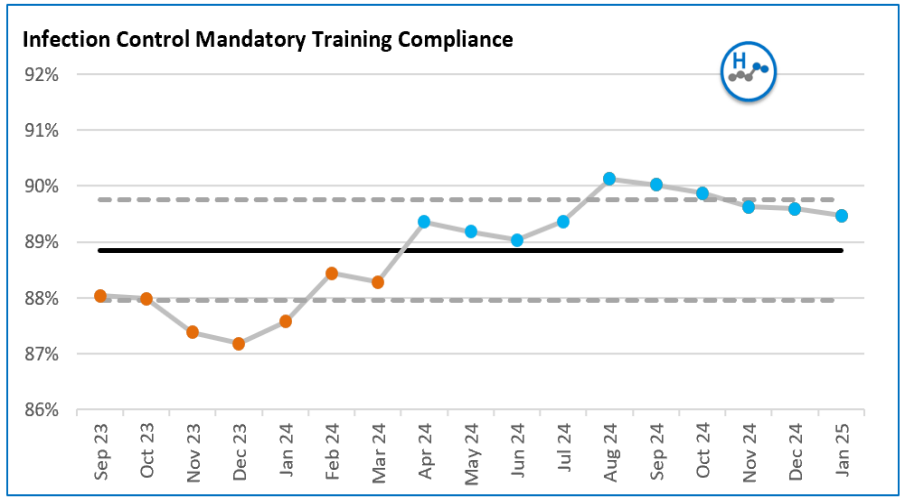
## Key Areas of Focus

- It is noted that all gram-negative bacteraemia increased in January 2025, IPC are carrying out case investigations to understand themes and identify any areas where improvements can be made

| Organism | Feb-24 | Mar-24 | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MRSA | 0 | 1 | 1 | 2 | 0 | 2 | 2 | 0 | 0 | 0 | 3 | 1 |
| MSSA | 6 | 6 | 4 | 1 | 4 | 8 | 8 | 5 | 5 | 3 | 5 | 3 |
| C Diff | 9 | 13 | 3 | 10 | 8 | 7 | 11 | 11 | 11 | 10 | 14 | 4 |
| E Coli | 8 | 8 | 7 | 14 | 9 | 14 | 13 | 7 | 9 | 12 | 14 | 18 |
| Kleb | 6 | 6 | 4 | 3 | 1 | 3 | 12 | 8 | 8 | 3 | 7 | 8 |
| Pseudo | 3 | 2 | 2 | 1 | 1 | 3 | 1 | 0 | 5 | 2 | 3 | 4 |
| Outbreaks | | | 2 | 0 | 4 | 1 | 2 | 1 | 0 | 0 | 4 | 5 |

# Quality (4) – Safe




## Background/target description

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

## Performance

**Infection Prevention and Control (IPC)** :

Hand hygiene audit

- Overall, Trust compliance at 96.2%, IPC discuss monthly at each care group IPC resource meeting to drive accurate reporting and oversight of hand hygiene compliance, noting that Hand Hygiene is a low special cause common variation.

**January 2025**

- Medical care group: 95.9% compliance
- Surgical care group: 96.4% compliance
- WCSS care group: 96.1% compliance

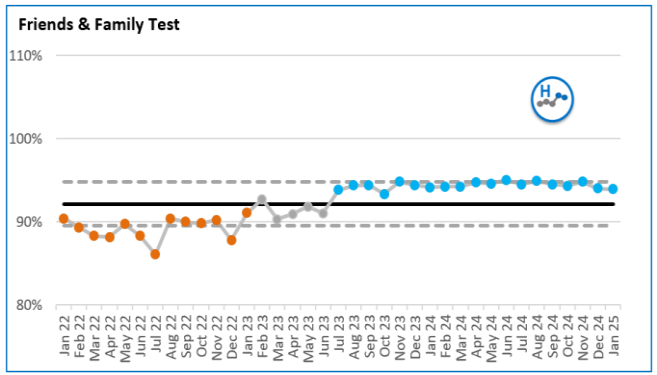
Infection Control Mandatory Training Compliance summary

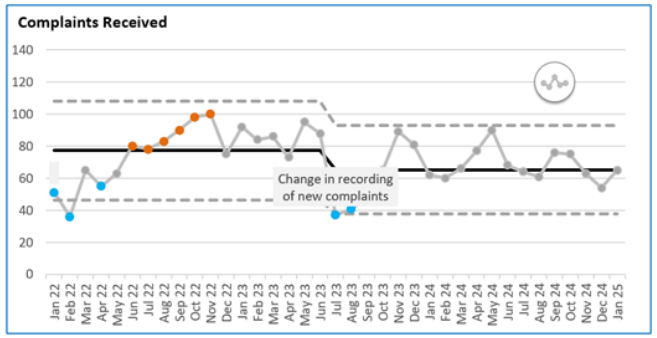
- Overall Trust compliance with Level 1 IPC training (all staff): 95.61%
- Overall Trust compliance with Level 2 IPC training (staff with patient contact): 86.53%

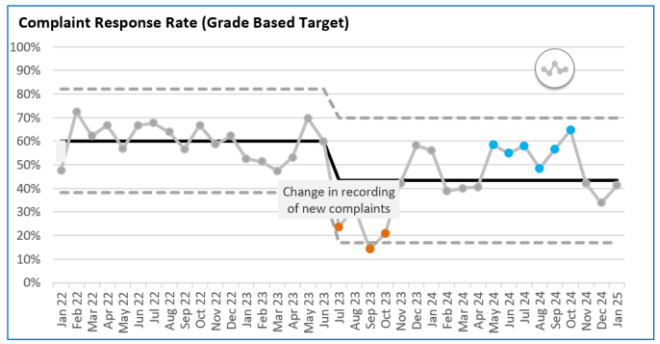
## Key Areas of Focus

- The focus remains Bare Below the Elbow and the fundamentals of IPC including hand hygiene and the correct use of PPE – alongside outbreak as hand hygiene and correct use of PPE are key

# Quality (5) – Caring




## Performance and Areas of Focus

**PALS and Complaints Data for January 2025:**

**Overview:**

- 629 PALS concerns raised
- 37 new formal complaints
- 28 Early Resolution complaints (ERC) processed.
- The number of complaints that were responded to and closed was 64

Complaints and PALS themes include communication and not meeting fundamentals of care. These concerns are being addressed at several meetings, including the Ward leaders and Patient Experience Group.

The number of open complaints over 55 days continue to be prioritised within the complaints team and care groups. The average complaint turnaround time was 41 days in January 2025. (The average complaint turnaround time was 60 + days in February 2024). More frequent meetings with GDoNs and HoN have commenced to focus even further on earlier resolution.

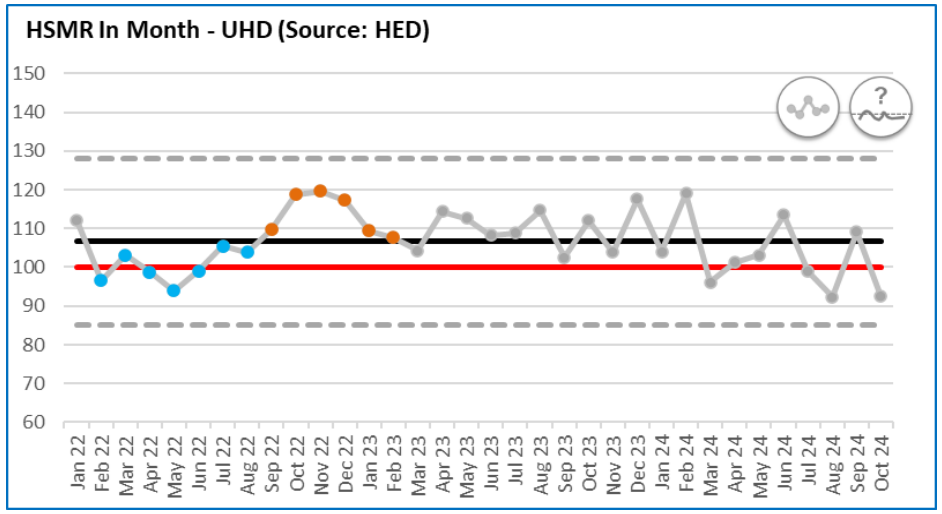
**Friends and Family Test (FFT)**

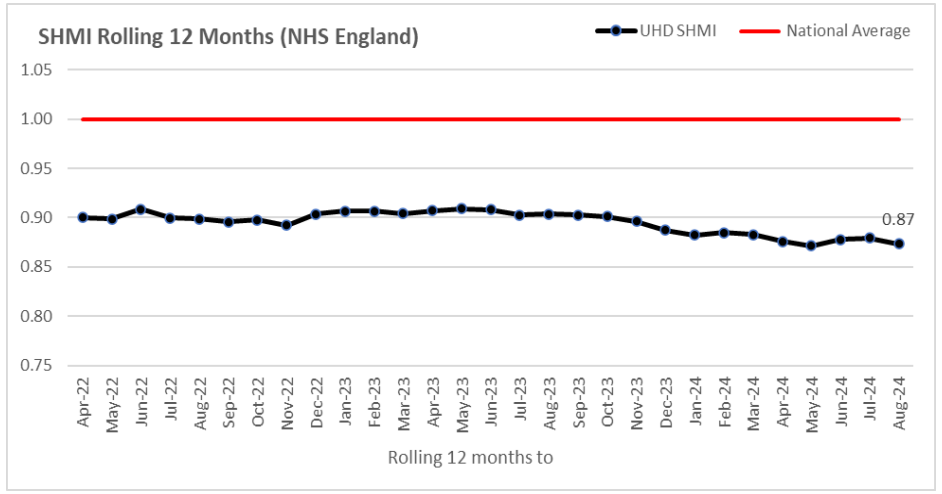
**FFT results:** FFT responses being received remain steady with a stable overall positive score  Seen in the SPC chart as special cause improved variation.  Note  mapping of FFT to areas is being examined in detail to improve data accuracy for location.

**Mixed Sex Accommodation Breaches**

There were 12 occurrences of MSA in January 2025 within Critical Care, 9 at Poole, 3 at RBH,

# Quality (6) – Effective & Mortality




## Background, Performance and Areas of Focus

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

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

Our in month HSMR for October 2024 is 92.4, below the national average of 100. Our rolling 12 month position is 104.1 and has been above the national average of 100 for over a year.

We continue to remain well below the national average in our SHMI (0.87) and it is the lowest of any acute trust in the South West.

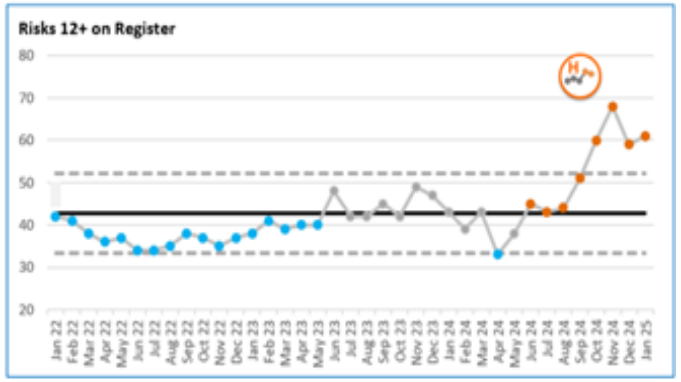
*The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust (within 30 days) and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

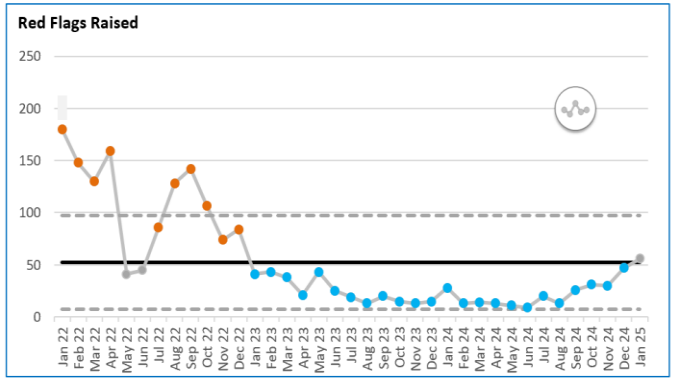
## Areas of Focus

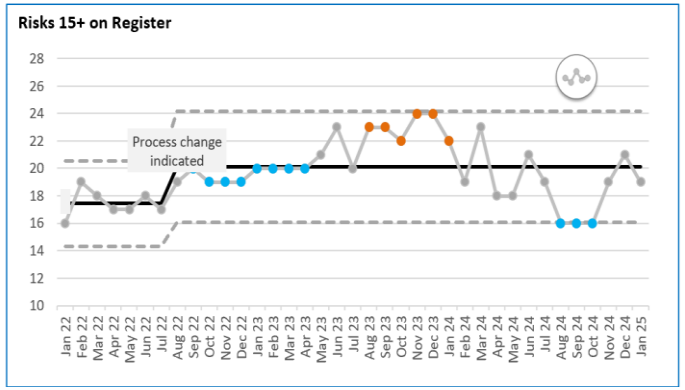
The Learning from Death process changed on the 11 November 2024. Deaths will now be selected against a clear set of criteria set out in the updated Learning from Deaths Policy – the aim is to ensure a sample size of circa 30% of total deaths. This will be monitored and reported down to consultant level data.

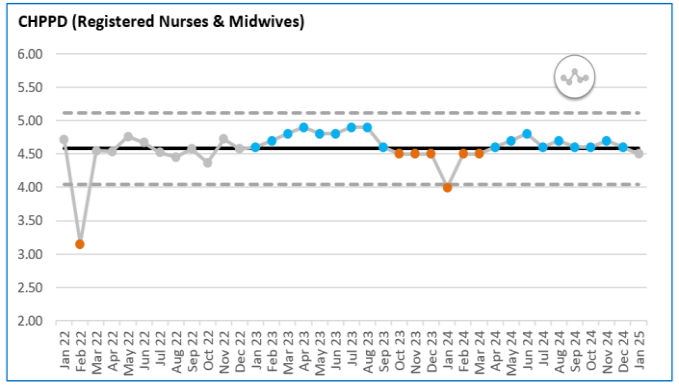
The Learning from Deaths Policy allows a 3 month time period for completion of required mortality reviews. Full month compliance data will therefore be not be available until the end of Q4 24/25.

# Quality (7) – Well Led




## Performance

- January 2025 care hours per patient day (CHPPD) for registered nurses and midwives combined is 4.5. Guidance for organisational level CHPPD for registered nurses and midwives advises this should be >3.
- The Red Flag data for January was 51 raised in month. 41% (21) reported challenges in the provision of enhanced care for patients, 20% (10) were raised due to an RN shortfall of more than 8 hours on a shift and 18% (9) were attributed to delays in delivering fundamental care. There were 3 (6%) of the red flags raised respectively for delays in medicine administration and time critical activity in Maternity. There were no critical staffing incidents reported indicating that mitigations were enacted to maintain safe staffing overall.
- Overall percentage rota fill rate against planned staffing (day & night) was 94.2% for January 2025.

## Key Areas of Focus

- Separate risk report provided to Trust Management Group (TMG) Quality Committee and Trust Board
- New UHD Trust Risk management strategy approved with greater focus on risk appetite, risk tolerance and risk escalation. Risks rated up to 12 can now be approved at Care Group level and do not require Exec sponsorship and approval at Board.
- This process change was introduced in October 24 and has resulted in a significant increase in risks rated 12.
- Risks rated 15-25 are now approved at TMG.

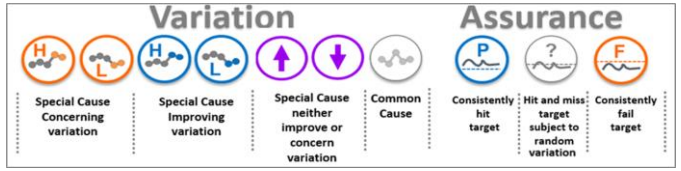
**Safe Staffing (Rota Fill Rates and CHPPD) - Total (Day & Night Combined) January 2024/25**

| Hospital Site name | Patient Count | Registered Nurses/Midwives | | | |
|---|---|---|---|---|---|
| | | Total monthly planned staff hours | Total monthly actual staff hours | Fill Rate % | CHPPD |
| Poole Hospital | 16408 | 85309.3 | 78924.0 | 92.5% | 4.8 |
| Bournemouth & Christchurch | 18090 | 78997.9 | 75933.5 | 96.1% | 4.2 |
| UHD Total | 34498 | 164307.2 | 154857.4 | 94.2% | 4.5 |

# 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 |
|---|---|---|---|---|---|---|---|---|
| Patient Safety Incidents (All) per 1,000 beddays | Jan 25 | 34.20 | - | | | 37.28 | 31.50 | 43.06 |
| Patient Safety Incidents (Moderate +) per 1,000 beddays - Closed only | Jan 25 | 0.40 | - | | | 0.39 | 0.04 | 0.74 |
| Medication Incidents (All) per 1,000 beddays | Jan 25 | 4.30 | - | | | 4.96 | 3.18 | 6.74 |
| Associated Pressure Ulcers (Cat 3 & 4) per 1,000 beddays | Dec 24 | 0.20 | - | | | 0.29 | 0.02 | 0.56 |
| Inpatient Falls (Moderate +) per 1,000 beddays | Jan 25 | 0.30 | - | | | 0.16 | -0.06 | 0.38 |
| Hospital Associated Infections - MRSA | Jan 25 | 0 | - | | | 0 | -1 | 2 |
| Hospital Associated Infections - MSSA | Jan 25 | 0 | - | | | 4 | -1 | 9 |
| Hospital Associated Infections - C Diff | Jan 25 | 0 | - | | | 8 | -2 | 17 |
| Hospital Associated Infections - E Coli | Jan 25 | 0 | - | | | 9 | -2 | 20 |
| Hospital Associated Infections - Kleb | Jan 25 | 0 | - | | | 4 | -4 | 11 |
| Hospital Associated Infections - Pseudo | Jan 25 | 0 | - | | | 1 | -2 | 5 |
| Hand Hygiene Compliance | Jan 25 | 96.2% | - | | | 96.7% | 94.7% | 98.7% |
| Infection Control Mandatory Training Compliance | Jan 25 | 0.0% | - | | | 83.6% | 67.8% | 99.4% |
| Friends & Family Test | Jan 25 | 0.0% | - | | | 89.6% | 80.0% | 99.1% |
| Complaints Received | Jan 25 | 65 | - | | | 65 | 38 | 93 |
| Complaint Response Rate (Grade Based Target) | Jan 25 | 41% | - | | | 43% | 17% | 70% |
| Mixed Sex Accommodation Breaches | Jan 25 | 0 | - | | | 8 | -12 | 29 |
| HSMR In Month - UHD (Source: HED) | Sep 24 | 109.40 | 100.00 | | | 107.02 | 86.45 | 127.59 |
| Deaths Within 36hrs of Admission | Jan 25 | 41 | - | | | 35 | 13 | 56 |
| Deaths Within Readmission Spell (5 day readmission) | Jan 25 | 22 | - | | | 21 | 9 | 34 |
| Risks 12+ on Register | Jan 25 | 61 | - | | | 43 | 33 | 52 |
| Risks 15+ on Register | Jan 25 | 19 | - | | | 20 | 16 | 24 |
| Red Flags Raised | Jan 25 | 56 | - | | | 52 | 8 | 97 |
| CHPPD (Registered Nurses & Midwives) | Jan 25 | 0.00 | - | | | 4.46 | 3.59 | 5.33 |



# Maternity (1)

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

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

## National position & overview

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

| Findings of review of all perinatal deaths using the national monitoring tool | Matters for Board information and awareness | Progress in achievement of Year 5 Maternity incentive scheme |
|---|---|---|
| **MBRRACE reportable cases:**<br><br>There were no incidents in January 2025 that have been reported for PMRT and (MBRRACE).<br><br>**MNSI**<br><br>There were no new MNSI cases in January | **Patient Safety Incident Response Framework (PSIRF)** has been implemented in maternity.<br><br>There are three incidences escalated for after action reviews in line with PSIRF.<br><br>1. Incorrect patient details on swab results published on incorrect Dorset care record<br>2. Anti cw antibodies detected at 13 weeks and test not repeated<br>3. Hep B vaccine given at 24 hours –incorrect timeframe.<br><br>**Top incidences LFPSE**:<br>Term admissions to NICU –ATTAIN at 8.1%. All cases being reviewed. QI project in progress with safety champions oversight.<br><br>**Safety champions reviews this month:**<br>January Safety champions report<br>January Listening event and walkabout<br><br>GMC trainee feedback and action plan | CQC action plan -<br>Assure:<br>Action Plan now closed as completed.<br><br>Maternity incentive scheme year 6 -<br>MIS standards assessment by ICB and auditors – final standards verified and submission of full compliance in February (once portal is open)<br><br>Insight and 3-year delivery plan -<br>Assure<br>End of year 1 report presented and actions for year 2 in place.<br><br>MSSP exit criteria -<br>Assure<br>All actions progressing and reset and review of progress by National team and now in the sustainable phase.<br><br>2024 CQC Maternity Survey results published, and the results show continuing improvement since 2022. |

# Maternity (2)

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

## Summary of maternity & neonatal metrics

| Provider | UHD | | | | |
|---|---|---|---|---|---|
| Metric Name | Latest Date | Value | Target | Variation | Assurance |
| Percentage of midwife posts which are vacant. (A negative value indicates an employed FTE is higher than a funded FTE, and that there's an overstaffing compared to funded FTE. | Jan 25 | 3.39% | | | |
| Percentage head count of midwives leaving the trust in the last 12 rolling months | Jan 25 | 5.93% | | | |
| Percentage of FTE days absent for midwives | Jan 25 | 7.10% | 3% | | |
| Number of incidents of Hypoxic-Ischemic Encephalopathy (HIE) in babies | Jan 25 | 0 | | | |
| Apgar score < 7 at 5 mins - term singletons (current three months) | Jan 25 | 12 | 13 | | |
| Number of women admitted to ITU associated with birth up to 28 days post-natal (any birth, not including any other trust birth) | Jan 25 | 0 | | | |
| All deaths of pregnant women and women up to one year following the end of the pregnancy (regardless of the place and circumstances of death) | Jan 25 | 0 | | | |
| % of babies receiving breast milk at discharge from midwifery 10-28 days | Jan 25 | 68.4% | | | |
| % of babies receiving breast milk at first feed | Jan 25 | 75.2% | 72% | | |
| Rate per 1,000 registerable live birth babies who died <28 days from birth | Jan 25 | 0 | | | |
| Number of registrable livebirth babies who died < 28 days from birth | Jan 25 | 0 | | | |
| % of term babies admitted to NNU | Jan 25 | 8.16% | 5% | | |
| Rate per 1,000 births which are preterm ( < 37 week's gestation) | Jan 25 | 57.4 | | | |
| Number of singleton babies born less than 27 weeks gestation or multiples born at less than 28 weeks or the weight of the baby is less than 800 grams. | Jan 25 | 7 | | | |

## Data and Target

The national PQS Diis Scorecard is rated based on SPC methods and comparison to national targets.

## Performance

Areas to note:
**Term admissions to NICU:** QI improvements in place however this month admissions greater than national target of 6 % showing improvements are currently not sustained . Review of all cases ongoing.

**% of bookings <10 weeks:** Some improvements over last few months but further work needed to reach 65 % target

## Key Areas of Focus

**Term admissions to NICU:** QI improvements continue.

**Increase in women smoking at delivery** which is reflective of staffing gaps last August/September and supports the importance of this service . This has been addressed with a forward plan of resilience should sickness occur in this small team.

**BEACH move**: Staff simulation training underway this month to ensure safety in new environment in obstetric and neonatal emergencies.

* Additional workforce metrics now on Diis metrics however some data quality issues being identified. All data has had cross-referencing to ensure all quality issues have been identified.

# Maternity (3)

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

## Summary of maternity & neonatal metrics

| Provider | UHD | | | | |
|---|---|---|---|---|---|
| Metric Name | Latest Date | Value | Target | Variation | Assurance |
| Annual rate of stillbirths per 1,000 births - rolling 12mths | Jan 25 | 3.20 | 2.5 | | |
| Number of still births | Jan 25 | 1 | | | |
| % of babies <3rd birthweight centile, born >37+6 weeks | Jan 25 | 100% | | | |
| No. of registrable babies born | Jan 25 | 296 | | | |
| Number of babies born | Jan 25 | 300 | | | |
| Number of women delivered (multiple births where at least one unregistrable and one registrable) | Jan 25 | 0 | | | |
| Number of women delivered (unregistrable) | Jan 25 | 4 | | | |
| Number of women delivered (all births) | Jan 25 | 296 | | | |
| Rate per 1,000 women with 3rd/4th degree tears (current three months aggregated) | Jan 25 | 27.1 | 28 | | |
| Rate per 1,000 women with PPH 1500ml or more (previous 3 months aggregated) | Jan 25 | 39.2 | 30 | | |
| % of women smoking at delivery (previous month) | Jan 25 | 8.04% | 6% | | |
| % of women with a CO measurement at time of 36 weeks gestation | Jan 25 | 83.4% | 95% | | |
| % of women (IMD-1) placed on a continuity of carer pathway | Jan 25 | 13.3% | | | |
| % of Black and Asian women placed on a continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks' gestation | Jan 25 | 48.3% | | | |
| % of women placed on a continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks' gestation | Jan 25 | 8.12% | | | |
| % of women with a CO measurement at time of booking | Jan 25 | 97.5% | 95% | | |
| % of women smoking at booking | Jan 25 | 7.29% | | | |
| % of bookings booked <10 Weeks | Jan 25 | 50% | 65% | | |
| Total number of bookings | Jan 25 | 398 | | | |

# Our People

**Tina Ricketts**
Chief People Officer

**Operational Leads:**
Irene Mardon - Deputy Chief People Officer

**Committees:**
People and Culture Committee

University Hospitals Dorset
NHS Foundation Trust

# Well Led - Workforce (1)

## Operational Plan Monitoring

| Staff Type | Plan/Actual | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Substantive | Actual | 8871.0 | 8868.3 | 8885.0 | 8865.7 | 8891.4 | 8931.7 | 9014.9 | 9028.4 | 9022.5 | 9035.6 | | |
| | Plan | 8889.7 | 8889.7 | 8889.7 | 8889.7 | 8889.7 | 8889.7 | 8889.7 | 8889.7 | 8889.7 | 8878.7 | 8867.7 | 8839.7 |
| Bank | Actual | 806.9 | 773.5 | 810.0 | 780.9 | 750.1 | 762.9 | 779.6 | 731.7 | 699.4 | 636.9 | | |
| | Plan | 827.0 | 808.8 | 790.5 | 772.3 | 754.0 | 735.8 | 711.2 | 686.5 | 661.9 | 637.3 | 612.6 | 588.0 |
| Agency | Actual | 255.5 | 235.4 | 202.0 | 216.9 | 215.1 | 218.0 | 219.3 | 201.5 | 195.7 | 166.7 | | |
| | Plan | 283.2 | 276.7 | 270.3 | 263.9 | 257.5 | 251.0 | 242.4 | 233.7 | 225.0 | 216.3 | 207.7 | 199.0 |

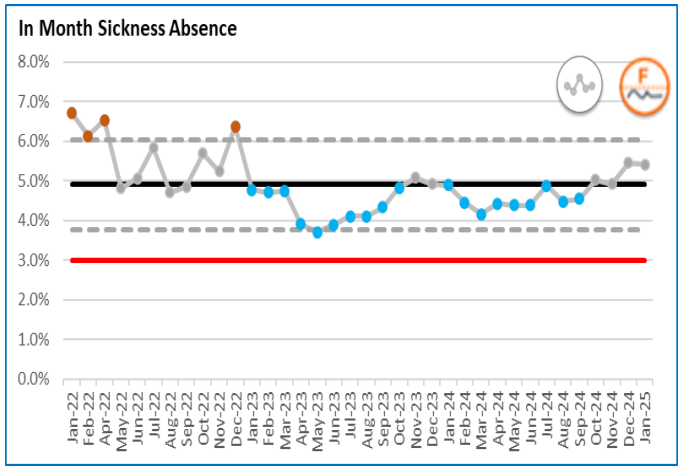
| Staff Type | Plan/Actual | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total Staff | Actual | 9933.4 | 9877.2 | 9897.0 | 9863.4 | 9856.6 | 9912.5 | 10013.8 | 9961.6 | 9917.5 | 9839.2 | | |
| | Plan | 9999.9 | 9975.2 | 9950.5 | 9925.9 | 9901.2 | 9876.5 | 9843.2 | 9809.9 | 9776.6 | 9732.3 | 9688.0 | 9626.7 |

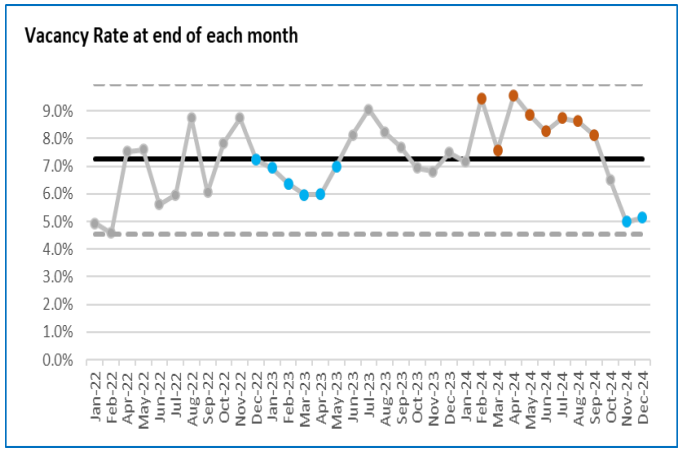
**Operational Plan Monitoring**

This table shows the performance against the workforce plan as at month 11, which confirms that in month we are above plan by c107wte. We are currently c213wte away from the March 2025 plan. However, our forecast is to be 163wte above plan at year end due in part to the planned opening of escalation areas and higher than planned use of healthcare support workers for specialing.

Reductions in bank and agency usage is now visible.

# Well Led - Workforce (2)




## Performance

**Sickness Absence and Wellbeing**

- In month sickness absence for January 2025 was 5.41% which is consistent with the seasonal variation. The latest rolling 12-month rate is 4.72% which is higher than the previous month.

**Vacancy Rate**

- The vacancy rate is reported a month in arrears to allow for reconciliation with the ledger. The latest vacancy position is 5.1% (as at end of December) which is a small increase from the 4.93% in November.
- In January 2025, we received a total of 6,671 applications, 5,565 of those were for general recruitment posts, which is the highest number that we have previously recorded, there does not appear to be an obvious reason for this. January is always a busy month for job seekers, and there is also the suggestion that increased use of AI in applications could be a factor.
- There were 214 starters in total in month, with 107 of those being internal appointments. 253 offers were made in total and 329 posts were advertised. Medical Recruitment accounted for 39 of those adverts, which is significantly higher than the Trend.

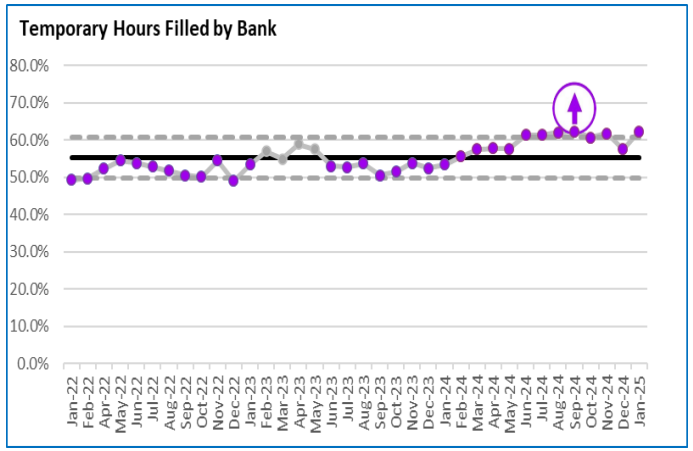
**Occupational Health, Psychological Support and Counselling Service (PSC) and Staff Vaccinations**

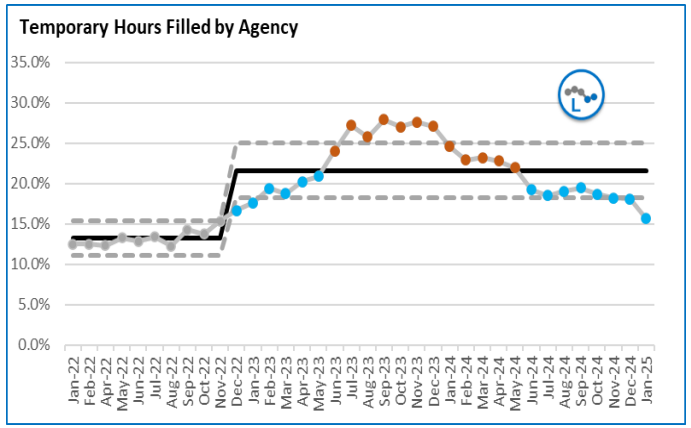
- Covid vaccinations ended on 31st January 2025. The Flu vaccination program for NHS staff continues until 31st March 2025.
- Self-referrals to the Psychological Support and Counselling service averaged 15 per week in January representing a 15 increase from December. The primary reasons reported for referral remain high stress (↓83%) and depression (↑49%) with ↓11% reported as signed-off work by their GP. Waiting times for an initial assessment remain within the target of less than 2 weeks. 64 staff are receiving ongoing support. However, due to vacancies the Counselling provision is currently closed to new Clients – they are being advised on alternative external services where applicable. Completed feedback indicates ↑69% of staff accessing the service reported the support they received as helping them to remain in work rather than going off sick due to stress/mental health.
- In addition to self-referrals (i.e., individuals), Team Support/Psychological Coaching is currently being provided to 3 Teams and Restorative Clinical Supervision to 2 Teams.

Vaccinations by Frontline Status

| Frontline Status | Headcount | Covid | Covid % | Flu | Flu % | Both | Both % |
|---|---|---|---|---|---|---|---|
| Frontline | 9930 | 2650 | 26.69% | 3357 | 33.81% | 2488 | 25.06% |
| Non-Frontline | 1170 | 407 | 34.79% | 451 | 38.55% | 387 | 33.08% |
| **Total** | **11100** | **3057** | **27.54%** | **3808** | **34.31%** | **2875** | **25.90%** |

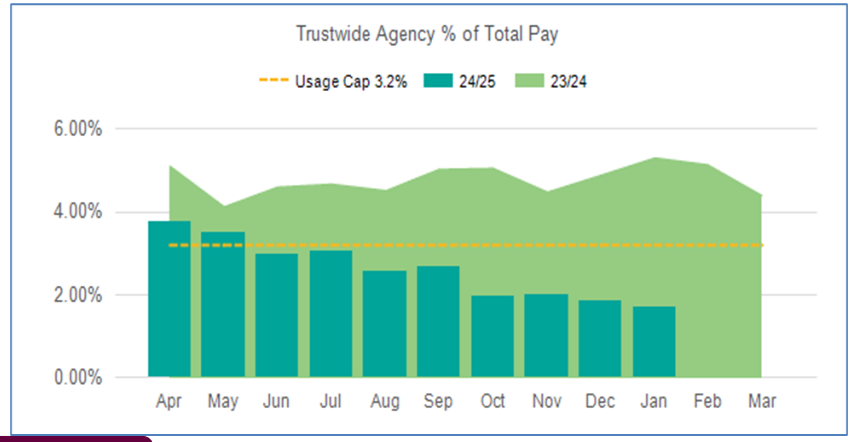
# Well Led - Workforce (3)

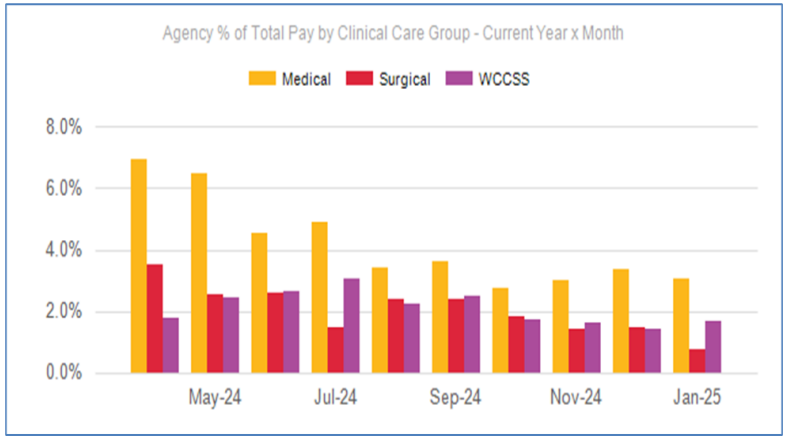


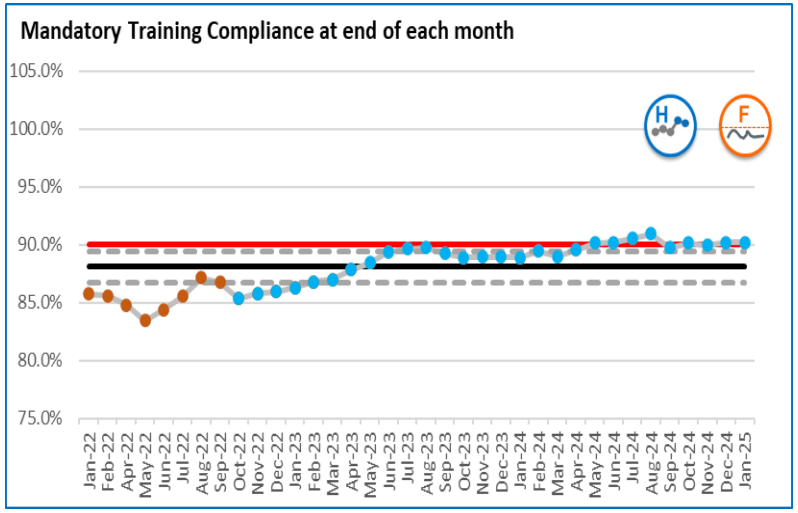

## Performance

- We have seen a further decrease in in-month agency spend from 1.86% in Month 9 to 1.69% in Month 10. This remains well below the national 3.2% target. Year to date agency spend is 2.57%.
- In month agency spend has seen a decrease in the Medical Care Group from 3.4% (December 2024) to 3.1% (January 2025) , the Surgical Care Group has seen a decrease from 1.5% to 0.7%. Women's, Children, Cancer and Support Services Care Group has seen an increase from 1.4% to 1.7%.
- The Trust reported  off-framework agency usage for M9  for nursing.(ED and Critical Care). There is a zero retun for month 10.
- The Trust currently engages with over 30 Allied Health Professional (AHP) agency workers who cover roles mainly within Pharmacy, Biomedical Sciences, Radiology, and Theatres. As part on the Trust's ongoing drive towards agency price cap compliance and in collaboration with the Southwest region, work has commenced to bring the supply of these workers into price cap compliance. The following areas have staff working above the cap compliance rate: Blood Sciences, Radiology and Pharmacy. A paper is being presented to Trust Management Group in relation to these areas



# Well Led - Workforce (4)




## Performance

### Mandatory Training

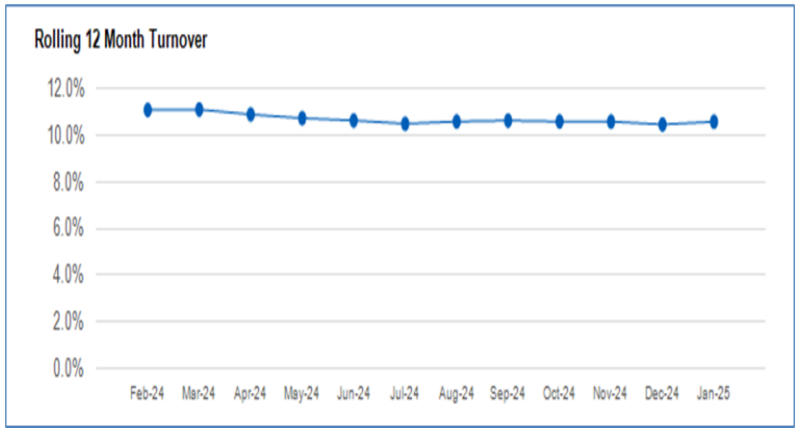
- Mandatory Training compliance has increased slightly to 90.20% as at end of January 2025

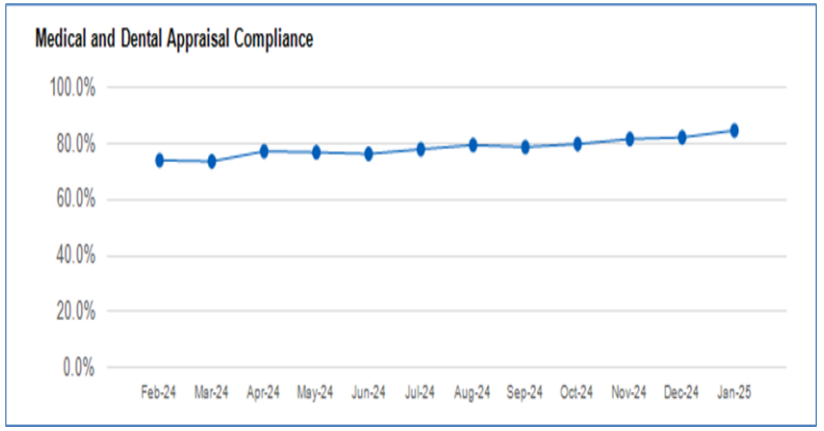
### Turnover

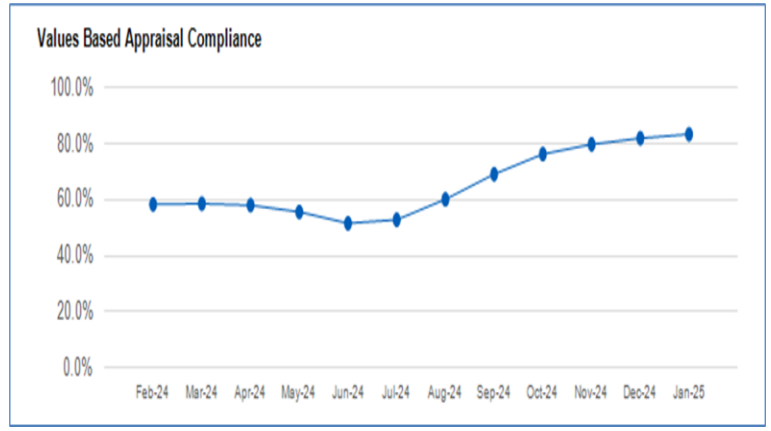
- The rolling 12month staff turnover rate (excluding fixed term temp) is at 10.6% as at end of January 2025, which is in line with previous month.

### Appraisal

- Non-medical appraisal compliance has increased since last month from 82.6% at end of December, to 83.4% at end of January. This is now using a rolling 12 month rolling period. Medical and Dental compliance has increased to 84.8%.



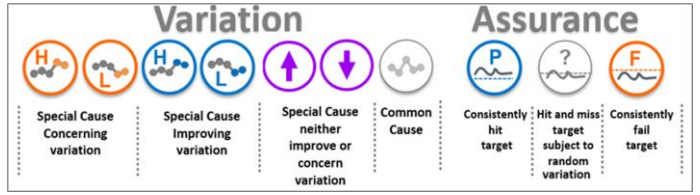



# Performance at a glance
# Well Led - Key Performance Indicator

## UHD Workforce

| KPI | Latest month | Actual | Target | Variation | Assurance | Mean | Lower process limit | Upper process limit |
|---|---|---|---|---|---|---|---|---|
| Vacancy Rate at end of each month | Dec 24 | 5.1% | - | | | 7.3% | 4.5% | 10.0% |
| In Month Sickness Absence | Jan 25 | 5.4% | 3.0% | | | 4.9% | 3.8% | 6.0% |
| Mandatory Training Compliance at end of each month | Jan 25 | 90.2% | 90.0% | | | 88.1% | 86.7% | 89.4% |
| Temporary Hours Filled by Bank | Jan 25 | 62.3% | - | | | 55.3% | 49.9% | 60.6% |
| Temporary Hours Filled by Agency | Jan 25 | 15.6% | - | | | 21.6% | 18.3% | 25.0% |
| Agency Pay as Proportion of Total Pay | Jan 25 | 1.7% | | | | 4.1% | 2.7% | 5.4% |
| | | | | | | | | |



# Population Health and System Working

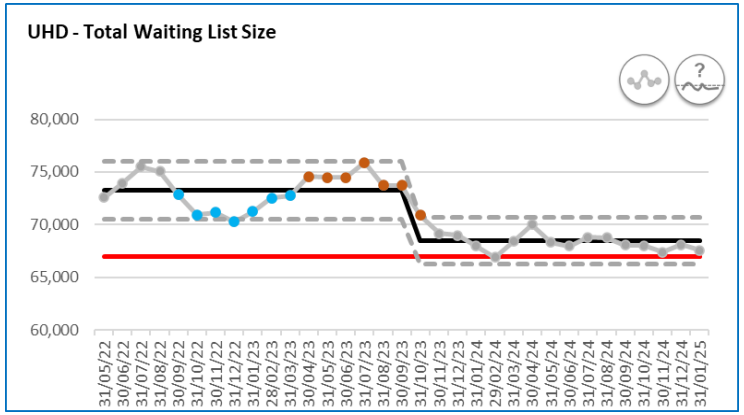
**Mark Mould**
Chief Operating Officer

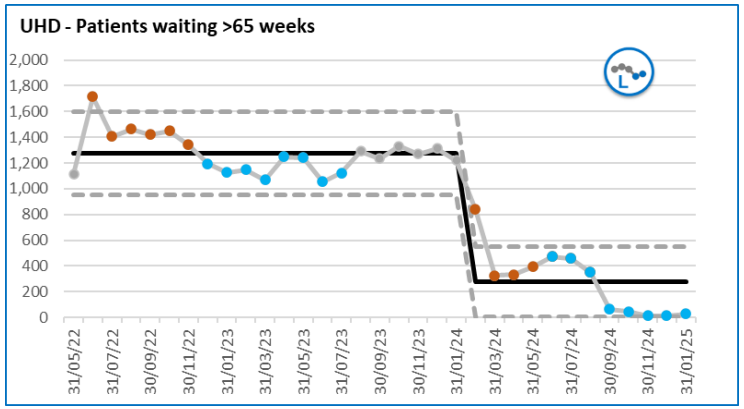
**Operational Leads:**
Judith May – Director of Operational Performance and Oversight
Mark Major – Deputy Chief Operating Officer
Abigail Daughters – Group Director of Operations – Surgery
Darren Jose – Group Interim Director of Operations – Women's, Children, Cancer and Support Services
Leanna Rathbone – Group Director of Operations – Medical

**Committees:**
Finance and Performance Committee

NHS
University Hospitals Dorset
NHS Foundation Trust

# Responsive – (Elective)
# Referral to Treatment (RTT)




| | Standard | UHD | % of pathways with a DTA |
|---|---|---|---|
| **Referral To Treatment** | | | |
| 18 week performance % | 92% | 60.6% | |
| Waiting list size (and trajectory) | 66,982 | 67,553 | 23% |
| Waiting List size % variance compared to trajectory | | 0.9% | |
| No. patients waiting 26+ weeks | | 16,430 | 36% |
| No. patients waiting 40+ weeks | | 6,830 | 43% |
| No. patients waiting 52+ weeks (and % of waiting list) | 3.2% | 2,167 | 52% |
| No. patients waiting 65+ weeks (and % of waiting list) | 0.0% | 29 | 97% |
| No. patients waiting 78+ weeks (and % of waiting list) | 0.0% | 0 | 0% |
| % of Admitted pathways with a P code | | 99.65% | |

## Data Description and Target

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

## Performance

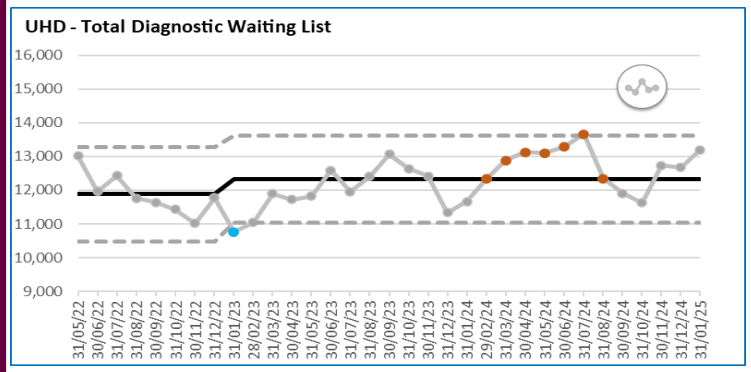
- The Referral to Treatment (RTT) waiting list size shows a decrease in January 2025 (-526) to 67,553 and the variation to the operational planning trajectory (66,982) has also decreased to 0.9% above trajectory. The target waiting list remains within current process control limits; indicating the target is achievable.
- The Trust delivered 111.4% value weighted elective activity year to date in January compared to the 2019/20 baseline period; this is above the operational plan year to date trajectory (108.6%).
- Zero waits above 78 weeks has been maintained. As forecasted however, the essential boiler works in the Sterile Services department in January saw a loss of 20 theatre sessions. Emergency and Cancer work was delivered. The impact on 65 week wait patients was that the Trust reported 29 breaches at the end of January. Of which, 8 were corneal patients awaiting graft material.
- Waits greater than 52 weeks are 2,167 and increased compared to December but remain below the operational plan trajectory for January (2,592). 52 waits were also impacted by the reduced SSD capacity.

## Key Areas of Focus

Maintaining elective activity rates above the 2019/20 baseline by:

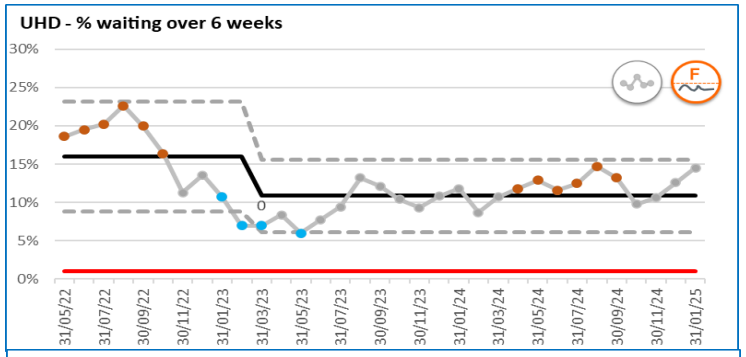
- Prioritised booking for all patients in the February and March 65 week cohort into capacity in February for outpatient slots and theatre capacity to deliver 0 65 week waits by end February (except for corneal grafts)
- Utilising UHD & ICB contract capacity with independent sector providers for treatment of long waiters.
- Increasing productivity within core capacity, including reducing missed appointments (DNAs) and improving theatre and outpatient session utilisation rates.
- Continued validation of the waiting list to achieve 90% of all pathways validated every 12 weeks
- Minimising the impact of urgent care demand and patients with ‘no criteria to reside’ on elective care beds.

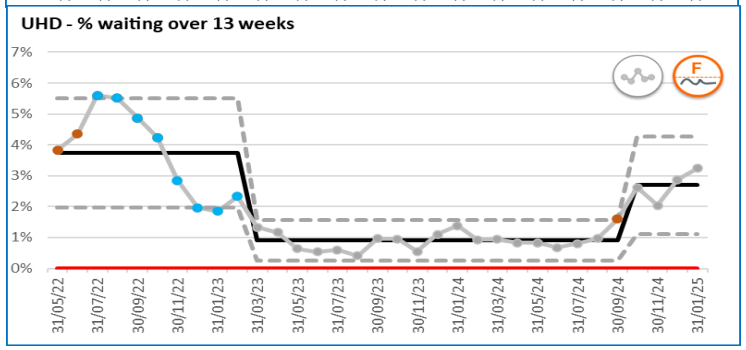
# Responsive – (Elective) Diagnostic Waits




**Diagnostic Performance (DM01)**

| | | | | |
|---|---|---|---|---|
| % of >6 week performance | *(6+ Weeks / Total)* | 1% | 1912/13197 | 14.5% |




## 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

January 2025 performance moved to 14.5% compared with 12.6% at the end of December 2024, (capacity in month was reduced due to the New Year bank holiday).
Performance remains within the upper and lower process control limits; however further improvement is required to meet the 1% target. There are currently 428 patients waiting more than 13 weeks for a diagnostic test; the majority of these (378) are Neurophysiology patients. Booking these long waiting patients is the focus for all modalities. Overall waiting list is 13,197 patients.

**Endoscopy** Performance moved to 7.9% at the end of January (5.2% at the end of December)

- Impacted due to long term endoscopist sickness and capacity issues with cystoscopy. There is ongoing use of 18 Weeks Support insourcing and waiting list initiatives (WLIs) to support delivery of the Community Diagnostic centre (CDC) activity plan.

**Echocardiography** performance has moved to 23.7% in January (from 8.9% in December).

- Performance is impacted by ongoing vacancy gaps and sickness reducing capacity and a significant increase in referral numbers.

**Neurophysiology** performance has moved to 63.4% in January (from 55.6% in December).

- Consultant vacancy (now combined with maternity leave) 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. Outsourcing commenced in November.

**Radiology** performance improved to 4.1% in January (from 4.8% in December).

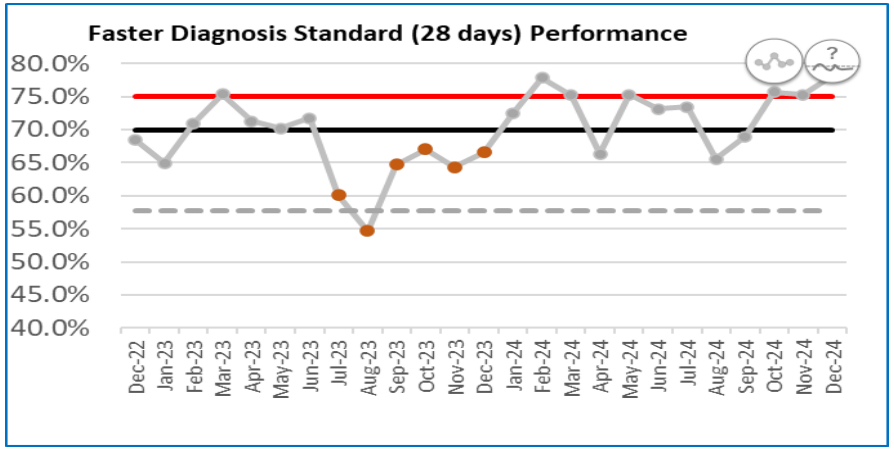
- Target is not being achieved predominately due to a sustained increase in number of in-patient MRI referrals.

## Key Areas of Focus

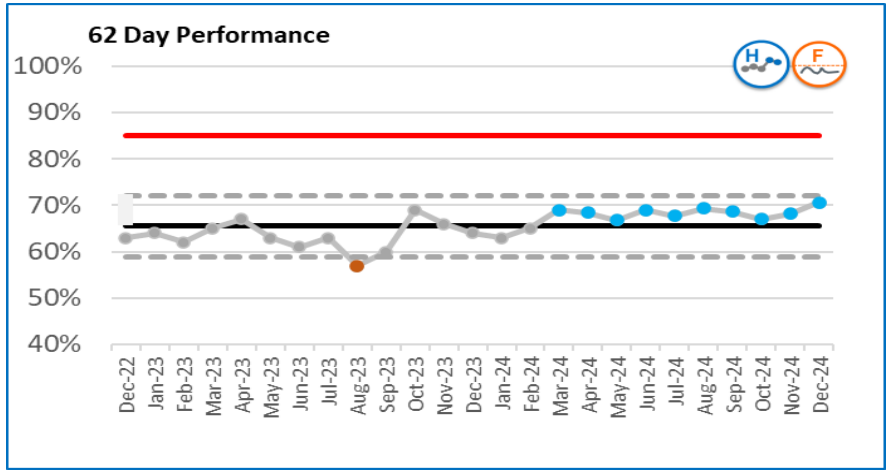
- **Endoscopy:** Cystoscopy are working to increase performance via private healthcare insourcing.
- **Echocardiography:** Recovering the standard diagnostic echo backlog.
- **Neurophysiology**: Haven Medical outsourcing to support recovery now commenced, at a rate of 4 lists per week (20 patients).New physiologist commenced early December. Consultant candidate withdrew from an Advisory Appointments Committee (AAC) panel scheduled for January. Additional Haven Medical capacity being scoped to enable faster reduction of backlog.
- **Radiology**: Further additional paediatric MRI (General Anaesthetic) lists added to clear paediatric backlog. There are 298 MRI patients waiting longer than 6 weeks at the end of January; however, we are converting CDC CT activity to MRI which will reduce the backlog over the next couple of months and exploring potential short-term mobile MRI placement or use of BU 3T MR scanner.
- **Cardiology** Cardiac CT and MR backlogs have now been resolved.
- **Sleep Studies**: Reviewing capacity and demand to manage growing backlog (89 patients wating longer than 6 weeks at end of January).

# Responsive (Elective)
# Cancer FDS & 62 Day Standard

**28 Day Faster Diagnosis Standard**
**(National Target 75.0% & Trust Trajectory 76.0%)**
Finalised UHD December 2024 Performance (78.1%)




**62-Day Standard**
**(National Target 85%, Trust Trajectory 69.0%)**
Finalised UHD December 2024 Performance (70.6%)




## Data Description and Target

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

## Finalised December 2024 Performance

- **28 Day Faster Diagnosis Standard** - Performance in December 2024 was 78.1%, achieving both the 75.0% national standard and the Trust trajectory of 76.0%  Nine out of thirteen tumour sites achieved the national standard.

- **62 Day Standard** - Performance in December 2024 was 70.6% achieving the Trust trajectory of 69.0%. Performance has continued to be above the mean for 10 consecutive months showing special cause improvement. The upper process control limit falls below the national standard, however. This is a recognised national challenge and therefore the Trust has an internal trajectory to meet 70.0% by March 2025. The main breach reasons in December 2024 were due to capacity challenges at the front end of the pathways and delays to surgical treatments.

- **31 Day Standard** - Performance in December 2024 was 94.5%.  The main reason for breaches against this standard were  due to Skin surgical capacity at Christchurch.  Additional capacity has been confirmed throughout Q4 to recover this standard.

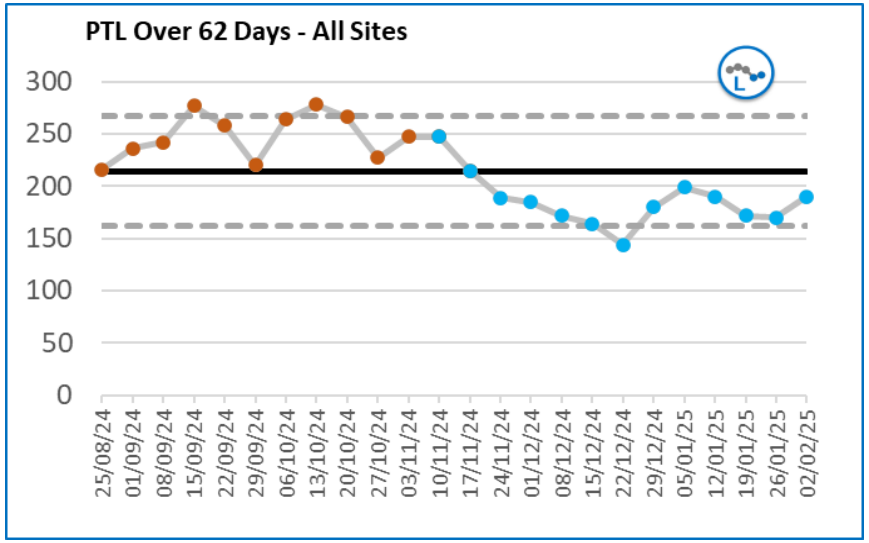
- **Patient Treatment List (PTL) Over 62 Days** - The total number on the PTL over 62 days decreased to 180 patients (40 below the 220 Target).

## Provisional January 2025 Performance (un-finalised)

- **28 Day Faster Diagnosis Standard -** Performance in January 2025 is currently meeting the national standard at 75.8% but it is just below the Trust trajectory of 76.5%.
- **62 Day Standard -** Performance in January 2025 is currently 57.9% against the Trust trajectory of 69.1%.  Performance is expected to increase as further treatments are reported, however due to challenges at the front end of the pathway in Q2/Q3, the internal Trust trajectory is unlikely to be achieved.
- **31 Day Standard** - Performance in January 2025 is currently 92.6% which is 3.4% below the standard.  The primary challenge is Skin surgical capacity at Christchurch. Additional minor operations (MOPS) capacity for Dermatology commenced in Q4 which will contribute to recovery for this standard.
- **Patient Treatment List (PTL) Over 62 Days** - The month end position for January 2025 decreased to 170 patients over 62 days (50 below the 220 Target).

# Responsive (Elective)
# Cancer Over 62 Day Breaches

**Over 62 Day PTL (Target: 220)**
Finalised UHD January Performance: 170




**High Level Performance Indicators**

| Cancer Standards | Standard | Final | Provisional |
|---|---|---|---|
| | | Dec-24 | Jan-25 |
| 28 Day Faster Diagnosis Standard | 75% | 78.1% | 75.8% |
| 31 Day Standard | 96% | 94.5% | 92.6% |
| 62 Day Standard | 85% | 70.6% | 57.9% |
| PTL Over 62 Days | 220 | 180 | 170 |

## Key Areas of Focus

In 2024/25 the focus for Cancer Performance has returned to the 3 main National Standards (28 Day, 31 Day and 62 Day).

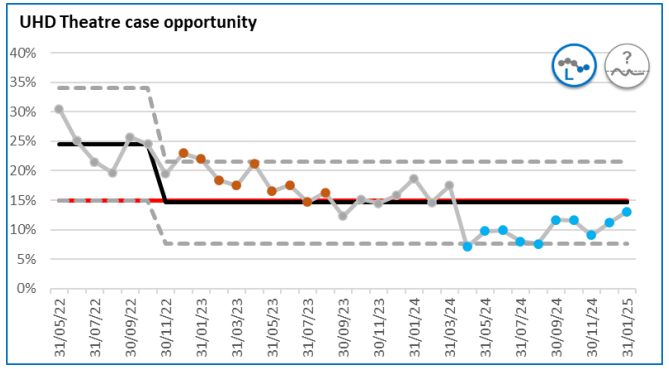
**Key areas of focus for Quarter 4 2024/25 are the 3 most challenged tumour sites:**

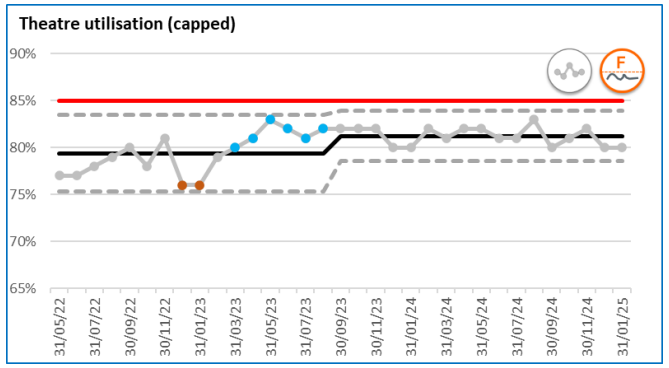
**Breast:**
- Sustaining 28D FDS performance above the internal trajectory throughout February and March 2025.
- Securing and sustaining additional radiology capacity to enable delivery of one stop fast track clinics.
- Ensuring minimal impact of planned consultant retirement on capacity and performance against cancer standards.
- Closer working with Histopathology to minimise delays in the diagnostic pathway.

**Skin:**
- Progression of the Dermatology Business Case to deliver increased capacity
- Recovering and sustaining 28D FDS performance above the internal trajectory throughout February and March 2025.
- Recovering and maintaining the 31D performance target throughout February and March 2025 with additional MOPs sessions.
- Aligning site specific waiting lists for treatment to ensure patients are treated in chronological order.
- Maintaining additional insourcing activity to accommodate the year-on-year increase in referrals and associated need for surgical interventions.
- Evaluate the impact of the Skin Analytics AI pilot to determine future service requirements.

**Colorectal:**
- Achieving the 28D FDS operational plan in Q4.
- Utilising the Trust Clinical Transformation forum to agree actions to reduce the time from diagnosis to decision to treat and positively impact the 62D standard.
- Recruit to Pathway Navigator and additional nursing posts following completion of the Pathway Analyser with the Wessex Cancer Alliance.

# Responsive (Elective)
## Theatre Utilisation




## Data Description and Target

Trust is pursuing a **capped utilisation** of 85% which takes into consideration downtime between patients.
Case opportunity is a measure of the time lost to inefficiency and expressed as the number of additional patients that could have been treated.
Day case rate (Target 85%), includes only those procedures classified by the British Association for Day Case Surgery (BADS)

## Performance

**Theatre Utilisation**

- Overall capped theatre utilisation in January 2025 is 80%, which is a 1% increase from December 2024 position. However, specialities remaining over 85% in month include BESS 87%, Colorectal @ 92%, Vascular 86%, and Upper Gastrointestinal Surgery just under @ 84%
- January overall performance fell below the operational plan trajectory of 82.09%, and was influenced by two factors:
  - Challenged in month activity due to SSD emergency gas works, reducing activity.
  - Hospital flow and bed capacity remain a challenge and a large factor in meeting the target. Whilst list planning is stable with good planned utilisation of lists, capacity challenges on the day due to hospital bed pressures are resulting in cancelations and reduction of activity.
- However, cases per session has slightly increased in month from 3.1 to 3.2.

**Day Case Procedures**

- The latest published Daycase (BADS) rate (October 2024), demonstrated UHD is consistently achieving 86%, remaining above the 85% target. Other notable improvements within theatres and theatre planning include:
- The number of surgical day case patients converted to inpatients remains below the national target
- Further reduction in unplanned over runs, evidencing accurate theatre scheduling

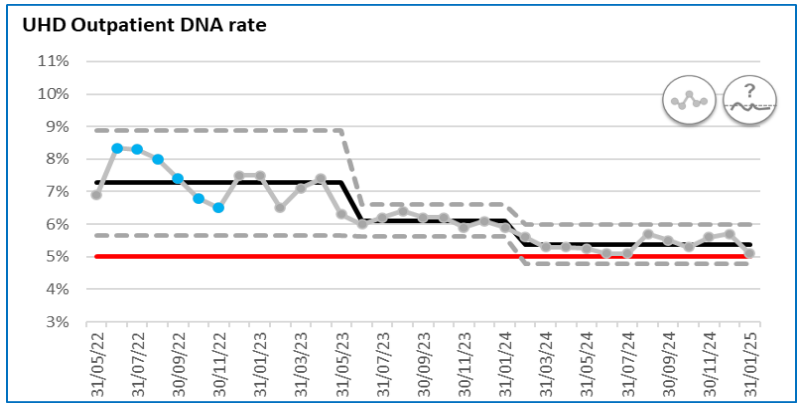
## Key Areas of Focus

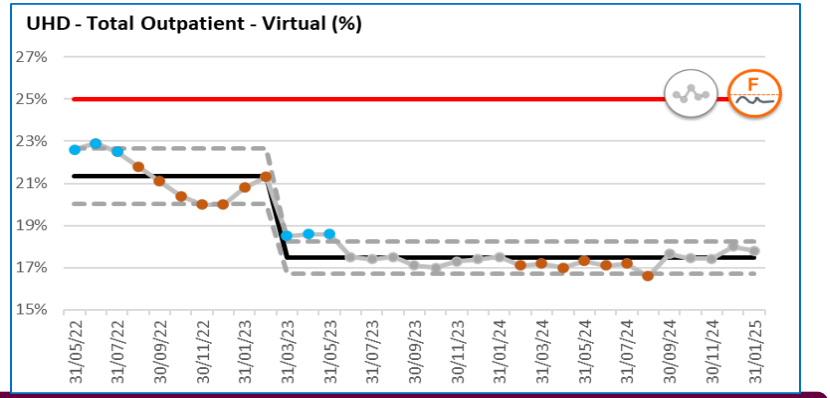
Key areas of focus:

- Increasing speciality activity - focusing on individual speciality level trajectories to meet March 2025 target
- Golden patient (speciality specific early identification, robust pre-operative assessment in a timely manner, and clinician's decision shared with anaesthetic colleagues) - Piloted in Orthopaedic before Trust-wide roll out.
- Launch of Theatre performance working group and first meeting planned February 2025
- Sterile Services Department (SSD) challenges – meeting commenced with estates and project manager assigned.
- Day surgery: Three workstreams established (operational and clinical leads assigned): Orthopaedics x3 procedures/pathways, laparoscopic hysterectomy, and day surgery pathways/capability. Forward plan also in place to on board further workstreams.

# Responsive (Elective) Outpatients

| Referral Rates (MRR Return) | | Standard | This Year | Trust Perf |
|---|---|---|---|---|
| GP Referral Rate year on year | | -0.5% | 100026 | -3.0% |
| Total Referrals Rate year on year | | -0.5% | 154841 | -0.9% |
| **Outpatient metrics** | | | | |
| Overdue Follow Up Appointments (Cons-Led Only) | | | | 28813 |
| New Attendances | | | | 23589 |
| Follow-Up Attendances | | | | 33928 |
| % DNA Rate | *(Total DNAs / New & Flup Atts)* | 5% | 3085 / 57517 | 5.1% |
| Hospital cancellation rate | *(Hospital Canx / Total Booked Appts)* | | 13360 / 82636 | 16.2% |
| Patient cancellation rate | *(Patient Canx / Total Booked Appts)* | | 8674 / 82636 | 10.5% |
| **Reduction in face to face attendances (acute only)** | | | | |
| % telemed/video attendances | *(Total Non F-F / Total Atts)* | 25% | 10231 / 57517 | 17.8% |




## Data Description and Target

- Reduction in Did Not Attend (DNA) rate (first and follow up) to 5%
- 25% of all attendances delivered virtually
- Reduction in overdue follow up appointments

## Performance

- The DNA rate in January reduced to 5.1%. Performance remains within normal variation and the process control limits indicate the target can be met within existing processes. The developments in outpatients supporting missed appointments include:
  - A Basic Rescheduling tool in Dr Doctor has been switched on, which allows patients to cancel their appointments digitally rather than needing to call the department.
  - A six-month pilot using a DNA predictor tool has commenced in the Trust and is demonstrating beneficial impact in Diabetes Services; the tool identifies people with a high likelihood of a DNA and enables teams to intervene before the appointment date. Specialties in each care group have been identified to participate in the further roll out programme.
  - Text reminders prior to appointments are implemented in 97.1% of services.
- Use of virtual appointments was 18.0% for January and remains within normal variation but below the national target.
- The number of patients overdue their target date for a follow up appointment increased by 1,477 in January. The increase reflects a reduction in follow up capacity during January due to the bank holiday. Extension of the overdue follow up reduction project has commenced.

## Key Areas of Focus

- Deliver against the slot utilisation improvement project, aimed at delivering a clinic utilisation rate of >90% .
- Trust-wide e-outcomes implementation: E-Outcomes was launched in the Medical Care Group in January and roll out is ongoing across the rest of the Trust with the WCCSS Care Group launching in February 2025.
- Extend implementation of DrDoctor Basic Rescheduling (currently live in 61% of clinics)
- Further roll out of contracted DrDoctor functionality to maximise slot utilisation and identify opportunities to automate booking processes where possible.
- Reducing hospital cancellations through better compliance with scheduling standard operating procedures.

# Responsive - (Elective) Screening Programmes

## Breast Screening

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

| BREAST SCREENING | STANDARD | ACHIEVED |
|---|---|---|
| Round Length within 36 months | 90.00% | 94% |
| Screening to first offered assessment appointment within 3 weeks | 98.00% | 59% |
| Screening to Normal Results within 14 days | 95.00% | 99% |
| Longest Wait Time (Months) | 36 | 37 |
| UPTAKE – QTR 2 (Jul - Sept 24) | 70% | 57.1% |

**Background/target description**
To ensure the breast screening access standards are met.
**Performance:**
- Two monthly targets have been successfully met

**Underlying issues:**
- The screen to assessment target remains challenging and continues to breach due to reduced assessment clinic availability. Radiology staff pressures are increasing due to an increase in staff vacancies due to a range of reasons. This is on the risk register as a risk score of 20. The breaches have been impacted by the Christmas holiday period, additional bank holidays and extreme pressure from the symptomatic service.
- There have been some delays to screening recalls in the west of the county in December and January due to the reduced levels of screening over the last year. This has affected the service's ability to move mobile screening units across locations in a timely manner to meet recall targets in that area. As a result, the round length figure has dropped to 94% but remains compliant.
- The quarterly uptake remains below the expected standard of 70%. The target is consistently met with recall (incident) clients; however, uptake is significantly lower in the first time (prevalent) clients. Offering open appointments does adversely impact uptake figures however the text service is ensuring we send reminders and information to clients. Returning to timed appointments is mandatory from April 2025 for the service nationally.

**Actions:**
- Additional Saturday clinics are supporting a reduction in the numbers of symptomatic patients breaching.

## Bowel Screening

| Bowel Screening Standard | Target | January Performance |
|---|---|---|
| SSP Clinic Wait Standard (14 days) | 95% | 100% |
| Diagnostic Wait Standard (14 days) | 90% | 93.64% |

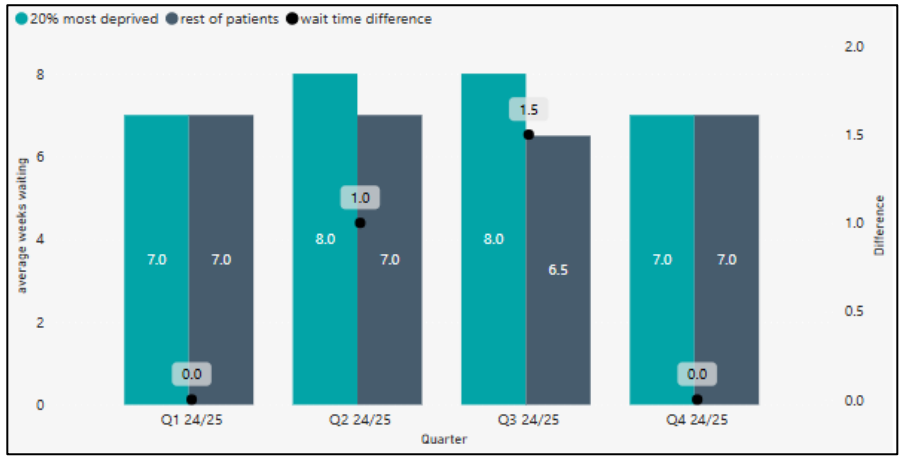
**Background/target description**
To ensure the bowel screening access standards are met.
**Performance:**
- Specialist Screening Practitioner (SSP) Clinic Wait Standard: This standard continues to be maintained at 100%.
- Diagnostic Wait Standard: This standard was delivered at 93.64% in January 2025.

**Underlying issues:**
- Succession plan being worked through but will take time for aspirant screeners to gain accreditation.
- Age extension fully rolled out. Now fully inviting all 50 year olds +.

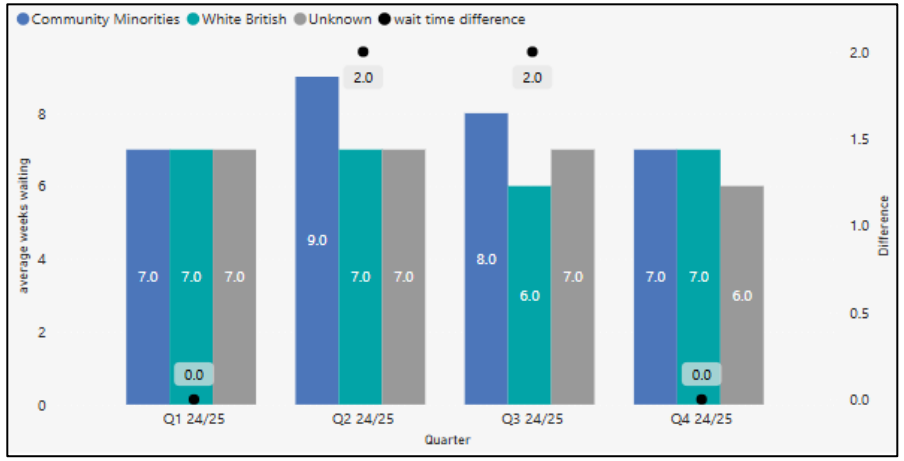
**Actions:**
- Future planning needed for the future fit@80 roll out. This may increase demand by up to 40% across the system. SSP training needed but awaiting date and funding. Likely roll out April 2026. Support identified for roll out via 18month Programme support role which has been recruited into and starting April 2025.
- Deliver plans with Dorset County to use additional insourcing capacity in 2024/25
- Support accreditation process for 4 Aspirant screeners.

# Health Inequalities

## Average Weeks (elective) waiting by Deprivation Group




## Average Weeks (elective) waiting by Ethnicity 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 for Quarter 4 2024/25 to date, 9% of patients on the waiting list live in the 20% most deprived areas of Dorset (IMD 1-2). The average weeks waiting at the point of treatment for people in IMD 1-2 shows no variation compared to people from IMD 3-10, demonstrating a return to Q1 performance and reduction in variation. Analysing the same data by age band identifies a 1 week variation for children (<18 yrs) remains. This is an improvement from the beginning of quarter 3, which previously showed a variation of 5 weeks.

**Waiting list by ethnicity:** 12% of patients on the waiting list are from community minority ethnicity groupings. An analysis of the average weeks waiting by ethnicity grouping identifies no variation between patients within community minority groups and white British populations in Q4. A slight variation is seen in patients with an unknown ethnic group, who on average are waiting 1 week less than those who's ethnicity is recorded. The waiting time variation for <18-year-olds from community minority groups seen in Q3 has shifted in the first month of Q4; with community minorities <18 years old seeing a reduction in waiting times, but those of unknown ethnicity have seen an increase in waiting to 13 weeks average. (variation of 4 weeks longer for white British and 5 weeks longer for those unknown)

## Key Areas of Focus

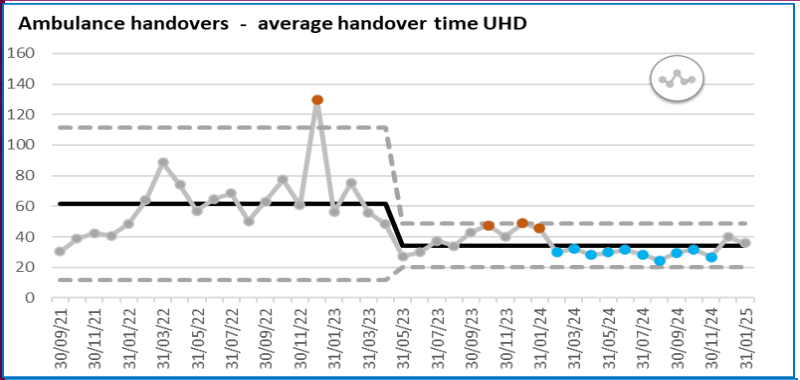
- The Trust's Health Inequalities group is continuing to deliver against the duties outlined within the NHS England's statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006) to collect, analyse and publish information on health inequalities.
- Active engagement with Dorset ICS newly emerging delivery groups on addressing health inequalities and population health.
- Continue analysis of the Dorset DiiS Population Health System Core20Plus5 PHM dashboard for adults and children via the Dorset ICS delivery group on variation.
- Promote awareness raising on health inequalities and population health through education and training opportunities.
- Promoting ethnicity recording.

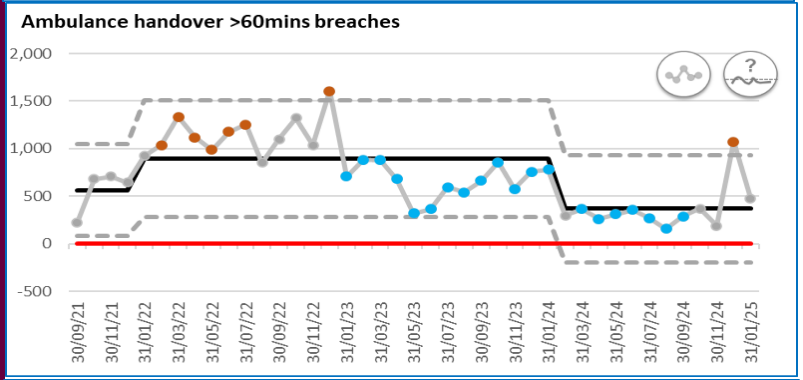
# Performance at-a-glance
# Responsive (Elective) - Key Performance Indicators Matrix

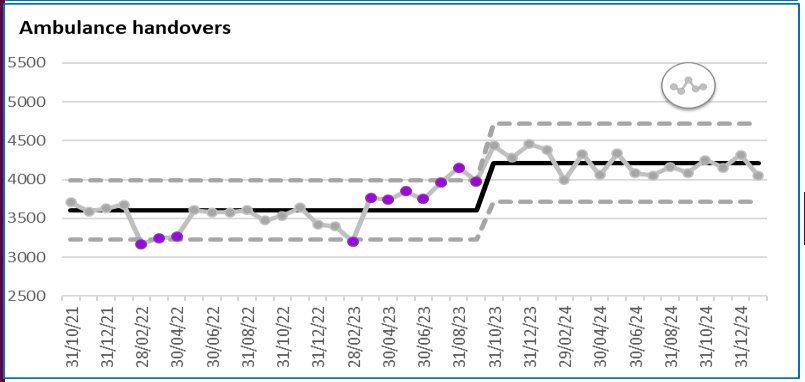
## UHD Elective Care

| KPI | Latest month | Measure | Target | Variation | Assurance | Mean | Lower process limit | Upper process limit |
|---|---|---|---|---|---|---|---|---|
| UHD - Total Waiting List Size | Jan 25 | 67553 | 66982 | | | 68458 | 66224 | 70691 |
| UHD - Patients waiting >78 weeks | Jan 25 | 0 | 0 | L | P | 0 | 0 | 0 |
| UHD - Patients waiting >65 weeks | Jan 25 | 29 | - | L | | 279 | 7 | 551 |
| UHD - Patients waiting >52 weeks | Jan 25 | 2167 | 2592 | L | P | 2157 | 1954 | 2360 |
| UHD - Patients waiting >52 weeks non admitted | Jan 25 | 1037 | 0 | L | F | 1302 | 1024 | 1579 |
| UHD - RTT Performance against 18 week standard | Jan 25 | 60.6% | 92.0% | | F | 61.1% | 59.4% | 62.9% |
| | | | | | | | | |
| UHD - Total Diagnostic Waiting List | Jan 25 | 13197 | - | | | 12326 | 11025 | 13626 |
| UHD - % waiting over 6 weeks | Jan 25 | 14.5% | 1.0% | | F | 10.9% | 6.2% | 15.5% |
| UHD - % waiting over 13 weeks | Jan 25 | 3.2% | | | F | 2.7% | 1.1% | 4.3% |
| UHD - Faster Diagnosis Standard (FDS) 28 days | Dec 24 | 78.1% | 75.0% | | | 71.2% | 60.1% | 82.3% |
| UHD 62 day standard | Dec 24 | 70.6% | | H | F | 65.8% | 58.9% | 72.7% |
| Trauma Admissions | Jan 25 | 344 | - | | | 371 | 313 | 428 |
| % of NOF patients operated on within 36 hrs (admission from ED) | Jan 25 | 74.0% | 85.0% | | | 61.8% | 34.5% | 89.0% |
| % Outpatient appointments with procedures | Jan 25 | 17.8% | | | | 17.4% | 15.7% | 19.0% |
| UHD - Total Outpatient - Virtual (%) | Jan 25 | 17.8% | 25.0% | | F | 17.5% | 16.7% | 18.3% |
| UHD Outpatient DNA rate | Jan 25 | 5.1% | 5.0% | | | 5.4% | 4.8% | 6.0% |
| Theatre utilisation (capped) | Jan 25 | 80.0% | 85.0% | | F | 81.2% | 78.6% | 83.9% |
| UHD Theatre case opportunity | Jan 25 | 13.1% | 15.0% | L | | 14.6% | 7.7% | 21.6% |

# Responsive – (Emergency) Ambulance Handovers




Data includes both SWAST and SCAS for handovers to ED

## Data Description and Target

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

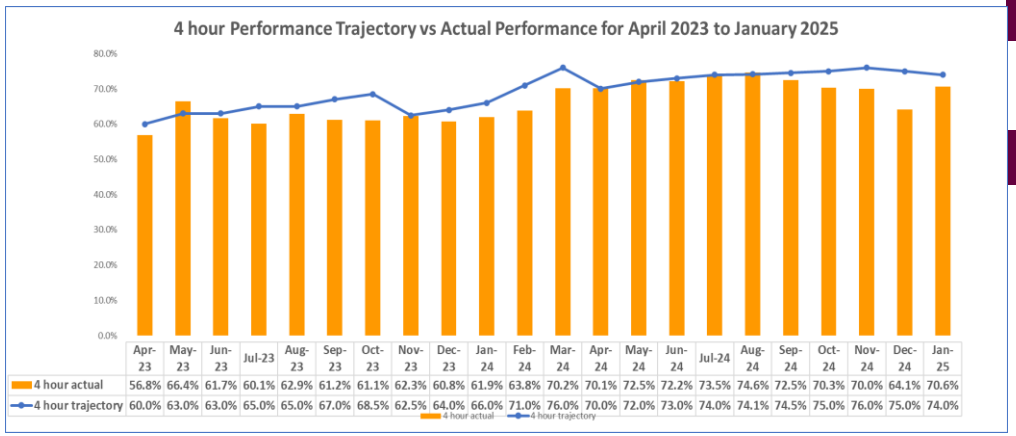
## Performance

- The total number of Ambulance handovers dropped slightly in January with 4,106 conveyances vs 4,374 in December. This equates to 133 handovers per day vs 141 in December. This was driven by both sites- Poole site saw a decrease from 75 to 70 conveyances per day, whilst Royal Bournemouth site saw a drop from 66 to 63 conveyances each day.
- However, ambulances waiting longer than 60 minutes has started to decreased from 536 in December to 453 in January. This remains within the realms of seasonal variation and is a significant improvement from January 2023 performance of 733. This amounts to a small drop of 11% of total handovers vs 12% in December.
- Average handover duration has also started to see improvement- Poole has dropped back from 39 minutes to under 30 minutes, and the RBH site has dropped from 44 minutes to 36. This continues to be lower than the regional average which remains at circa 60-70 minutes.
- Days of poor performance continue to be driven by overcrowding within the ED with the department consistently lodging patients in non-clinical areas (corridor). The predominant reason for delayed handover remaining insufficient capacity.
- Despite this PH is still currently performing in the context of the region. For January, Poole was 5 of 18 Trusts and RBH continues to hold at number 7. Again, Trust's 1-4 all saw far less conveyances than RBH and PH, with peer Trusts placing 15+ in the region.
- In December, Poole reported a total of 648 lost hours vs 782 in December. Bournemouth saw 756 vs 917 in December.

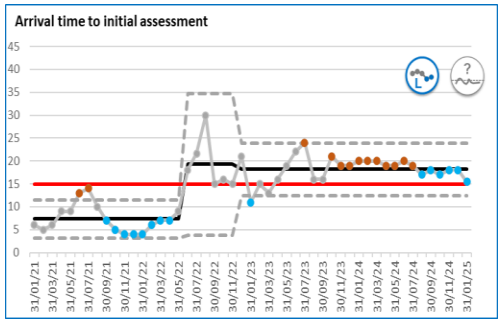
## Key Areas of Focus

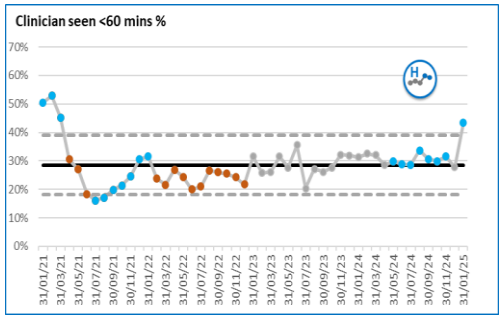
- Key risks: Provision of care in non-clinical areas (corridor)
- 9%+ of total conveyances spent a period of time in a non-clinical area in January compared to 7.87% in November and 11.37% in December.
- To note: plan to implement SWAST Timely Handover Process (THP) in March- handover at 90 minutes regardless of ED capacity, SOP being worked through internally to understand subsequent impact.

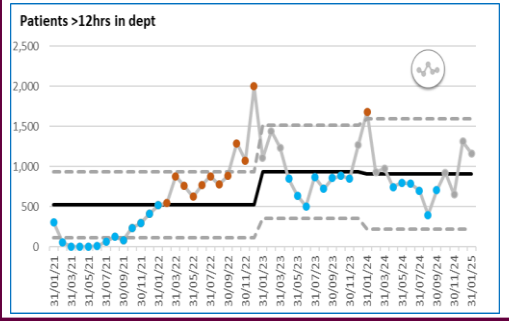
# Responsive (Emergency) Care Standards

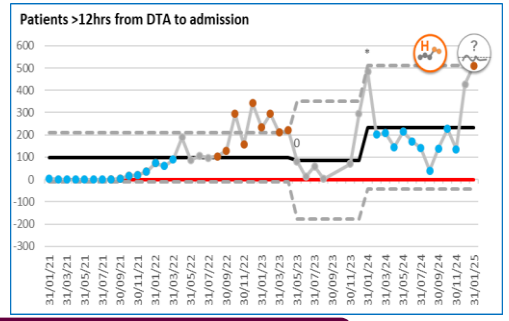



| | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4 hour actual | 56.8% | 66.4% | 61.7% | 60.1% | 62.9% | 61.2% | 61.1% | 62.3% | 60.8% | 61.9% | 63.8% | 70.2% | 70.1% | 72.5% | 72.2% | 73.5% | 74.6% | 72.5% | 70.3% | 70.0% | 64.1% | 70.6% |
| 4 hour trajectory | 60.0% | 63.0% | 63.0% | 65.0% | 65.0% | 67.0% | 68.5% | 62.5% | 64.0% | 66.0% | 71.0% | 76.0% | 70.0% | 72.0% | 73.0% | 74.0% | 74.1% | 74.5% | 75.0% | 76.0% | 75.0% | 74.0% |




## Data Description and Target

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

## Performance

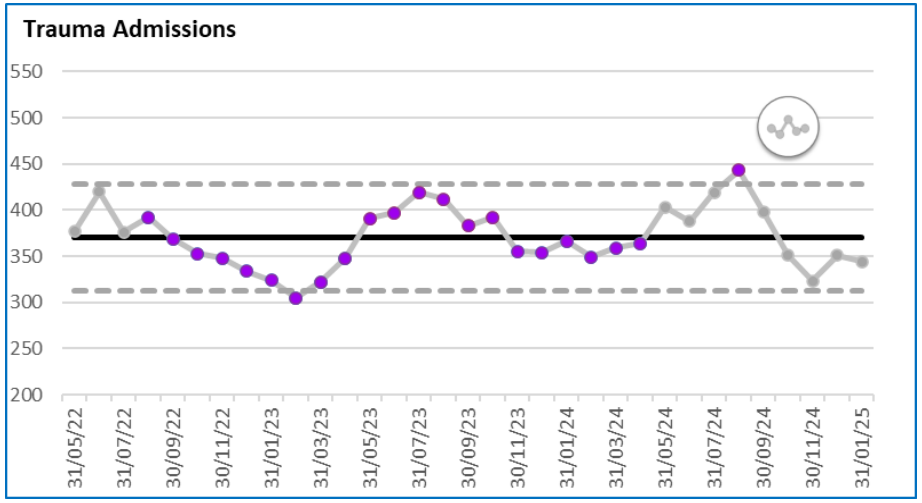
Performance continues to be challenged though January though has seen some recover. January delivered 70.6% against an internal trajectory of 74%. The target increases in February to 76% to land the financial year in March on 78%.

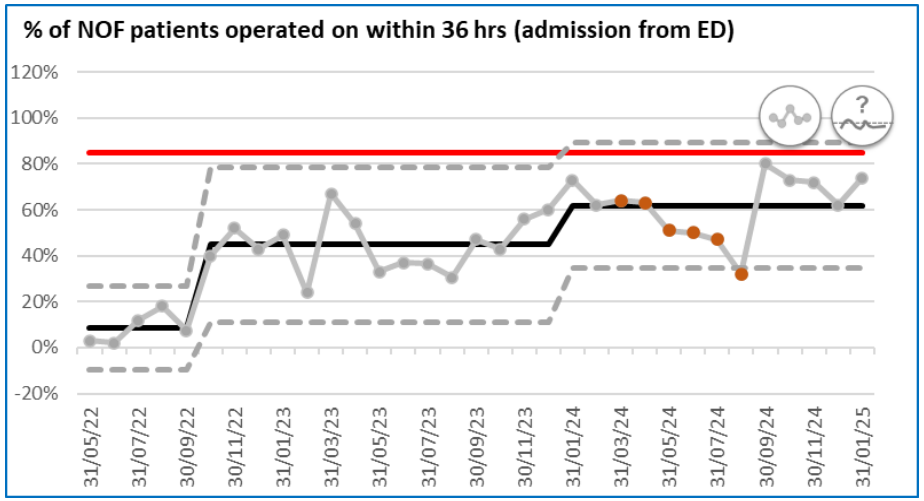
- Total attendances for January in contravention with previous January's did see a drop in attendances compared to December. Attendances were 13,621 vs 14,926 in December. This resulted in 439 attendances per day vs 481 in December which is also a minor drop from January 2023. Performance however is 8.7% greater than the same reporting period in 23/24 (61.9%).
- Arrival time to initial assessment has seen improvement and was 15.5 minutes vs 18.2 minutes in December and is the lowest it has been in 2 years.
- Meantime in the department also saw a decrease to 295 minutes vs 323 minutes in December and 346 minutes in January 2023.
- Patients waiting more than 12 hours in the department remains high but has seen some improvement from December dropping to 1,163 patient's vs 1312 in December. This was unfortunately not mirrored in patients waiting longer than 12 hours following a decision to admit which was 428 in December and increased to 510 in January reflecting challenges with admitted flow.
- However, arrival time to decision to admit did decrease to 218 minutes from 275 minutes in December.
- Significant IPC issues requiring isolation capacity linked with Flu, Norovirus, RSV & Covid continued to be a challenge in the first half of the month limiting available capacity downstream to support as well as physical space to clinically treat patients.

## Key Areas of Focus

- Breaches decreased by an additional 50 patients a day in January dropping from 211 to 161 per day.
- Type 1 Non-Admitted performance was 74% at PH and 72% at RBH meeting the Trust trajectory of 73%
- Admitted performance however missed the trajectory of 36% though did increase from 21% to 26%.
- Ongoing monitoring and reporting against the winter plan to mitigate seasonal pressures from further impacting performance with a focus on the national '6 week Sprint' to 78% in March.

# Responsive (Emergency)
## Trauma Orthopaedics




### Data Description and Target

**National Hip Fracture Database (NHFD) Best Practice Tariff Target:** Fractured neck of femur (#NoF) patients to be operated on within 36 hours of admission. NHFD average 59%
**Quality Target**: 95% of fractured neck of femur (#NoF) patients to be operated on within 36 hours of ***ED admission*** and being clinically appropriate for surgery.

### Performance

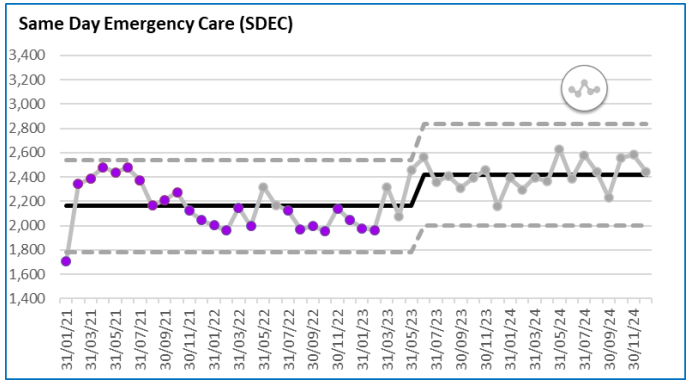
January performance for time to theatre for fractured neck of femur (#NoF) patients: 87% achieving surgery within 36 hours of being fit for surgery and 74% operated on within 36 hours from admission.

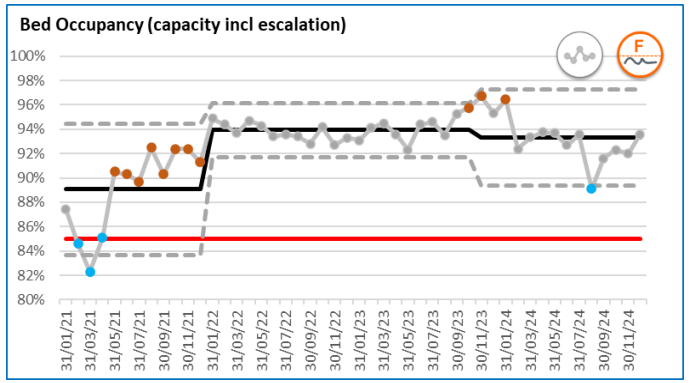
- Overall trauma admissions in January were stable at 344, 200 of whom required surgery. This included 79 admissions with a fractured neck of femur (#NoF).
- A total of 80 #NoF's were operated on in January (including one admitted in December but not fit for surgery until January).
- 10 of these 80 #NoF patients were unfit for surgery on admission.
- 11 patients with Shaft of femur (SoF) fractures were admitted in January all of whom required surgery.
- 16 patients required additional operations, equating to an additional 19 theatre cases (complex fractures).
- 17 patients were treated through the Hand Hub procedure room in January.

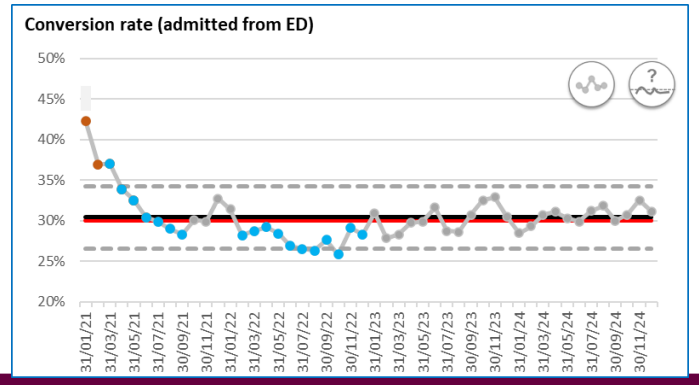
### Key Areas of Focus

- Essential works involving CSSD Gas shutdown in January presented challenges with teams mitigating these changes with mutual aid from Salisbury.
- Radiology support for theatres was impacted with staff absences.
- The number of trauma outliers remains low, supporting the prompt review of trauma patients.
- Continued focus on maximising trauma theatre efficiency and mitigating periods of escalated service demand.
- CQC inspection (28-29/1/25): Verbal feedback positive, highlighting improvement workstreams and increased attainment of NHFD Best Practice Standards.
- Improvements in care of NOF patients shared and celebrated with all teams.

# Responsive – (Emergency) Patient Flow




## Data Description and Target

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

## Performance

In January an average of 1077 beds were occupied daily, an increase of 4 beds compared to December, with an average occupancy of 95.2% (a further 2% increase from December). It is important to note that not all G&A beds can be utilised therefore the actual operational occupancy is c3% more than reported.

The average number of escalation beds open in January was 8.7 at RBH compared to 2 at PH. In the main these beds were used to maintain flow against a surge in the number of cases of flu particularly at the beginning of the month. RBH continues to have repurposed funded core beds for Stroke on Ward 7L, escalation has been a combination of CIU daycase and unfunded core on 7L.

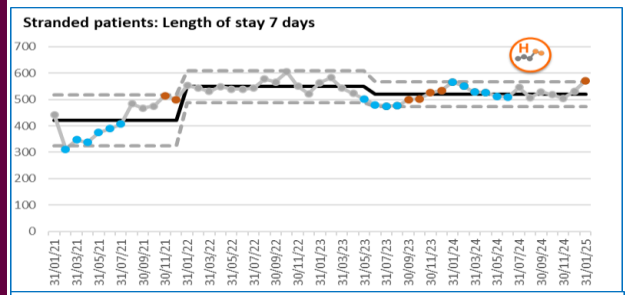
Virtual Ward capacity has now increased from 75 beds to 100 beds. The occupancy rate in January for the Virtual Ward was 73%, this was an increase of 1% compared to December. The ability to increase occupancy has been driven by increased acuity across the organisation.

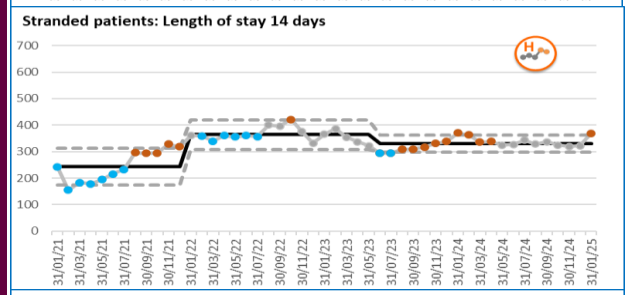
The average number of patients with No Criteria to Reside (NCtR) has increased from an average of 192 in December to 226 in January 2024. This is a significant increase and being felt in compromised flow across the organisation.

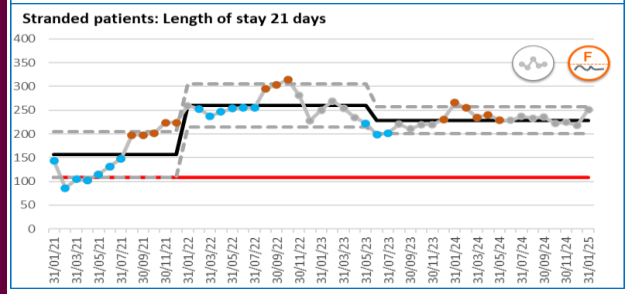
## Key Areas of Focus

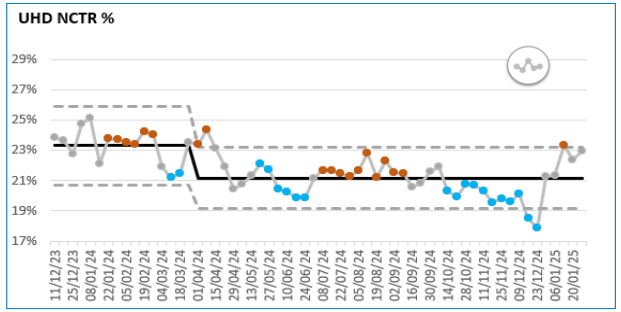
- Winter plan schemes continue to be measured and reported to Operational Delivery Group (ODG) with much emphasis on maintaining SDEC services to avoid unnecessary admissions.
- Same Day Emergency Care (SDEC) continues to make progress with self-assessments being undertaken across each service to help shape the future operating model. Expanded medical SDEC service at weekends at Bournemouth site now in place as part of the winter plan.
- Virtual ward continues to be an area of focus.
- New escalation process for Long length of stay (LLOS) patients is being rolled out following support from ECIST team. However, focus remains on early planning to avoid patients becoming 'stuck,' in process, legal or other.

# 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. 2023/24 ICB ambitions to reduce the number of patients with No Criteria to Reside (NCtR) were substantially missed, currently no ICS baseline or trajectory has been established for 24/25.

## Performance

21+ day length of stay position shows the Trust as significantly beyond the target of a maximum of 108 patients despite a reduction in the number and growth at the Poole site.  Royal Bournemouth Site remains static.

No Criteria to Reside (NCtR) has increased to 226 on average, which remains of trajectory in comparison to the winter plan which in January was a trajectory of 145.

P0 discharges are at an average of 100 a day although there is considerable variation on the daily number which can be correlated to operational flow. Weekend P0 numbers particularly on a Saturday have dropped to below 100 in comparison to November and December. The P1-3 discharges have increased slightly from 15 in December to 17 a day in January.

## Key Areas of Focus

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. ECIST have supported the Trust in establishing an effective LLOS escalation process in addition to local processes and reviews.  There is a focus on looking at those patients over 21 days with a criteria to reside and alternative pathways by the MDT.  A new initiative 'Walkabout Wednesday,' supported by a senior MDT is due to commence from January with the aim of avoiding delay early in pathways, through visible and supportive presence on wards: this 'Patient First,' approach will also help to enhance the escalation process. The process also includes the allocation of a 'discharge navigator,' at day 50 and a senior sponsor at day 75.

The trust has started to roll out 'my care needs' across Older People's Wards which supports early discharge planning and again, should help to prevent long length of stay for patients, through early identification of delay. There is interest in this initiative from other colleagues across Dorset.

A Dorset-wide UEC strategic partner (Newton) has been commissioned to affect Discharge across Dorset and are looking at the implementation stage currently. This will have a focus on a number of areas including Transfer of Care Hubs (TOCs).

# 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 25 | 15 | 15 | | | 18 | 12 | 24 |
| Clinician seen <60 mins % | Jan 25 | 43% | - | | | 29% | 18% | 39% |
| Patients >12hrs from DTA to admission | Jan 25 | 510 | 0 | | | 234 | -42 | 510 |
| Patients >12hrs in dept | Jan 25 | 1163 | - | | | 906 | 218 | 1593 |
| 4 hour safety standard | Jan 25 | 70.6% | 74.0% | | | 66.5% | 60.3% | 72.8% |
| Ambulance handovers - average handover time UHD | Jan 25 | 35.8 | - | | | 34.3 | 19.9 | 48.7 |
| Ambulance handovers - average handover time RBH | Jan 25 | 39.1 | - | | | 36.9 | 20.1 | 53.6 |
| Ambulance handovers - average handover time Poole | Jan 25 | 32.5 | - | | | 31.7 | 18.0 | 45.4 |
| Ambulance handover >60mins breaches | Jan 25 | 476 | | | | 368 | -197 | 932 |
| Ambulance handovers | Jan 25 | 4048 | - | | | 4214 | 3709 | 4719 |
| Bed Occupancy (capacity incl escalation) | Jan 25 | 95% | 85% | | | 93% | 90% | 97% |
| Stranded patients: Length of stay 7 days | Jan 25 | 571 | - | | | 520 | 472 | 567 |
| Stranded patients: Length of stay 14 days | Jan 25 | 369 | - | | | 330 | 297 | 363 |
| Stranded patients: Length of stay 21 days | Jan 25 | 252 | 108 | | | 229 | 200 | 258 |
| Non-elective admissions | Jan 25 | 6573 | - | | | 6125 | 5258 | 6993 |
| > 1 day non-elective admissions | Jan 25 | 4079 | - | | | 3830 | 3279 | 4380 |
| Same Day Emergency Care (SDEC) | Jan 25 | 2492 | - | | | 2422 | 2023 | 2822 |
| Conversion rate (admitted from ED) | Jan 25 | 32.0% | | | | 30.4% | 26.6% | 34.2% |

# Sustainable Services

**Pete Papworth**
Chief Finance Officer

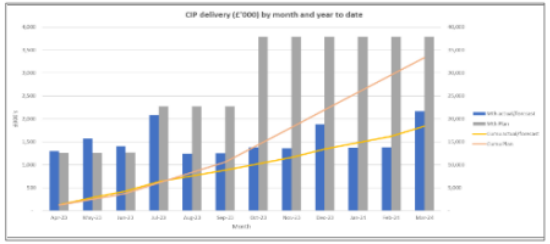
**Operational Lead:**
Adrian Tron, Deputy Chief Finance Officer

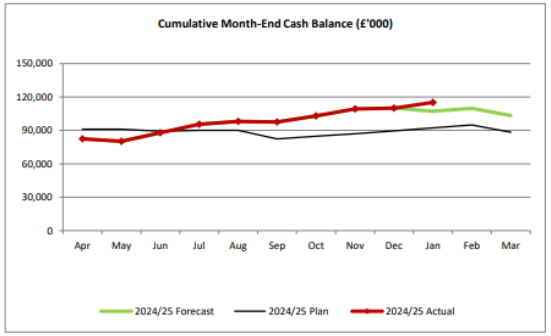
**Committees:**
Finance and Performance Committee

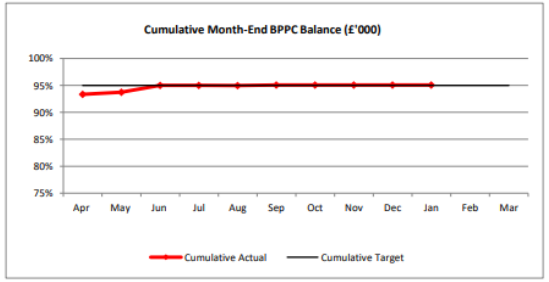
NHS
University Hospitals Dorset
NHS Foundation Trust

# Finance

| FINANCIAL INDICATORS | Year to date | | |
|---|---|---|---|
| | Budget | Actual | Variance |
| | £'000 | £'000 | £'000 |
| Control Total Surplus/ (Deficit) | (3,940) | (5,963) | (2,023) |
| Capital Programme | 127,607 | 119,898 | 7,709 |
| Closing Cash Balance | 92,307 | 115,133 | 22,826 |
| Public Sector Payment Policy | 95.0% | 94.9% | (0.1)% |




At the end of January 2025, the Trust has reported a deficit of £5.963 million against a planned deficit of £3.940 million, resulting in an adverse variance of £2.0 million. The variance is due to the phasing of the recovery actions compared to the original plan.

Income is £3.780 million favourable to plan year to date. Income is £3.485 million favourable to plan year to date. Included within this is a £3.862 million favourable position against Dorset ICB (Integrated Care Board) related to ERF (Elective Recovery) delivery. NHSE income is £1.872 million favourable and Hampshire and Isle of Wight ICB £1.042 million adverse due to ERF performance. Other Non-NHS patient care income is £111,000 favourable due to RTA (Road Traffic Act) income (£198,000 favourable), LVA (low volume activity) income (£145,000 favourable) and overseas patient income (£36,000 favourable), partially offset by a shortfall in private patient income of £271,000. The favourable income flows in respect of ERF aligns to recovery actions required to deliver the full year plan.

Operating expenditure is £58.219 million adverse to plan year to date. This includes a £46.772 million impairment which is adjusted for when calculating the Trust's overall year to date performance against control total. Pay is £6.442 million adverse to plan year to date, primarily due to premium nursing agency expenditure and non-delivery of recurring pay EIP (Efficiency Improvement Plans). Clinical supplies expenditure is £2.057m adverse to plan year to date mainly due to additional activity in the Surgical care group. Drugs expenditure is £4.274 million adverse to plan year to date mainly due to Dorset ICS (Integrated Care System) and Hampshire ICS block contract drugs. Purchase of healthcare is £3.531 million adverse to plan year to date mainly due to CDC (Community Diagnostic Centre) costs (offset by income). Premises and fixed plant expenditure is £3.930 million favourable to plan year to date due to energy costs. Agency spend in month is £0.788 million and is under the cap value equating to 3.2% of total pay expenditure. This is a significant reduction when set against the expenditure in March.

Efficiency savings of £33.977 million have been achieved against a target £33.556 million. As of 31 January 2025, EIP (Efficiency Improvement Plans) are reporting a forecast risk adjusted saving of £41.4 million, non-risk adjusted is in line with the target of £42 million including the trust-wide cross cutting schemes.

The Trust has reported capital expenditure of £119.9 million against a plan of £127.6 million. The underspend is due to slippage on committed schemes due to phasing delays, primarily NHP (New Hospital Programme). The forecast shows a balanced position on the basis that a re-profile of CDC national funding of £6m has been agreed.

| CAPITAL | Year to date | | |
|---|---|---|---|
| | Budget | Actual | Variance |
| | £'000 | £'000 | £'000 |
| Estates | 6,931 | 4,700 | 2,231 |
| IT | 9,590 | 7,801 | 1,789 |
| Medical Equipment | 1,355 | 614 | 741 |
| Donated Assets | 455 | 1,066 | (611) |
| Strategic Capital | 109,276 | 105,717 | 3,559 |
| **Total** | **127,607** | **119,898** | **7,709** |

As at 31 January 2025 the Trust is holding a consolidated cash balance of £115.1 million which is fully committed against the future Capital Programme.

In relation to the Public Sector Payment Performance the Trust is currently delivering performance of 94.9% against the national standard of 95%.

The Trust now produces a monthly forecast as detailed in the report. At the end of January, the revised forecast financial trajectory for the year end position is still forecast as break-even, noting the risk in relation to winter pressures.

# Digital

**Beverley Bryant**
Chief Digital Officer

University Hospitals Dorset
NHS Foundation Trust

# Information Technology

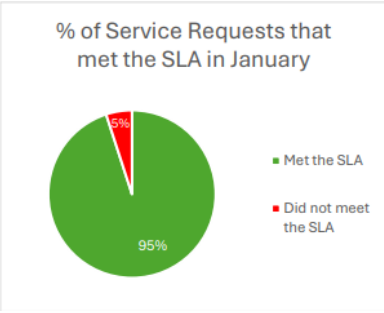
## IT Tickets logged

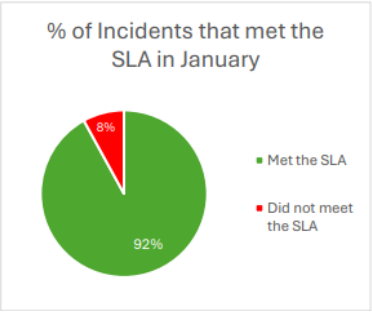
| Top Tickets logged per Service | | | |
|---|---|---|---|
| Service | Service Requests | Incidents | Total |
| Clinical Application | 1,487 | 1,332 | 2,819 |
| Password | 0 | 1,555 | 1,555 |
| Service Desk | 1,234 | 87 | 1,321 |
| Non-Clinical Software | 807 | 327 | 1,134 |
| Email | 524 | 90 | 614 |
| Hardware | 217 | 317 | 534 |
| Printing | 0 | 210 | 210 |
| Telecoms | 82 | 70 | 152 |
| Network | 45 | 69 | 114 |
| Mobile Device | 8 | 34 | 42 |
| IT / Cyber Security | 4 | 12 | 16 |

## Monthly P1 Position

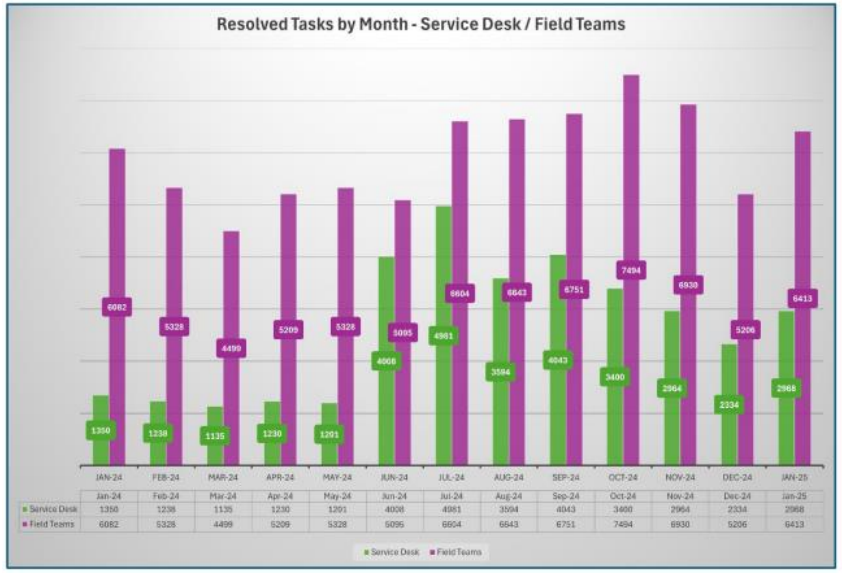
| Priority 1 Incidents | | | | | |
|---|---|---|---|---|---|
| Incident Description | Ref Number | Fixed within current SLA? | Actual Fix Time (Hours) | Cause Resolution | 3rd Party assistance |
| EPR - Error received when opening patient records | 1229399 | Yes | 4 | Server / load balancer Issues | Yes |
| Image Now - unable to open bookings | 1230468 | Yes | 3 | ImageNow database server problems. Rebooted and now working. | No |

## Service Call SLA Position

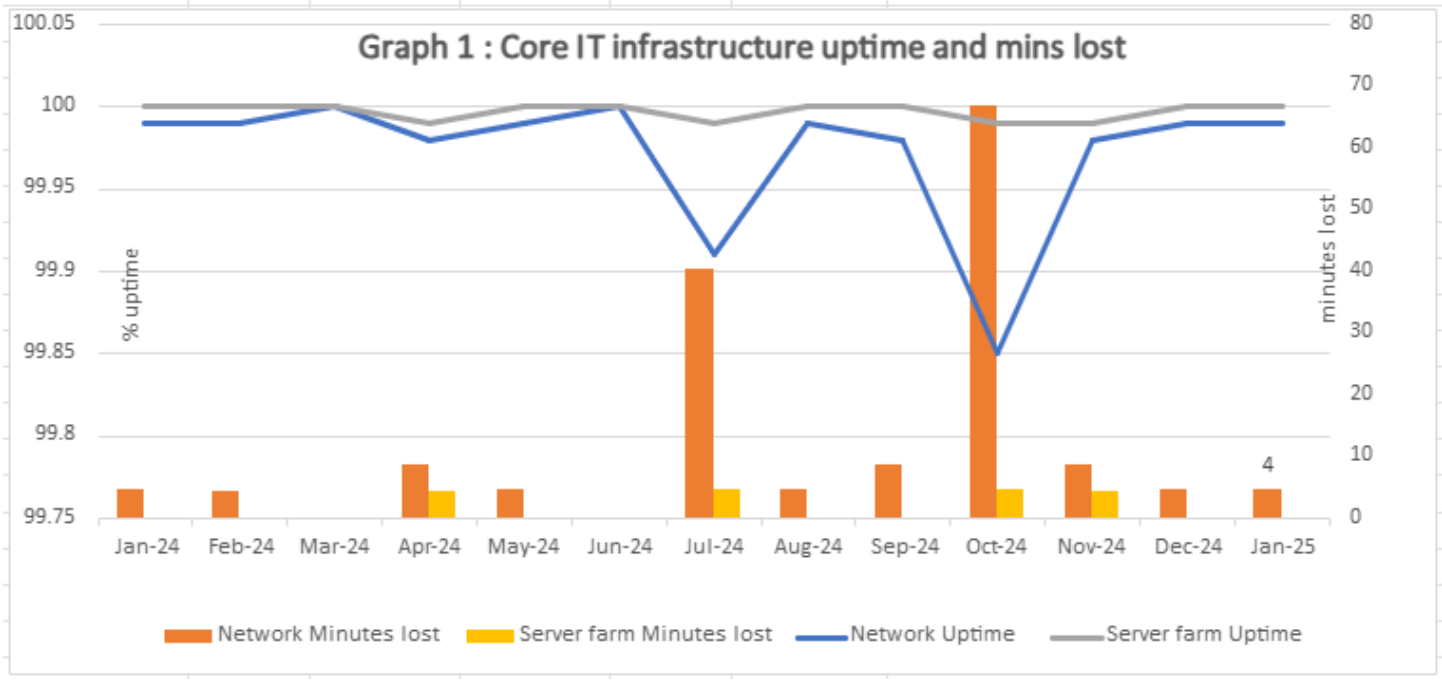



## Resolved IT Tasks




## Core Infrastructure Uptime



# Information Governance & Cyber

**Table 4: Freedom of Information compliance**

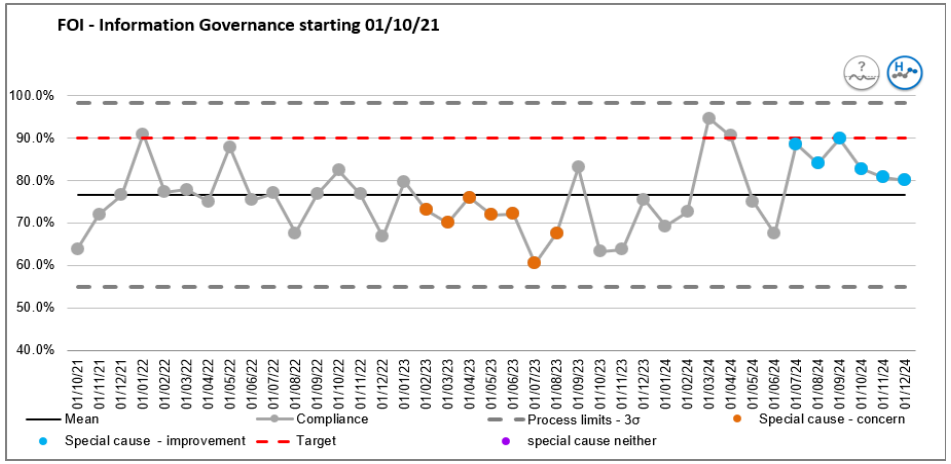
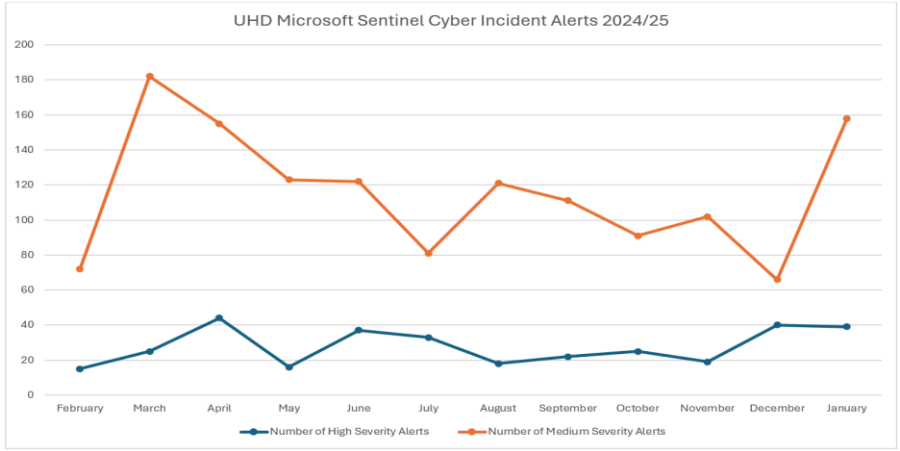



**Table 5: SIEM Incident Alerts**

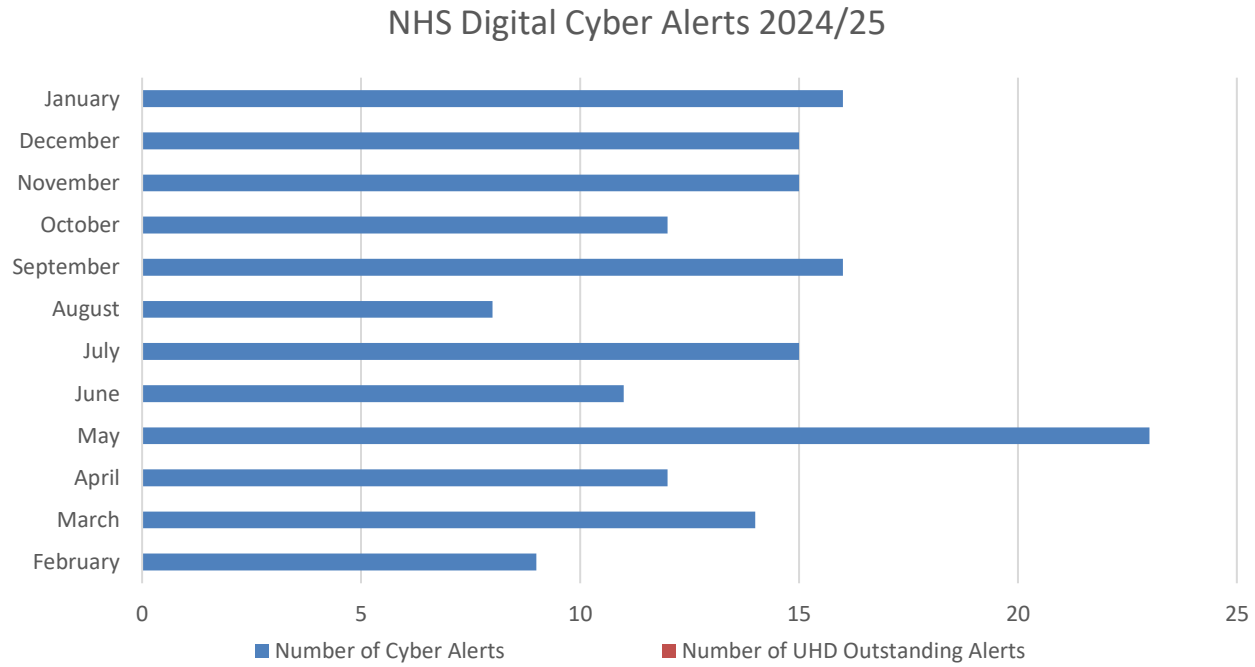



Microsoft Sentinel is a cloud-native security information and event management (SIEM) platform that uses built-in AI to help analyse large volumes of data across an enterprise. The alerts are based on potential suspicious activities.

**Commentary**

**Table 4:** shows a Statistical Process Control chart for the UHD Freedom of Information Act Compliance.
**Chart 5:** Show Microsoft Sentinel Cyber alerts trending for UHD
**Table 6:** Current position on NHS Digital Cyber Alerts

**Table 6: NHS Digital Alerts**

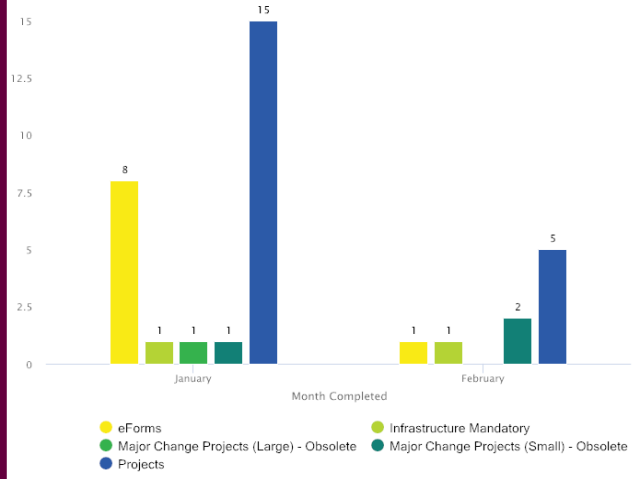


# Development & Medical Records

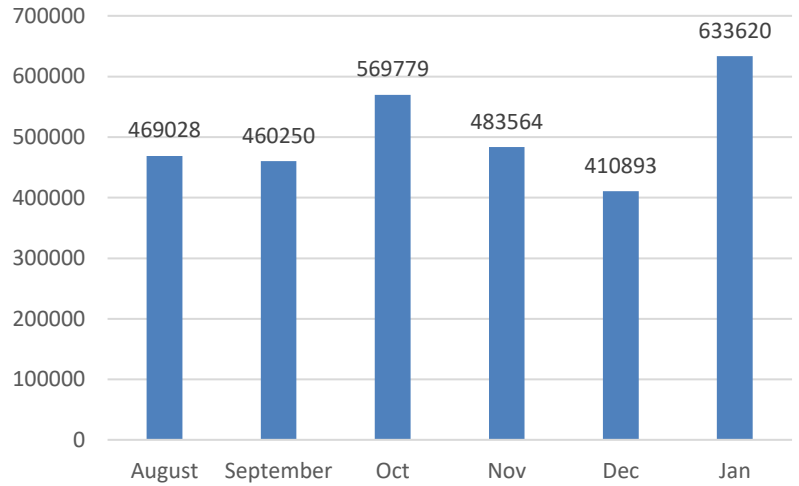
## EHR Programme Timeline

| Curent Go live | February 2028 |
|---|---|
| Previous Go Live | October 2027<br>June 2027 |
| Reason for Change | OBC now in approval process to hold the above dates. |

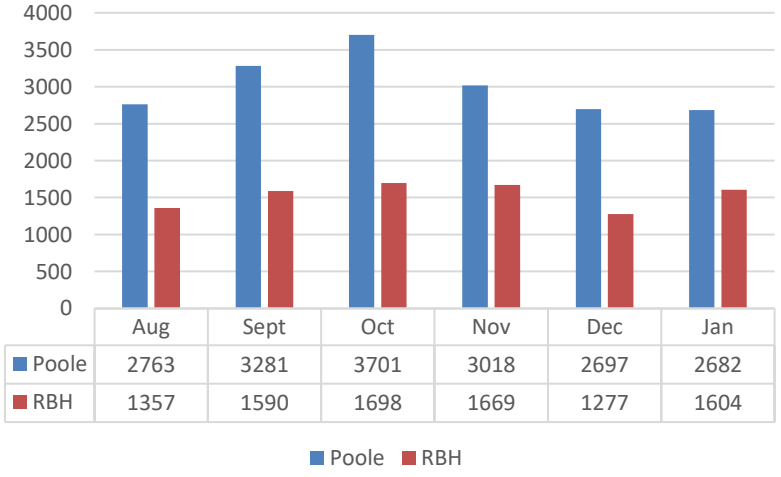
## IT Projects Completed by Month for 2025




## Number of Pages Scanned - Paperless Indication




## Number of Blank Case-notes Returned from Clinic Per Site



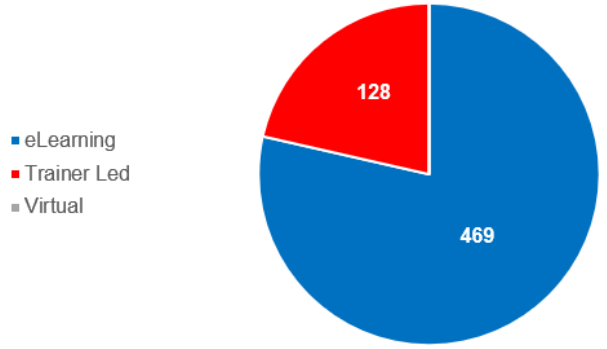

| | Aug | Sept | Oct | Nov | Dec | Jan |
|---|---|---|---|---|---|---|
| Poole | 2763 | 3281 | 3701 | 3018 | 2697 | 2682 |
| RBH | 1357 | 1590 | 1698 | 1669 | 1277 | 1604 |

## Training Statistics
## Face to Face or eLearning Delivered

**Total Trained - January 2025**

**597**

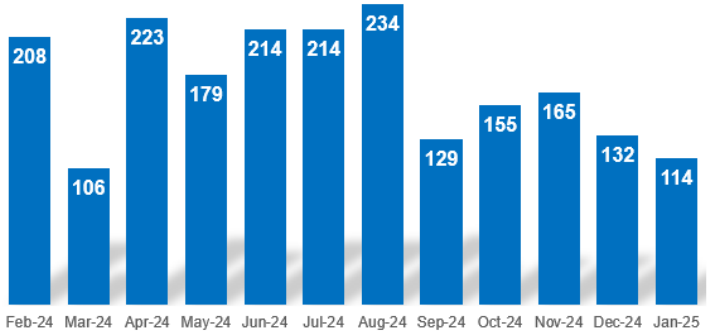
Total by Course Delivery Mode:




## Data Quality - Numbers of Merged Records per Month

An indication of Duplicate Records created and resolved
99.5% NHS number Compliant per month

**Number of Merged Records each Month**



University Hospitals Dorset
NHS Foundation Trust

# BOARD OF DIRECTORS - PART 1 MEETING

**Meeting Date: 05 March 2025**

**Agenda item: 6.2.1**

| | |
|---|---|
| **Subject:** | Key Issues and Assurance Report to Board of the Quality Committee meetings held on 28 January 2025 and 26 February 2025 |
| **Prepared by:** | Cliff Shearman, Chair of the Quality Committee |
| **Presented by:** | Cliff Shearman, Chair of the Quality Committee |

| | |
|---|---|
| **Key Issues/ matters discussed by the Committee:** | At its meeting on 28 January 2025, the Committee received the following:<br>• Board Assurance Framework: Breakthrough Objectives & Strategic Initiatives<br>• Risk Register: risks rated 12-25 (Quality & Safety)<br>• Integrated Performance Report<br>• Maternity Safety Champions Report<br>• Medical Equipment Devices<br>• National Standards for Healthcare Food and Drink – Quarterly Report<br>• Assurance, Alerts/Escalations: Clinical Governance Group<br>The Committee also received a policy for approval.<br><br>At its meeting on 26 February 2025, the Committee will receive the following:<br>• Deep Dive: Paediatrics<br>• Risk Register: risks rated 12-25 (Quality & Safety)<br>• Integrated Performance Report<br>• Maternity and Neonatal Quality & Safety Report Q3<br>• Maternity Safety Champions Report<br>• Mortality and Learning from Deaths<br>• Clinical Audit and Effectiveness Report<br>• Quality Impact Assessment Report<br>• Assurance, Alerts/Escalations: Clinical Governance Group<br>• Quality Committee Terms of Reference<br>This meeting has not yet taken place at the time of submission of this report; verbal update will be provided at the Board meeting. |
| **Significant issues for escalation to Board for action:** | Items to escalate to the Board of Directors:<br>• Infection Prevention Control.<br>• Medical Devices Review.<br><br>In addition, following would be raised to the Board for awareness:<br>• Maternity and Neonatal Quality and Safety Champions Reports<br>• National Healthcare Standards on Food and Drink. |
| **Progress of Board** | BAF Risk 4 – score remained at 6 for the January and February 2025 meetings, with a target of 6. |

| | |
|---|---|
| **Assurance Key Risks Assigned to Committee:** | BAF Risk 5 – score remained at 8 for January and February 2025 meetings, with a target of 6.<br>BAF Risk 6 – score remained at 9 for the January and February 2025 meetings. |

University Hospitals Dorset
NHS Foundation Trust

**BOARD OF DIRECTORS - PART 1 MEETING**

**Meeting Date: 05 March 2025**

**Agenda item: 6.2.2**

| | |
|---|---|
| **Subject:** | Maternity and Neonatal Quality and Safety Report Quarter 3, October - December 2024 data |
| **Prepared by:** | Lorraine Tonge, Director of Midwifery and Neonatal services |
| **Presented by:** | Kerry Taylor, Head of Midwifery and Neonatal services |

| | |
|---|---|
| **Strategic themes that this item supports/impacts:** | Population & System ☒<br>Our People ☒<br>Patient Experience ☒<br>Quality Outcomes & Safety ☒<br>Sustainable Services ☐ |
| **BAF/Corporate Risk Register: (if applicable)** | Medical staffing 1202 |
| **Purpose of paper:** | Review and Discussion |
| **Executive Summary**: | This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety. The purpose of the report is to inform the Local Maternity and Neonatal System (LMNS) and Board of Directors of present and/or emerging safety concerns.<br><br>The report follows the reporting requirement to Trust Boards to meet the Maternity incentive scheme year 6. It triangulates intelligence from the maternity safety champions reports, maternity quadrumvirate and safety champions, safety champions listening and walkabout events in conjunction with IPR dashboard slides attached to give the board a summary of the key areas of focus for maternity.<br><br>**Areas of continued improvement**<br><br>In March 2024 the Trust received the MBRRACE (2022) Perinatal Mortality Report. This report outlined that the stabilized and adjusted extended perinatal mortality rate data values for stillbirth and neonatal death at the UHD during 2022 which was 5-15% lower than the average the comparator group of trusts or Healthcare Boards of a similar size. It also demonstrated the stabilized and adjusted neonatal mortality rate at 0.86 which is over 15% lower than comparable trusts.<br><br>his report identifies new national averages for stillbirth and neonatal death, current UHD rate benchmarking tools (table 1 and table 2) have been adjusted to reflect this from March 2024. |

This UHD Maternity and Neonatal Safety report identifies at the end of Q3, the UHD current rolling 12-month crude stillbirth rate is 2.7 per 1000 births and adjusted rate of 3.0 per 1000 births which is below the reported national average of 4 per 1000 births (2024).

The UHD Neonatal mortality rate for Q3 is 0.52 per 1000 births below the national average of 1.7 per 1000 with one neonatal death this quarter. This death occurred at 25 weeks when baby was born and transferred to UHS due to gestation.
A joint review will occur to share learning across care providers.

UHD have an overall improvement plan which has been developed to align all national and local improvement drivers into encompassing Ockenden 2022, the 3-year single delivery plan 2023, Saving Babies Lives Care Bundle v3, CQC inspection report received in 2023, CQC maternity patient survey, the NHSE MSSP exit criteria and locally identified safety priorities, MIS year 6, maternity self-assessment, Score culture and staff survey improvements.

During this quarter it was verified by the external auditors BDO and the ICB that all 10 MIS safety standards were met. In addition to MIS there were two external reviews through the MSSP and quality assurance of our screening programme.
Both were successful visits which showed us maternity and neonatal growth. The outcome was that we have progressed to the sustainable phase on the MSSP programme working towards the exit with the next assessment at the end of March.

The Trust continues to report to the LMNS for assurance of progress and on continual improvement on this improvement plan.

Midwifery and neonatal staffing continuous sustained vacancy rate which enables staff to focus on patient care and maintain high standards.

There also have been medical Consultant Obstetric appointments, and a new Neonatal Consultant appointed in January. This has enabled allocation of leadership roles through job planning to support the assurance of maternity and neonatal services.

Preparations for staff moves to the BEACH were completed through staff consultation and staff are now eager for the change in April.

**Areas for continued focus**

During this quarter we outlined our new MatNeo governance structure, and we are now embedding this new process.

The team presented the quality improvement project to improve post-partum hemorrhages to the safety champions and although we are not outliers', continued improvement work was recognized to enable an improved patient experience. The team continues to make these improvements.

| | |
|---|---|
| | The Avoiding Term Admissions into Neonatal Units (ATAIN) rate for Q3 is 4.4 % per quarter which represents an improved position however rolling yearly rates remain above the regional target of 5%and national target of 6% and therefore QI continues.<br><br>A thematic overview of the locally identified 'avoidable' admissions to the neonatal unit was presented to the safety champions and exploration of action plan. Further work identified and the mat neo team will bring back to safety champions impact of changes made. |
| **Background:** | The purpose of the Maternity and Neonatal 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 and evidence in Trust Board minutes. |
| **Implications associated with this item:** | Council of Governors ☐<br>Equality and Diversity ☐<br>Financial ☒<br>Operational Performance ☒<br>People (inc Staff, Patients) ☒<br>Public Consultation ☐<br>Quality ☒<br>Regulatory ☒<br>Strategy/Transformation ☐<br>System ☐ |
| **CQC Reference:** | Safe ☒<br>Effective ☒<br>Caring ☒<br>Responsive ☒<br>Well Led ☒<br>Use of Resources ☒ |

| **Report History: Committees/Meetings at which the item has been considered:** | **Date** | **Outcome** |
|---|---|---|
| Maternity quadrumvirate | 07/02/2025 | Noted and approved through Governance processes. |
| Safety champions meeting | | Noted and approved through Governance processes safety champions reports |
| Directorate meeting | October<br>November<br>December | Noted and approved through Governance processes safety champion reports |
| Care Group Board | October<br>November<br>December | Noted and approved through Governance processes safety champions reports |

| | | |
|---|---|---|
| Quality Committee | 26/02/2025 | Meeting has not yet taken place at the time of submission of this report. |

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

University Hospitals Dorset
NHS Foundation Trust

# MATERNITY AND NEONATAL SAFETY REPORT

## QUARTER 3: OCTOBER – DECEMBER 2024

Author: Lorraine Tonge

Director of Midwifery and Neonatal Services

## REPORT OVERVIEW

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document 'Implementing a revised perinatal quality surveillance model' (December 2020). The purpose of the report is to inform the Local Maternity and Neonatal System (LMNS) Board and the Board of Directors of present or emerging safety concerns within Maternity and Neonatal services. The information within the report reflects actions and progress in line with Ockenden 2022 and the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS).

## 1.0 PERINATAL MORTALITY RATE

The following graphs demonstrate UHD performance against the national ambition to reduce stillbirth in the UK by 50%, and the local ambition for continual progression in reducing perinatal mortality at the UHD. From March 2024 the national averages have been adjusted to reflect the publication of the MBRRACE-UK report of 2022 perinatal mortality.

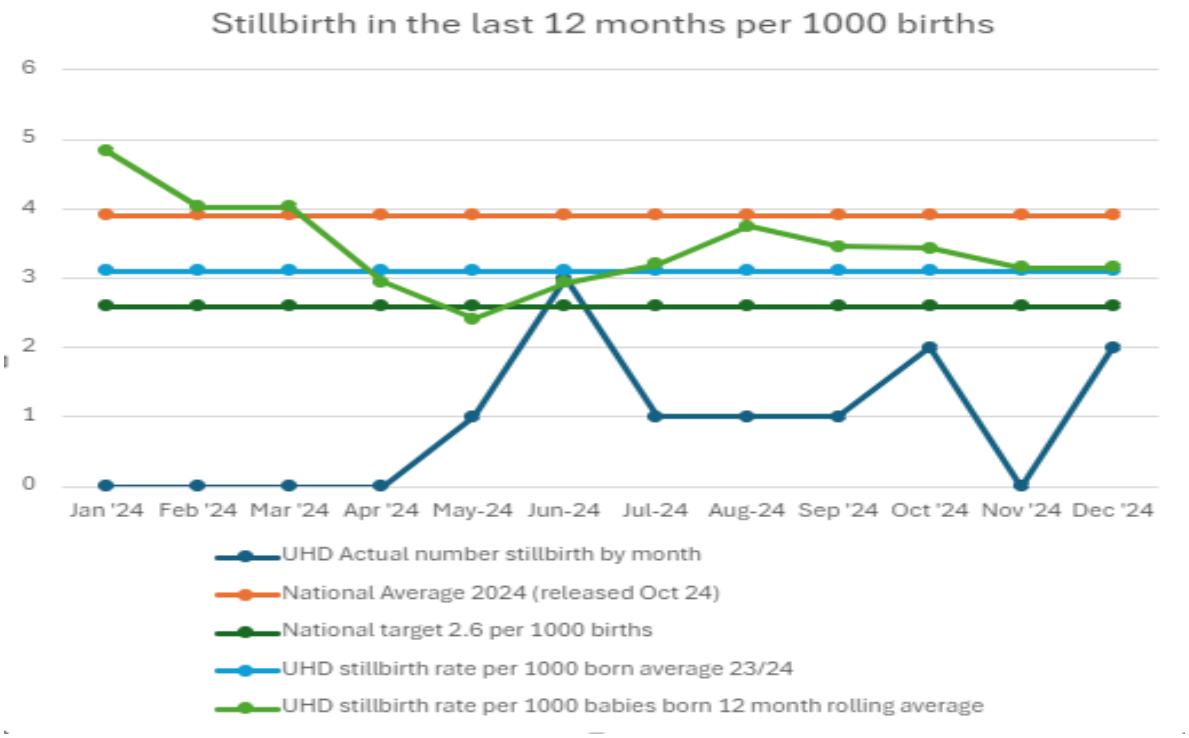



Table 1: UHD NHS Trust stillbirth rate per 1000 births over last 12 months.

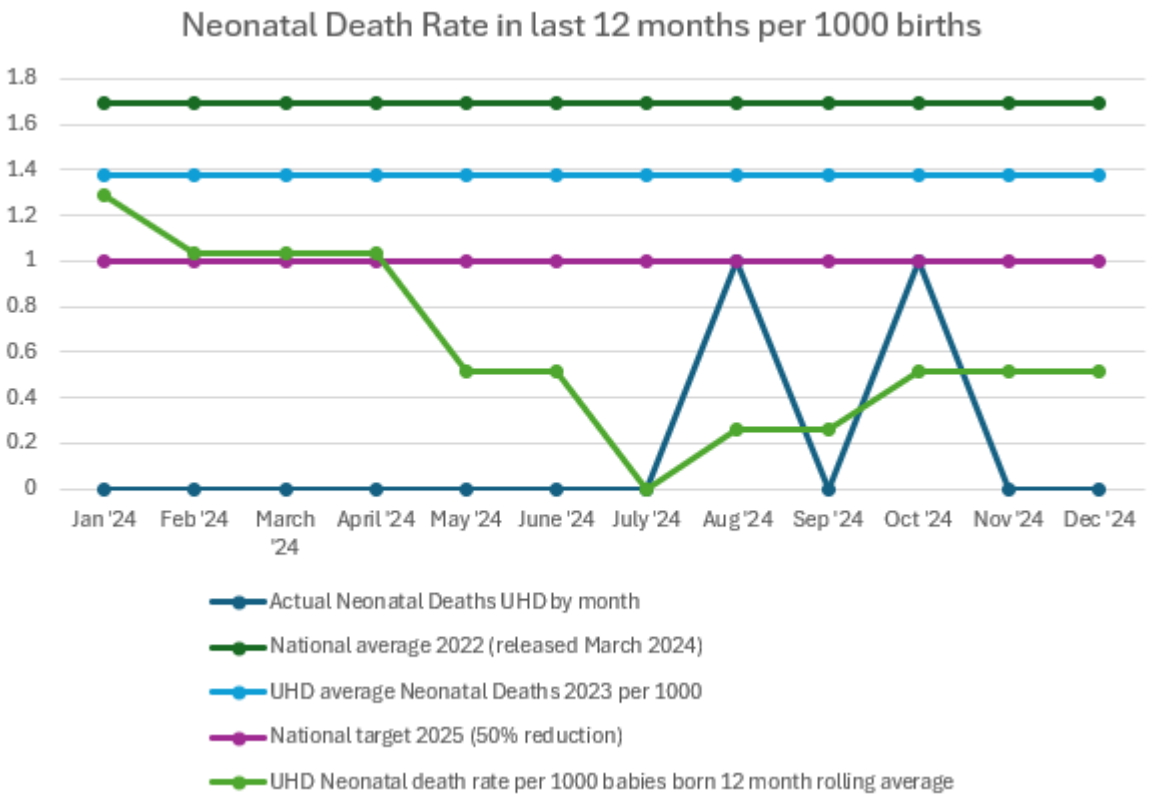



Table 2: UHD NHS Trust rolling neonatal Death rate per 1000 births is 0.3 over last 12 month.

Mothers and Babies: Reducing Risk through Audits and Confidential Enquires-UK (MBRRACE-UK) collects data on perinatal death defined as babies born without signs of life from 22 weeks' gestation to term and neonatal deaths at any gestation up to 28 days of age, excluding terminations of pregnancy.

The UHD Electronic Patient Record records all stillbirths (24 weeks or greater gestation) and neonatal deaths at the UHD. Births between 22-24 weeks are pulled manually and added to the data set submitted to MBRRACE-UK.

Perinatal deaths are defined from birth after 22 weeks' gestation and include neonatal deaths at any gestation where the baby is born with signs of life, but stillbirths are defined from 24 weeks at diagnosis of death. The rate of stillbirth and perinatal death may therefore be different. Trusts are provided with initial MBRRACE-UK perinatal mortality rate per 1000 births, results are subsequently stabilised and adjusted to reflect UHD statistics if representative of the national socioeconomic demographics. MBRRACE-UK collates the data for those babies who were born at the UHD and subsequently died elsewhere. This report has therefore separated these values to ensure alignment of internal mortality data figures ahead of reported and adjusted MBRRACE-UK figures.

**UHD perinatal mortality cases reported to MBRRACE meeting PMRT criteria Q3**

| | Late fetal loss | Stillbirth | Neonatal death |
|---|---|---|---|
| October 2024 | 0 | 2 | 1<br>(25/40 baby died in UHS but antenatal care by UHD) |
| November 2024 | 0 | 0 | 0 |
| December 2024 | 0 | 2 | 0 |
| TOTAL reported to MBRRACE meeting PMRT criteria | **0** | **4** | **1** |

Table 3: UHD perinatal mortality cases reported to MBRRACE meeting PMRT criteria Q3

There were four perinatal deaths (excluding Medical Termination of Pregnancies (MTOP)) were reported in Q3. This consisted of 4 stillbirths, of which 1 was a term gestation (>37 weeks) and 3 prior to 37 weeks.

There was 1 Neonatal Death (external). Baby was delivered at 25+1 due to maternal pre-eclampsia and transferred to UHS where sadly died on day 3.PMRT review will be held by UHS. Incident will be reviewed as AAR by UHD.

During March 2024 the service received the MBRRACE-UK perinatal mortality review report of 2022 statistics. This report outlined that the stabilised and adjusted extended perinatal mortality rate data values for stillbirth and neonatal death at the UHD during 2022 was 5-15% lower than the average the comparator group of Trusts or Healthcare Boards of a similar size.

At the UHD the demographics of the women and birthing people we serve when compared to national average of trusts with comparable birth rates, show UHD stabilised stillbirths' rates at 3.09 per 1000 total births 0.1 below the group average of 3.19 per total 1000 births. It also demonstrated the stabilised and adjusted neonatal mortality rate at 0.86 which is over 15% lower than comparable Trusts.

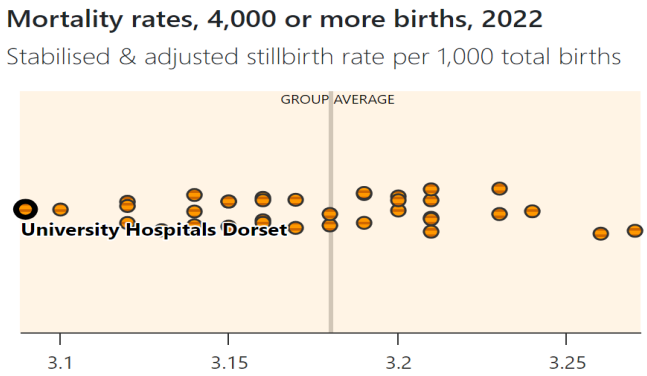
From the current rolling 12-month average UHD stillbirth rate is 3.21per 1000 which is above the national target of 2.6 per 1000 however below the national average of 4 per 1000 and UHD neonatal deaths 12 month rolling average is 0.52 per 1000 below national average 1.7 per 1000.

**Mortality rate compared with the group average**

Over 15% lower | 5 to 15% lower
Within 5% | Over 5% higher
Suppressed

University Hospitals Dorset NHS Foundation Trust

| Year | Births | Crude stillbirth rate | Stabilised & adjusted stillbirth rate | Stabilised & adjusted stillbirth rate (95% CI) | Crude neonatal mortality rate | Stabilised & adjusted neonatal mortality rate | Stabilised & adjusted neonatal mortality rate (95% CI) | Crude extended perinatal mortality rate | Stabilised & adjusted extended perinatal mortality rate | Stabilised & adjusted extended perinatal mortality rate (95% CI) |
|---|---|---|---|---|---|---|---|---|---|---|
| 2019 | 4,203 | - | 2.98 | (2.44 to 3.51) | - | 0.89 | (0.49 to 1.62) | 3.09 | 3.87 | (3.34 to 4.85) |
| 2020 | 4,346 | 3.68 | 3.27 | (2.53 to 4.32) | 1.62 | 1.27 | (0.80 to 1.95) | 5.29 | 4.53 | (3.70 to 5.89) |
| 2021 | 4,348 | - | 3.15 | (2.44 to 4.03) | - | 0.91 | (0.56 to 1.51) | 2.99 | 4.06 | (3.35 to 5.26) |
| 2022 | 4,012 | - | 3.09 | (2.42 to 3.71) | - | 0.86 | (0.51 to 1.48) | 1.25 | 3.94 | (3.26 to 4.92) |



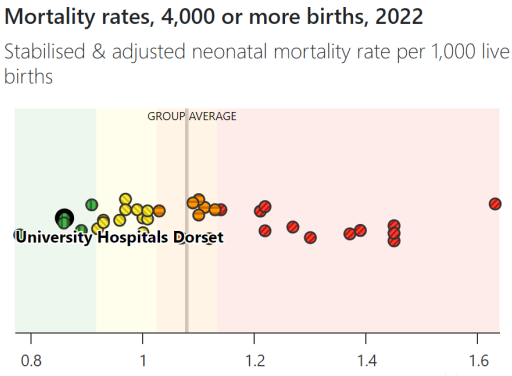




Table 4: UHD mortality rates compared with Trust average of comparable group - data source MBRRACE 2022

## 2.0 PERINATAL MORTALITY REVIEW TOOL (PMRT)

All perinatal deaths that occur within the Trust have been reported using the PMRT tool since 2018. PMRT reporting is a requirement of Safety Action 1 of the NHS-R Maternity Incentive Scheme year 6.

In Q3 there were four baby losses (all antenatal stillbirths) reported by UHD Maternity Service to MBRRACE-UK which met the criteria for PMRT review. No cases were eligible for referral to the Maternity and Newborn Safety Investigation program (MNSI). No cases required further investigation through PSIRF. All four cases were notified to MBRRACE-UK within 7 working days. All families were informed of the PMRT process and review, and their feedback has been sought. All four reviews have commenced within the recommended time frame.

| MIS Year 6, Safety Action 1 - MBRRACE-UK/PMRT standards for eligible babies meeting the PMRT criteria (From 8th December 2023) | Required Standard |
|---|---|
| a) Notification: All perinatal deaths eligible to notified to MBRRACE-UK to take place within 7 working days | **100%** |
| b) Seek parents' views of care: Ensure parents are given opportunity to provide feedback, share their perspectives of care and raise any questions and comments | **95%** |
| c) Review the death and complete the review: multi-disciplinary reviews should be started within two months of the death | **95%** |
| c) Review the death and complete the review: multi-disciplinary reviews should be completed and published within six months of a baby's death | **60%** |
| d) Report to the Trust Executive: Quarterly reports should be submitted to the Trust Executive Board on an on-going basis for all deaths | **100%** |

UHD Maternity Services continue to experience a significant delay in receiving postmortem and placental histology investigation reports (>6 months). Where necessitated, PMRT Reports are closed (supported by the MBRRACE team), pending receipt of the clinical investigation reports to confirm the cause of death, in order not to breach the Standards timeframe.

| MBRRACE ID | Type of loss | Gestation at diagnosis | Gestation at delivery | Date of Birth | Birthweight and Centile | MBRRACE-UK Notification <7 days | Parents contacted for involvement | Review commenced <2 months | Report completed <6 months |
|---|---|---|---|---|---|---|---|---|---|
| 95405 | Antenatal Stillbirth | 38+6 | 39+3 | 01/10/2024 | 3635g 78.57 | Yes | Yes | Yes | In progress (publish by 01/04/25) |
| 95755 | Antenatal Stillbirth | ?30 *Concealed pregnancy, no antenatal care | ?30 | 22/10/2024 | 2360g 99.9 | Yes | Yes | Yes | In progress (publish by 22/04/25) |
| 96374 | Antenatal Stillbirth | 27+5 | 27+5 | 05/12/2024 | 1285g 92.87 | Yes | Yes | Yes | In progress (publish by 05/06/25) |
| 96413 | Antenatal Stillbirth | 35+3 | 36+0 | 08/12/2024 | 2135g 8.11 | Yes | Yes | Yes | In progress (publish by 08/06/25) |

Table 5: Eligible cases for PMRT Q3 and reported to MBBRACE.

## 2.1 LEARNING FROM PMRT REVIEWS IN Q3

### Cases Closed

In Q3 there have been 2 PMRT cases closed following receipt of the clinical investigation reports.

There was learning identified by the group which did not contribute to the outcome but could improve future patient care - A service improvement action has been implemented that all PMRT letters are now translated by the Trust's Patient Experience Team to the mother's preferred language/dialect. A reminder to all staff of the importance of translation services is sent out regularly by the Maternity Risk Team. A recent audit showed the improvement made from 0% in January 2024 to 42% in November 2024 of women having interpreting services at all appointments. Further improvements required to reach 70% target, and this will be monitored by the senior outpatient matron with a further audit planned and improvement plans in place.

### Summary of PMRT cases reviewed in Q3.

There were two PMRT meetings held in Q3. Both meetings were held between UHD and Dorset County Hospital NHS Foundation Trust (Dorchester). A total of 4 UHD cases were reviewed:
1 case was a second review, and 3 cases first reviews.

For 3 cases, there were no care issues identified for the mother which would have impacted upon the outcome for the baby.

The review group identified one case (a neonatal death) where learning was identified which may have impacted on the outcome. This case had been referred to MNSI for an investigation in (Aug 24). There was immediate learning from the rapid review identified that the high-risk pathway had not been followed for a high-risk induction of labour. In this case care was given on the low-risk midwife led unit. An immediate action has been taken and implemented that any induction of labour considered for the low-risk midwife led unit must have an obstetric review to make the decision with the woman on the safest place for birth. (The Board will receive a full report of learning on receipt of the investigation from MNSI.)

The review group identified co-incidental learning actions from the reviews to support service quality improvements outlined below:

## Perinatal Mortality Review Meeting Action Tracker

**Open Actions -**

| PMRT Meeting | MBRRACE Datix | Issue | Action | Responsible/Due | Comments/ Progress |
|---|---|---|---|---|---|
| | 96413 L142227 | Non-English-speaking mother did not contact Maternity Advice Line | Contacting maternity advice line for any concerns discussed with other throughout her antenatal care. Can we be sure non-English-speaking mothers will contact maternity advice line | AK, GG, JT, LL | 11.12.24 Email sent to Community, Triage and Maternity advice line Leads for further discussion following MDT review. PMRT review o/s |
| | 95675 L139657 | 4th concealed pregnancy; DNA follow up sexual health appt for contraception. | Explore options to provide long-acting contraception prior to discharge home | AE, KG | 7.11.24 (MDT) AE has offered to explore further |
| 21.11.24 | Case 3 94658 L135053 and general discussion | Positive current or recent Parvovirus infection found on admission blood. Plus recent 8-9 cases within maternity (not fetal loss) | Ensure up to date information leaflet on Parvovirus available | GB/BF/Digital Team | 27.11.24 BF – Parvovirus leaflet submitted for approval prior to being uploaded to Badgernotes |
| 21.11.24 | Case 3 94658 L135053 and general discussion | Positive current or recent Parvovirus infection found on admission blood. Plus recent 8-9 cases within maternity (not fetal loss) | Ensure up to date information and recommendations/staff education available to maternity staff | HC | |
| 13.11.24 (UHS) | 95675 L139312 | Baby bloods not labelled correctly during resuscitation in theatre | Remind staff of the importance of labelling and checking bloods taken, even during an emergency | EC | 27.11.24 For Risky Business comms |
| 13.11.24 (UHS) | 95675 L139312 | PET risk assessment not completed correctly – aspirin not recommended | For audit of notes to ascertain if one missed opportunity or if further work required on assessment of aspirin requirements and compliancy<br><br>Antenatal Care Policy – ensure includes importance and timing of risk assessments.<br><br>Community Leads and matrons aware of case and will disseminate importance to all staff via newsletter | Risk Team, audit RM ECr<br><br>HP, GG<br><br>GG | 22.11.24 Newsletter disseminated (see L139312 document) |
| 10.10.24 | 94486 / general discussion | Growth USS and further screening | Local guidance requiring update? | NMC | NMC to discuss at next MDT Business Meeting and Fetal Medicine: if referred for growth USS and umbilical doppler normal, should also have MCA dopplers and CPR? |

Table 6: incidental learning from PMRT reviews.

## 3.0 MATERNITY AND NEONATAL SAFETY INVESTIGATIONS (FORMERLY THE HEALTHCARE SAFETY INVESTIGATION BRANCH) AND MATERNITY AND NEONATAL PATIENT SAFETY INCIDENCES.

### 3.1 BACKGROUND

MNSI undertake maternity investigations in accordance with the Department of Health and Social Care criteria (Maternity Case Directions 2018), taken from Each Baby Counts and MBRRACE-UK. In accordance with these defined criteria, eligible babies include all term babies (at least 37 completed weeks of gestation) born following labour who have one of the following outcomes:

- Maternal Deaths
- Intrapartum stillbirth
- Early neonatal death
- Severe brain injury diagnosed in the first seven days of life

### 3.2 INVESTIGATION PROGRESS UPDATE

There was no new referral which met MNSI criteria in Q3.

There was one final MNSI report received. This report gave no safety recommendations to the Trust. The MNSI commented that “the emergency was well managed, and staff worked as a team and communicated their decisions.”

| **Datix/LERN Ref Description Ongoing/New in Q3** | **Month reported** | **Details of event** | Investigation / Review / Reporting |
|---|---|---|---|
| Ongoing case MI-037917- L135383 Early neonatal death | Aug 24 | MNSI referral made with parental consent. All requested information uploaded to HIMs portal. Staff and interviews completed. Awaiting final report | MNSI MBRRACE reportable PMRT review |
| **Datix/LERN Ref Description Completed in Q3** | **Month reported** | **Details of event** | Investigation / Review / Reporting |
| MI-036834 - L124770 Term baby therapeutically cooled. | Feb 24 | Neonatal transfer to Tertiary Neonatal Unit for ongoing care and active therapeutic cooling.<br>Staff interviews with MNSI are complete.<br>Final report received – No safety recommendations for the Trust. | MNSI<br>NHS Resolution Early Notification Scheme |

Table 7: identifies ongoing and final reports MNSI reviews in Q3.

## 3.3 MATERNITY PATIENT SAFETY INCIDENT INVESTIGATION (PSII)

UHD has now moved to PSII which replases the previous serious incidence process. Quarter 3 , there was  one PSII opened and four After Action Reviews (AAR's).

| Datix/LERN Ref Description | STEIS reportable | Month reported | Progress | Investigation / Review / Reporting |
|---|---|---|---|---|
| L138633 - Head trauma following 7 pulls on Kiwi | Yes | Oct-24 | Declined by MNSI as does not meet criteria. Discussed at Insight Group. PSII in progress | PSII with thematic analysis |
| L139170 - Demonstration resuscitaire taken into theatre during live case | No | Oct-24 | AAR awaiting Care Group approval sign off | AAR |
| L139236 - Baby incorrectly indentified, admitted and investigations reported as a different baby | No | Oct-24 | Draft AAR report due to be discussed at PSIRF Insight Group in February for sign off | ARR |
| L142195 - A formula fed baby was given expressed breast milk (EBM) from another mother in error | No | Dec-24 | AAR in progress | AAR |
| L143291 - 4 Litre MOH and ITU admission following vaginal delivery | No | Dec-24 | AAR completed, awaiting comments and to be presented and the Mat Neo Patient Safety meeting in February for sign off | AAR |

Table 8: open PSII and AAR's in Quarter 3

| Datix/LERN Ref Description | STEIS reportable | Month reported | Key Learning identified/actions |
|---|---|---|---|
| L112873 Retained hand towel vaginally | No | Aug 23 | • Hand towels now included in swab counts.<br>• Hand towels removed from working tray once used and discarded.<br>• Clinicians recommend inspection of perineum's at each contact if perineal injury occurred and education re offensive lochia. |
| L115546 Stillbirth at 32 weeks' gestation | No | Sept 23 | • Work completed so that on each appointment that next appointment is arranged with the woman.<br>• QI actions on translation services completed |
| L116602 4th degree tear | No | Oct 23 | • OAIS technique added to PROMPT training.<br>• Working with the University to include students in this training. |
| L119424 Term baby therapeutically cooled | No | Nov 23 | • Ongoing care plans are in line with obstetric care plans and any deviations need full documentation of reasons for changes.<br>• Education re increasing oxytocin.<br>• Refresher on use of emergency call bells. |

| | | | |
|---|---|---|---|
| L120035<br>Term admission to NICU pathological jaundice | No | Nov 23 | • Education to all staff re-signs of jaundice in the global majority babies in progress.<br>• Purchase of additional TBR machines – now on postnatal and labour wards.<br>• All inpatient babies receive a TBR with parents' consent |
| L132361<br>Intrauterine death @ 26+6 | Yes | Jun 24 | • To increase awareness and support and assist in staff well-being throughout the maternity services.<br>• To add to maternity Risk Register and access mitigate the inability to use ICE system in the community.<br>• Education for staff on sample taking.<br>• Shared learning with ICB for wider learning with GP's |
| L138339<br>EBM was given to wrong baby | No | Oct 24 | • Relocation of expressed milk fridges<br>• Polices updated to monitor to process of checking.<br>• Aligned NICU and maternity processes to be the same. |

Table 9: closed PSII/AAR/SI Q3

PSII and AAR's/Board reports with learning diseminated completed this quarter and lessons have been shared within the department and will been shared regionally for wider learning.

### 3.4 LITIGATION

Summary of Q3 maternity claims and early notification scheme:

- 0 new claims received.
- 1 Maternity claim where damages were agreed.
- 0 claim files were closed.
- 0 new ENS matters reported.
- 0 ENS matters settled.
- 0 ENS matters closed.
- 1 Maternity/Neonatal Inquest held.
- 2 Healthcare Law Matters received.

When reviewing and triangulation of incidents, learning and improvement, alongside the claim settled this quarter common themes for focus where:

1. **Storage of written medical notes.**
   Since 2021 maternity records are now electronic on Badger net system however profession midwife advocates (PMA's) are increasing staff awareness on the importance of record keeping and impact of poor records.
2. **Lengthy time for polices/SOP's being updated.**

Processes and length of time being reviewed with joint work with NICU to monitor guidelines and Sop's. Obstetric and neonatal leads appointed with midwife assistance to address this concern.

3. **Trust guidance relating to assisted births (2020), does not specify a requirement for clinicians to categorise either the urgency of their decision or a target time frame for decision to delivery interval here is no classification.**
   Categorisation and urgency of instrumental delivery under review as no national guidance currently. Guideline out to consultation with staff.
4. **Guidance to reflect that the senior doctor and the consultant should decide in advance if the consultant should be informed prior to the senior doctor undertaking an instrumental procedure."**
   This is being added to assisted birth policy
5. **Importance of communication with parents**
   Continuous work to address improving communication.

Learning and Improvement drivers from these events are fed back in a variety of formats including safety champions report safety messages to all staff, staff e-mails, staff safety briefings, patient safety "risky business" newsletter, quality and safety whiteboards displayed in clinical areas 60 second updates and directorate risk and governance meeting.

### 3.5 CORONER REGULATION 28 MADE DIRECTLY TO TRUST

Not applicable.

## 4.0 OCKENDEN UPDATE

### 4.1 OCKENDEN FINAL REPORT UPDATE – Q3 2024-2025

The Trust is not required to submit evidence of compliance with the 15 Immediate and Essential Actions outlined within the Ockenden report of 2022. Monitoring of compliance and improvement towards compliance is monitored via the maternity improvement plan which is monitored though Directorate Governance, Maternity and Neonatal safety champions via the safety champions report presentation every month.

UHD have an improvement plan which has been developed to align all national and local improvement drivers into encompassing Ockenden 2022, the 3-year single delivery plan 2023, Saving Babies Lives Care Bundle v3, CQC inspection report received in 2023, CQC maternity patient survey, the NHSE MSSP exit criteria and locally identified safety priorities, MIS year 6, maternity self-assessment, Score culture and staff survey improvements.

The Trust reports to the LMNS for assurance of progress on continual improvement.

## 5.0 TRAINING COMPLIANCE FOR ALL STAFF GROUPS IN MATERNITY RELATED TO THE CORE COMPETENCY FRAMEWORK AND WIDER JOB ESSENTIAL TRAINING

Compliance with fetal monitoring, neonatal resuscitation, and multi-disciplinary training (MDT) Emergency Skills Training (PROMPT) basic neonatal life support is required to be above 90% across all staff groups to fulfil the requirements set out within the CNST MIS year 6. There is also the expectation of training in Saving Babies Lives Care Bundle v3 and the core competency framework v2 to become multidisciplinary to enhance the standards of learning. This is currently not measured in MIS year 6 and will require additional resources to fully implement.

In December 2023 UHD did not meet the required standard for MIS year 5 however significant improvement can now be seen in Q3 (Nov) with >90% met in all MIS training standards.

In December there was a slight decrease in compliance 89% for the for-consultant Obstetricians due to one Consultant unable to attend training. This has been addressed. However, it should be noted that this is a small team. There is a robust systematic process in place to continue achieving > 90% in MIS year 7 and all staff are committed to achieving this standard.

| MIS safety action 8- Mandatory training | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Standard | | Expected compliance | Dec-23 | Jan-24 | Feb-24 | Mar-24 | Apr-24 | May-24 | 24-Jun | Jul-24 | 24-Aug | Sep-24 | 24-Oct | Nov-24 | Dec-24 |
| Fetal Monitoring (Module 2) | Obstetric consultants | 90% | 87.50% | 100% | 100% | 100% | 100% | 100% | 93.30% | 93.30% | 100% | 100% | 100% | 100% | 94.40% |
| | All other obstetric doctors contributing to the obstetric rota | 90% | 82.40% | 100% | 94.74% | 94.74% | 100% | 94.74% | 94.70% | 94.70% | 100% | 100% | 75% | 100% | 100% |
| | Midwives | 90% | 91% | 92.50% | 95.80% | 96.42% | 97.20% | 96.08% | 96.91% | 97.67% | 98.31% | 98.86% | 97.83% | 99.29% | 98.20% |
| PROMPT (Module 3) | Obstetric Consultants | 90% | 80.00% | 80% | 86.66% | 93.33% | 93.75% | 93.75% | 93.75% | 93.75% | 93.75% | 100% | 100% | 93.75% | 89.47% |
| | All other obstetric doctors contributing to the obstetric rota | 90% | 85.20% | 85.20% | 68.57% | 77.70% | 94.73% | 97.14% | 94.73% | 92.10% | 92.10% | 81.81% | 81.07% | 91.89% | 100% |
| | Midwives | 90% | 89.60% | 90.60% | 93.95% | 96.73% | 98.31% | 98.02% | 97.66% | 98.88% | 98.88% | 98.37% | 97.23% | 97.28% | 97.29% |
| | Maternity Support Workers | 90% | 87.00% | 77.52% | 84.53% | 94.50% | 96.84% | 97.87% | 94.62% | 95.83% | 95.83% | 98.96% | 100% | 96.59% | 96.42% |
| | Anaesthetic consultants and autonomously practising anaesthetists | 90% | 85.00% | 88.80% | 89.47% | 90% | 95% | 94.73% | 85.71% | 85.71% | 85.71% | 80%% | 92% | 96% | 92% |
| | All other anaesthetic doctors who contribute to the obstetric rota | 90% | 68.57% | 77.40% | 82.14% | 92.85% | 96.42% | 96.42 | 90.32% | 100% | 100% | 84.21% | 89.47% | 94.11% | 100% |
| | Can you demonstrate that at least one emergency scenario is conducted in the clinical area? | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| | Can you demonstrate that 90% of all team members have attended an emergency scenario in a clinical area? | Yes | No | No | No | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Neonatal Basic Life Support | Neonatal consultants or paediatric consultants covering neonatal units | 90% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 86% | 100% | 100% |
| | Neonatal junior doctors (who attend any births) Clinical fellows | 90% | 100% | 100% | 100% | 100% | 67% | 67% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | Neonatal nurses (band 5 and above who attend any births) | 90% | 100% | 100% | 100% | 100% | 93% | 92% | 93% | 92% | 97% | 90% | 90% | 100% | 100% |
| | ANNPs | 90% | 78% | 80% | 94% | 94% | 100% | 100% | 100% | 84% | 93% | 89% | 100% | 100% | 100% |
| | Midwives | 90% | 89.60% | 90.60% | 93.95% | 96.73% | 98.31% | 98.02% | 97.66% | 98.88% | 98.88% | 98.37% | 97.23% | 97.28% | 97.29% |
| | Nursery Nurses | 90% | | | | | | | | | | | | 100.00% | 100% |
| | All trusts must have an agreed plan in place including timescales for registered RC-trained instructors to deliver the in house basic neonatal life support annual updates and their local NLS courses | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Midwife Update Day (Module 4 & 5) | Midwives | 90% | 90.36% | 90.60% | 94.75% | 96.73% | 99.6 | 98.04 | 96.10% | 95.66% | 95.66% | 95.47% | 87.74% | 94.96% | 94.98% |

Table 10: Maternity Training MIS year 6 standards for Fetal Monitoring, Prompt, Neonatal basic life support and Midwife update training compliance.

## 6.0 BOARD LEVEL SAFETY CHAMPIONS

The Maternity and Neonatal Safety Champions are active in their role to listen to the staff voice in maternity and neonatal services. All staff are encouraged to interact with Safety Champions during walkabouts and listening events with the Chief Nursing Officer, the Non- executive Director for Midwifery and the Obstetric, Neonatal and Maternity Safety champions. The Perinatal quadrumvirate leadership team meet monthly with the safety champions (at the safety champions monthly meeting) to identify any support needed and escalate any concerns.

Some themes which were raised during walkabouts listening events and from the maternity quadrumvirate were:

The move to the BEACH building has created new ways of working and challenges on outpatient services and office space. The DOM and Clinical Director are working with the transformation team to identify space and will liaise with individual teams' outcomes of allocation. There is an increase in demand for outpatient services as complexities and public health concerns increase with less space available in primary care to deliver services. Work continues with the ICB in finding sustainable solutions.

Positive feedback was given by community teams', and they were proud of their service and support they were given by team and senior leaders.

Feedback was given regarding racism and incivility. The clinicians were honest and open with the safety champions and shared their experiences. The team value this feedback as incivility and racisms impacts safety outcomes and we do not accept this behaviour. The senior team are working with all staff groups in maternity with OD support to address these issues.

During the safety champion walkabouts, Labour ward session demonstrated the positive outcomes from there quality improvement work on 3$^{rd}$ and 4$^{th}$ degree tears and the NICU were excited to move to the new unit and exploring new ways of working together as a Mat Neo unit.

Themes, commonalities, and actions from this feedback is monitored via the Maternity and Neonatal Safety Champions meetings and is triangulated with further service insights through Maternity safety champions report to drive our continuous improvement work.

## 7.0 NHS RESOLUTION MATERNITY INCENTIVE SCHEME UPDATE Q2 2024/25

The service is able to declare full compliance with all 10 Safety Actions detailed in the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme in January 2024.

| | Maternity incentive scheme -safety action detail | Submission Rag MIS year 5 | Submission Rag MIS year 6 |
|---|---|---|---|
| 1 | Are you using the National PMRT to review perinatal deaths to the required standard? | | |
| 2 | Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? | | |
| 3 | Can you demonstrate that you have transitional care services in place to minimize separation of mothers and their babies? | | |
| 4 | Can you demonstrate an effective system of clinical* workforce planning to the required standard? | | |
| 5 | Can you demonstrate an effective system of midwifery workforce planning to the required standard? | | |
| 6 | Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three? | | |
| 7 | Listen to women, parents and families using maternity and neonatal services and coproduce services with users | | |
| 8 | Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training? | | |
| 9 | Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues? | | |
| 10 | Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 to 7 December 2023? | | |

Table 11: Declaration for compliance with MIS Year 5 and MIS year 6

The Clinical Negligence Scheme for Trusts released their Safety Actions for Year 6 on 31 March 2024.

Assessment by external auditors and integrated care Board for verification of evidence occurred in November and could confirm in December that all standards had been met.

Standards remain continuous and we are currently awaiting MIS year 7 guidance.

## 8.0 SAFETY ACTION 6 - MIS SAVING BABIES LIVES CARE BUNDLE V3

| | Baseline Assessment | Assessment 1 | Assessment 2 | Assessment 3 | Assessment 4 | Assessment 5 | Assessment 6 | Assessment 7 | Assessment 8 | Assessment 9 |
|---|---|---|---|---|---|---|---|---|---|---|
| Review Quarter | Q1 23-24 | Q1 23-24 Final | Q2 23-24 | Q2 23-24 final | Q3 initial | Q3 final | Q4 | Q4 final | Q1 24/25 Final | Q2 24/25 Final |
| Assurance Review Date | 04/09/23 | 20/09/23 | 04/12/23 | 21/12/23 | 22/01/24 | 20/02/24 | 22/04/24 | 11/06/24 | 30/08/24 | 07/11/24 |
| Element 1 | 10% | 20% | 80% | 100% | 90% | 90% | 90% | 90% | 80% | 100% |
| Element 2 | 35% | 45% | 70% | 70% | 60% | 65% | 70% | 75% | 70% | 95% |
| Element 3 | 0% | 0% | 50% | 50% | 50% | 100% | 100% | 100% | 100% | 50% |
| Element 4 | 20% | 40% | 40% | 40% | 40% | 40% | 60% | 60% | 40% | 80% |
| Element 5 | 48% | 52% | 78% | 85% | 59% | 67% | 67% | 78% | 81% | 85% |
| Element 6 | 33% | 50% | 83% | 83% | 83% | 83% | 100% | 100% | 83% | 100% |
| TOTAL | 34% | 43% | 73% | 79% | 64% | 70% | 74% | 80% | 76% | 90% |

Table 12: UHD Maternity position for implementation of Saving Babies Lives Care Bundle v3 -- Q2

Saving Babies Lives Care Bundle Version 3 implementation was assessed externally by the LMNS using the national implementation tool on NHS Futures Platform. The UHD evidenced position in Q3 is reported in table is 90% complete.

Key areas of improvements seen from Q1 were:

Element 4: Fetal monitoring in labour improvement in intermittent auscultation.

Element 5: Mid-stream urine testing for those at risk of preterm birth and improvement in delayed cord clamping in preterm birth infants.

Quarterly assessment by the ICB will continue in 2025 to monitor sustainability of changes made.

## 9.0 SAFE MATERNITY STAFFING

### 9.1 MIDWIFERY STAFFING

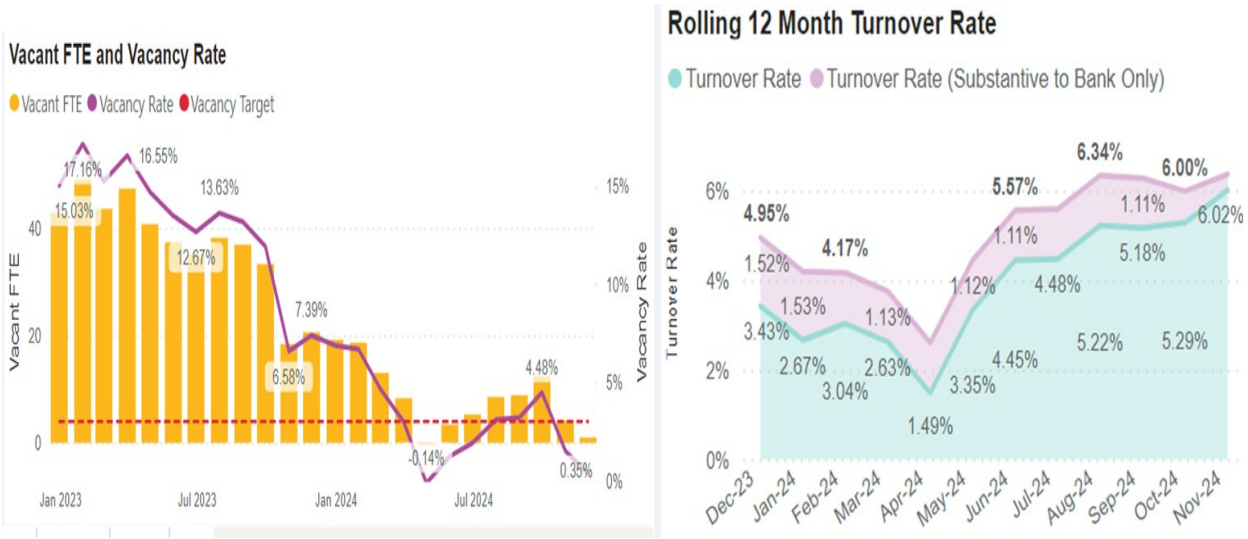



Table 13: Midwifery rolling vacancy and turnover rate -data source COSMOS 6th of January 2025

From our data on cosmos, (and data is verified through workforce reviews), there has been significant sustained improvement in midwifery vacancy rate from 16.63% in December 2023 to a current vacancy of 0% .This positive position is reflective of a collective responses and actions taken to address the vacancy and in preparation for our move in April 2025 when fluctuation of staff turnover expected and to safely provide the additional set up training required.

Turnover rate, staff satisfaction has also improved showing a positive workforce which is reflective to patient safety.

Staff sickness rate has increased in this quarter during the winter period with flu and viral infections has impacted staff absences. The unit provided peer vaccinations in house sessions with additional trust wide provision but poor uptake by staff. Work is underway to understand why staff did not take the vaccinations and ongoing planning and engagement is underway.

| Measure | Aim | Oct | Nov | Dec |
|---|---|---|---|---|
| Midwife to funded birth ratio BR plus | 1:23.5 | 1:23.5 | 1:23.5 | 1:23.5 |
| Midwife to actual birth ratio | 1:23.5 | 1:22.5 | 1:20.5 | 1:22 |
| Episodes of inability to provide Supernumerary labour coordinator at start of shift | 0 | 0 | 0 | 0 |
| 1:1 care in labour not provided | 0 | 0 | 0 | 0 |
| Confidence factor in birthrate plus recording | 90% | 86.02% | 90.4% | 81.5% |

Table 14: Midwifery staffing safety measures

The birth ratio is above the expected level as there has been a decline in the birth rates since 2021 however there has been an increase in complexity within pregnancy, birth and postpartum. A birth rate plus assessment is in progress which will provide the Trust with an updated position and reflect of care required ratios. It will also take into consideration the move to the BEACH at RUBH in April 2025. The move to the BEACH provides uncertainty of how this will impact the birth rate although it is expected to increase due to updated facilities available.

## 9.2 OBSTETRIC STAFFING

| Measure | Aim | Oct | Nov | Dec |
|---|---|---|---|---|
| Consultant presence on labour ward (hours/week) | 60 hrs. <4000 births | 70hrs | 70hrs | 70hrs |
| Twice daily MDT ward rounds | 100% | 100% | 100% | 100% |
| Compensatory rest rostered (doctors who are working a non-resident on on-call out of hours) | 100% | 100% | 100% | 100% |

Table 15: Obstetric staffing safety measures

The recommended Consultant presence on the labour ward at UHD meets the criteria set for units with births less than 4000 as per RCOG guidance 2009 however in addition to this there is an expectation through the Ockenden immediate essential actions that consultants do twice daily ward rounds. To meet this standard the consultants are rostered 12 hours presence Monday to Friday and 5 hours Saturday and Sunday to complete twice daily ward rounds and 100% compliance was achieved in Q3. There are minor gaps in rotas for consultant presence on labour ward, however this is mitigated through the employment of locum consultants. Should there be a gap due to unexpected sickness there is a system in place for escalation and the consultant team will step into the vacant position.

Compensatory rest is monitored through rosters and continued to be rostered in Quarter 3

Alongside these measures in year MIS year 6 additional standards have been set for continuous monitoring to ensure compliance of short term and long-term locums are meeting the required standard set by the RCOG. This a continuous standard measured and presented through maternity governance for full compliance.

Long term locums are supported throughout their employment from the obstetric team and meet the standards as per RCOG guidance on engagement of long-term locums with induction, regular feedback, and completion of a yearly appraisal.

Data bases are kept for short term and long-term locums and reviewed monthly by the Obstetric lead.

The Trust is compliant with monitoring of consultant attendance for the clinical situations listed in the RCOG workforce document: ‘Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology’.
An initial audit was presented by Consultant Obstetrician in September Directorate quality and risk meeting. Discussion and learning shared with the team and the importance of safety reinforced. There is an ongoing audit which will be presented to the team bi-annually. Data is collected by a labour ward co-ordinator and records of any incidences of non-attendance is reported through LERNs, so the case is reviewed for any immediate learning.

Obstetric Consultant job planning and service review has been completed. Obstetric staffing remains on this risk register but during this quarter. Locum consultant have been advertised as substantive posts and currently recruiting to these posts.

With the service review there is the requirement for further appointments to address clinical need. Areas identified were the mental health service and increase in planned LSCS.

Job planning has also strengthened leadership roles with the department so there is the addition of an obstetric lead and MDT training facilitator. This leadership strengthens maternity safety.

Resident doctor rotas SHO and GP rotas were fully recruited and changeover in Q4 expected.

## 9.3 NEONATAL NURSING STAFFING

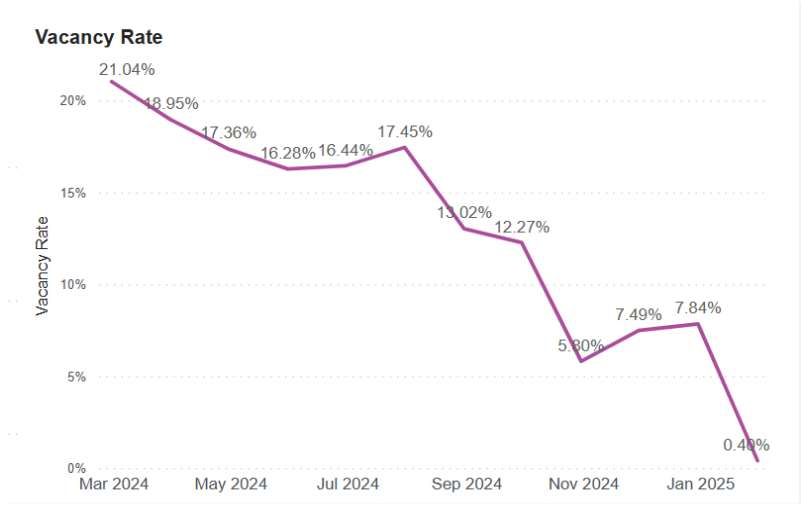



Table 16: Neonatal nursing vacancy rate - data source COSMOS 6th January 2025

The neonatal nursing establishment meets the British association of perinatal medicine (BAPM) neonatal Nurse staff standards.

During this quarter we have appointed into the Neonatal Marton vacant post who joined the midwifery matron team in November.

Newly qualified nurses have been recruited which now gives an improved vacancy rate of 0.4% however this reduced the overall position.

It was identified that the current compliance with QIS Registered Nurse workforce is 53% (against standard requirement of 70%) this has been due to the recruitment of junior band 5 nurses. However, 2 candidates started the course in November 2024 for completion in 12 months with a request to train 7 colleagues in 2025. This reflects the national picture of QIS within Neonatal services.

## 9.4 NEONATAL MEDICAL STAFFING

The neonatal medical workforce has been reviewed in alignment with the BAPM recommendations, and it was recognised that to achieve the standard, a 1:7 on call commitment from the neonatal Consultants was required. There are six neonatologists and therefore an additional consultant was required. With the support from the safety champions and the executive team, we have recruited the 7th consultant neonatologist.

This additional post has also given the opportunity to review job plans and strengthen the leadership roles with the neonatal team.

## 10.0 INSIGHTS FROM SERVICE USERS AND MATERNITY VOICES PARTNERSHIP CO-PRODUCTION

### 10.1 COMPLAINTS/COMPLIMENTS/PATIENT ADVICE AND LIAISON SERVICE/CONTACTS

| | Oct | Nov | Dec |
|---|---|---|---|
| Complaints | 5 | 3 | 3 |

Table 17: Complaints Q3 24/25

Compliments are received through a variety of sources from the MNVP monthly survey, thank you cards and through friends and family monthly feedback. This feedback is given to the members of staff and award a STAR certificate in recognition of their good work.

During Q3, eleven complaints were received. The themes remain consistent with quarter 2 Themes from complaints identified were communication, consent and birth choices, Triangulation of complaints with CQC maternity patient feedback 2024 showed us that the availability of staff and communication concerns were the main factors affecting service user experience. Service users also said that they wanted more information in the antenatal period.

To address these themes, training on birthright has been given to staff with further sessions booked for this year. Areas within this training were consent communication and birth choices. Community teams have also updated the information given antenatally on choices of birthplace. Further work on providing antenatal classes is restricted due to funding resources available. The CQC maternity patient survey did not give concerns re infant feeding support. However, UHD has been working towards baby friendly initiative and has appointed a maternity lead in Q4 which will improve the overall patient feeding experience.

### 10.2 MATERNITY AND NEONATAL VOICES PARTNERSHIP (MNVP)

The Maternity and Neonatal Voices Partnership (MNVP) hold a key stakeholder membership in the LMNS and have been providing feedback into the meetings and direct feedback to the DoM from service user feedback.

The NHSE Maternity and Neonatal Programme have published the Maternity and Neonatal Voices Partnership Guidance in November 2023.

The priorities for the service are currently undergoing system-wide agreement within the Local maternity and Neonatal System (LMNS).

MNVP hours have been increased and agreed via the LMNS Programme Board to support the work plan across the Dorset wide system at DCH and UHD.

This will support delivery of the key priorities:

- Listen to Women & Families from all backgrounds & ethnicities.
- Support development of perinatal mental health services
- Improve digital systems and process for our families.

- Improvement in infant feeding.
- Working in collaboration to improve the complaints process and responses to service users.
- Improved involvement in governance and communication to support delivery of the 3-year Maternity and Neonatal delivery plan and transformation.

In July the **MNVP** and members of the public conducted the 15 steps exercise on the maternity unit. Verbal feedback has been given by the MNVP and a final report is expected in October.
An initial action plan has been initiated for improvement which was presented at Safety Champions in September and shared with all teams. Practical suggestions for environmental improvements were made with recognition that we will be moving to a new building in April 2025. All suggestions will also be considered for the new premises.

## 11.0 AVOIDING ADMISSION INTO THE NEONATAL UNIT (ATAIN) & TRANSITIONAL CARE

### 11.1 THE NATIONAL AMBITION

In August 2017 NHSI mandated a Patient safety alert to all NHS Trusts providing maternity care. The safety alert was issued to reduce harm from avoidable admissions to neonatal units for babies born at or after 37 weeks. This fell in line with the Secretary of State for Health's ambition to reduce stillbirth, neonatal brain injury and neonatal death by 50% by 2030. The national ambition for term admissions is below 6%, however Trusts should strive to be as low as possible.

This ambition is also aligned with the vision created within Better Births (2016), which aims to drive forward the NHS England-led Maternity Transformation Programme, with a key focus on:

- Reducing harm through learning from serious incidents and litigation claims
- Improving culture, teamwork, and improvement capability within maternity units

### 11.2 WHY IT IS IMPORTANT

There is overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding, long-term morbidity for mother and child. This makes preventing separation, except for compelling medical reason, an essential practice in maternity services and an ethical responsibility for healthcare professionals.

### 11.3 ATAIN DATA

The ATAIN data showed us in Q2 that we were not meeting the National target of 6% target. This was recognized through the maternity and neonatal governance process.

A detailed deep dive with a re-evaluation of the current action plan was presented to the safety champions in November.

The maternity and neonatal team worked together on actions and Q3 has shown improvement in overall performance with term admissions now at 4.5% this quarter.

Babies are frequently admitted for more than one reason. The table below shows the primary reason for admission. Respiratory and infection are the most common reasons for term admissions to NICU.

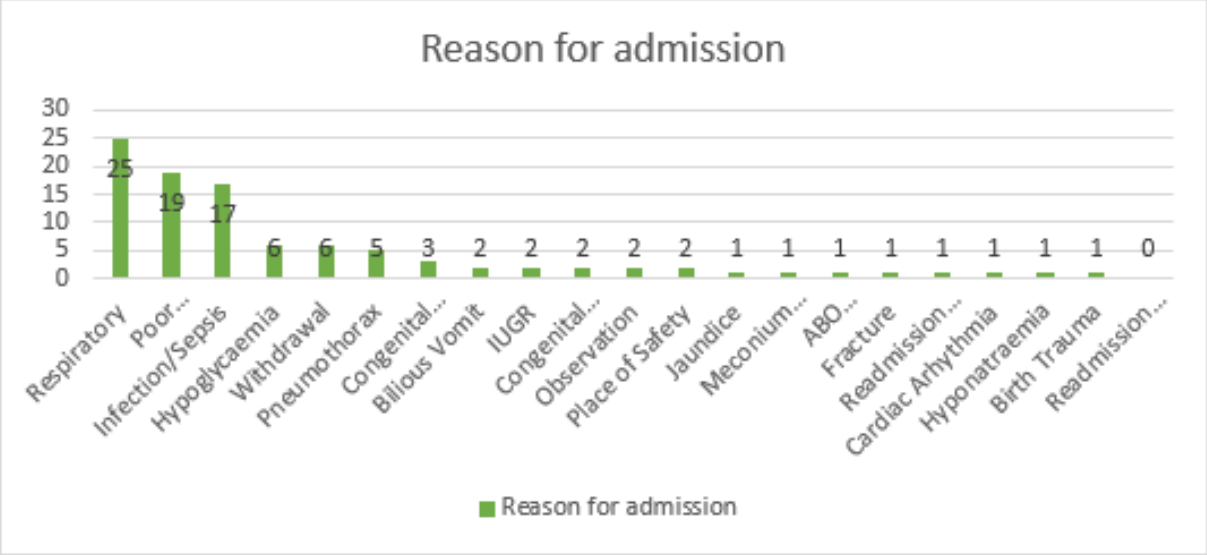



Table 18: reason for admission to NICU/LNU

During this quarter the ATAIN working group identified 5 avoidable admissions into the Local Neonatal Unit (LNU):

| Date | LERN number | Reason for admission to NICU | Reason deemed avoidable admission | Learning/Actions |
|---|---|---|---|---|
| **Oct 24**<br>**1** | L139036 | RDS. | Haven Birth. Concerns with IA recognised but not escalated. | **Learning:**<br>FH concerns on Haven should be escalated in the same way as those on labour ward.<br><br>**Actions:**<br>Haven activity captured on labour ward board.<br>Involved staff aware.<br>Cascade of learning to teams. |
| **Nov 24**<br>**1** | L141479 | Low APGARs 6:6, hypoglycaemia. | Poor documentation around immediate post birth care, therefore difficult to assess. | **Learning:**<br>Baby discharged from NICU on AM ward round but not reunited with mother for several hours.<br>**Actions:**<br>Babies to be reunited asap once fit.<br>Warm bundle reiterated to clinical teams.<br>Individual aware of importance of record keeping. |
| **Dec 24** | L143594 | Hypothermia, infection. | GDM on insulin, no documentation re warm bundle therefore difficult to assess. | **Learning.**<br>Warm Bundle reminder to staff.<br>**Actions.**<br>Confirm if additional hot cots are required. |
| | L142801 | Double phototherapy. | Possibly jaundiced at discharge <24hrs. | **Learning.**<br>Jaundice <24hrs is pathological and baby should not be discharged. |
| | L142689 | Triple phototherapy. | Born by forceps, known risk factor. TBR not performed according to guideline. | **Actions.**<br>To ascertain if additional TBR's are required in community.<br>New Jaundice Guideline to be ratified in Feb 25.<br>Case to be shared. |

Table 19: learning from avoidable admissions to NICU/LNU

## 11.4 ATAIN QUALITY IMPROVEMENT

Due to the small number avoidable cases, these themes have fed into the ATAIN cases of 23/24 to facilitate identification of themes or trends within the avoidable admissions.

The thematic review has identified 2 areas of commonality within the 'avoidable' admissions within 2023/24.

This relates to the provision of thermoregulatory care and initial feeding preventing hypoglycaemia of the newborn which led to the newborn requiring respiratory support. The identified commonality of the care provision in the immediate postnatal period after birth (the first hour after birth of the baby) initiated a quality improvement project led by the senior matron for inpatients on initial care in thermoregulation and prevention of hypoglycaemia. Full details of the Quality improvement in response to these findings to drive continuous improvement are detailed within the report and will be monitored through directorate reporting.

During Q3, the Transitional Care service was facilitated 100% of the time with >50% of neonatal care provision within a Transitional Care Pathway (TCP), providing neonatal care at the mother's bedside.

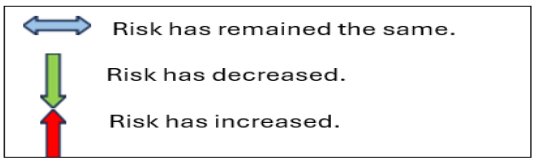
**Additional thematic actions taken following avoidable term admissions to NICU in Q3:**

- QI project 'Warm Bundle' continues across maternity inpatient areas.
- Work continues with staff awareness of escalation to Consultant Obstetricians to open 2nd theatre when required.
- Babies should be reunited with parents as soon as possible.
- Ensure equipment levels are adequate, and equipment is standardised across NICU and Maternity.

## 12.0 RISK REGISTER

During this Quater a full summary of the Maternity and risk register is detailed in table 17. Actions towards closing the gaps identified within the individual risk assessments on Datix, and continued mitigation of risk, will be monitored through Specialty and Divisional governance with Trust Management Executive, oversight to ensure appropriate actions are taken in accordance with the

Trust risk framework.




| Date opened | ID | Title | Risk level (current) | Rating (current) | Increase / decrease |
|---|---|---|---|---|---|
| 20/07/2017 | 1202 | Medical Staffing Women's Health | Moderate 8 - 12 | 12 | ⟺ |
| 01/08/2024 | 2098 | Elective caesarean capacity | Moderate 8 - 12 | 10 | ⟺ |
| 15/01/2024 | 2018 | Ventilator on Portable Incubator | Moderate 8 - 12 | 9 | ⟺ |
| 15/12/2023 | 2005 | Fetal Monitoring at UHD | Moderate 8 - 12 | 8 | ⟺ |
| 07/07/2023 | 1919 | Fire evacuation procedure in Poole Maternity unit needs updating | Moderate 8 - 12 | 8 | ⟺ |
| 26/04/2023 | 1876 | Inability to provide Medical cover for Maternity Triage service out of hours | Moderate 8 - 12 | 8 | ⟺ |
| 01/09/2022 | 1795 | Replacement of neonatal resuscitaires | Moderate 8 - 12 | 8 | ↓ |
| 02/08/2024 | 2100 | Maternity Drug Assay in-house testing | Low 4 - 6 | 6 | ⟺ |
| 07/12/2023 | 2001 | Mental Health Service for Maternity | Low 4-6 | 6 | ↓ |
| 01/08/2024 | 2097 | Viewpoint 6 obstetric ultrasonography package | Low 4-6 | 6 | ↓ |
| 30/03/2024 | 2047 | Translating Services in Maternity | Low 4-6 | 6 | ↓ |
| 24/03/2021 | 1523 | 24/7 service Labour Line | Low 4-6 | 6 | ↓ |
| 18/04/2023 | 1874 | Entonox Exposure to staff in the Maternity unit | Low 4 - 6 | 5 | ⟺ |
| 16/11/2023 | 1995 | Baby Abduction systems and processes | Low 4 - 6 | 4 | ⟺ |
| 26/04/2022 | 1736 | Placenta Accreta Management | Low 4 - 6 | 4 | ↓ |
| 17/11/2021 | 1684 | Unable to achieve safe standard for Induction of Labour (IoL) | Low 4 - 6 | 4 | ⟺ |
| 24/08/2021 | 1648 | Neonatal Consultant Rota | Very low 1-3 | 3 | ⟺ |

Table 20: Mat Neo risk register

## 12.1 CLOSED RISKS IN Q3

During Q3 there were three risks closed:

**Risk 1918 Reliability of new call bell system** as target rating achieved and new hard wired call bell system on postnatal ward. Vigorous monitoring and testing have shown this system is reliable with processes to follow should there be a system failure.

**Risk 1956 Safe Storage and safe transportation of portable Entonox cylinders.** Storage facilities now available on both sites.

**Risk 1658 Midwifery Community Services (Clinics, Homebirth Service and Staffing).** Now fully staffed with rotations in place to prevent reoccurrence of risk.

## 12.2 REDUCED RISKS IN Q3

**Risk 2097 "Viewpoint 6 Obstetric ultrasonography package" –** has been downgraded from moderate risk (8) to low risk (6) due to Viewpoint 6 upgrade being completed. This risk will be reviewed again once the transition has been successfully implemented, and all appropriate equipment is enabled.

**Risk 2018, Ventilator on Portable Incubator-** reduced from 'moderate '12' to moderate '9', as there have been no incidents related to identified risk, but potential for the Risk remains.

**Risk 2001, Mental Health Service for Maternity-** reduced from moderate '8' to Low '6', as a Band 6 midwife has been recruited into post.

**Risk 1736, Placenta Accreta Management -** reduced from moderate '10' to low '4' as a clinical management pathway for PAS is established and a guideline for emergency treatment published. (No incidents for PAS for over the last 12 months)

## 12.3 NEW RISKS IN Q3

There were no new risks identified this quarter

## 13.0 RECOMMENDATION

The Board of Directors is asked to receive and discuss the content of the report. It also required to record in the Trust board minutes as requested to provide evidence for the maternity incentive scheme.

University Hospitals Dorset
NHS Foundation Trust

**BOARD OF DIRECTORS - PART 1 MEETING**

**Meeting Date: 5 March 2025**

**Agenda item: 6.2.3**

| | |
|---|---|
| **Subject:** | Mortality Surveillance Group Report |
| **Prepared by:** | Becky Jupp, Deputy Chief Medical Officer |
| **Presented by:** | Dr Peter Wilson, Chief Medical Officer |
| **Strategic themes that this item supports/impacts:** | Population & System ☐<br>Our People ☐<br>Patient Experience ☐<br>Quality Outcomes & Safety ☒<br>Sustainable Services ☐ |
| **BAF/Corporate Risk Register: (if applicable)** | N/A |
| **Purpose of paper:** | Review and Discussion |
| **Executive Summary**: | The Mortality Surveillance Group has been undergoing change to structure and processes. We have been embedding the new governance structures within care groups and directorates as well as ensuring stronger links with Medical Examiner's office, and sub-groups within the corporate team that relate to morbidity and mortality.<br><br>This is the first report from the new system. At present it is not complete and the Committee is welcomed to make comments on improvement.<br><br>Assurance: our SHIMI remains low and our rolling HSMR continues to fall although is still above national average (104).<br><br>There is an advise on our data this month for outlier in multiple sclerosis which is being investigated.<br><br>At future meetings there will be data and narrative from Learning from Deaths. |
| **Background:** | The report provides details of key issues discussed at the Mortality Surveillance Group meeting on the 23 January 2025 |
| **Key Recommendations**: | For information, escalation, and assurance as applicable. |

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

| **Report History: Committees/Meetings at which the item has been considered:** | **Date** | **Outcome** |
|---|---|---|
| Quality Committee | 26/02/25 | Meeting has not yet taken place at the time of submission of this report. |
| Mortality Surveillance Group | 13/02/2025<br>23/01/2025 | TBC |

| | | |
|---|---|---|
| **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 | ☐ |

| | |
|---|---|
| **Report To** | **Quality Committee** |
| **Date of Meeting** | **17/02/2025** |
| **Title of Report** | **Mortality Surveillance Group Report – Q3** |
| **Author** | **Becky Jupp, Becky Protopsaltis, Grace Maughan** |

## Key Discussion Points and Matters Arising to be Escalated from Meeting

### ALERT:

- The reporting structure for Mortality Surveillance Group is changing to reflect Patient First methodology. There will be a period of transition and this report will evolve to reflect this.
- Mortality metrics are being reviewed and agreed at Care Group Catch-Balls.
- Each month UHD receives Mortality Alerts from HED (Healthcare Evaluation Data). These are triggered when there is a higher-than-expected value above and beyond a given threshold. For 'red' alerts, this threshold is the upper control limit. UHD were alerted to the following red alert in February 2025.

| Alert | Alert Period | SHMI Diagnostic Group | Score | Alert Level |
|---|---|---|---|---|
| SHMI | Nov 2023 - Oct 2024 | 48 :: 80 - Multiple sclerosis, 81 - Other hereditary and degenerative nervous system conditions | 204.36 | Red |

This is being investigated and findings will be shared in the next quarterly report.

### ADVISE:

In February 2025, our HSMR internal reporting changed to report by Treatment Function Code (TFC) instead of Main Specialty, following agreement from CMO, Deputy CMO and Group Directors of Medicine. This will mean specialties such as Stroke, which is a TFC and not a Main Specialty, will now be able to view their individual and specific HSMR. This will result in changes in HSMR at Directorate level HSMR, but Care Group level reporting will remain the same. Historical data has been updated to ensure accurate trends are viewed.

In January, following confirmation from our supplier HED, it was identified that stillbirths are included in HSMR reporting which is standard for all trusts. UHD are now looking at HSMR at a much more granular level than we have done previously so this had not been recognised before now. SHMI is not affected by stillbirths.

The new Learning From Deaths process has been running for three months. The MSG is considering optimal reporting structures for this, and a two-way learning process, that is embedded Board to Ward.

**ASSURE:**

**UHD is in the top 13 trusts which have a 'lower than expected' SHMI, out of the 119 Trusts** included in the reporting. The latest published data covers the period September 2023 – August 2024 and is 0.87 (where the national average is 1). For all 10 of the SHMI diagnosis groups that are reported, UHD is either 'as expected' or 'lower than expected'.

UHD's rolling 12-month HSMR continues to steadily decrease. The latest reporting period is November 2023 – October 2024 and is 104.4. For comparison, this was > 110 for the period March 2023 – February 2024.

## Executive Summary

The data from HED shows that UHD has a SHMI score of 0.87, which is lower than the national average. This puts UHD in the top 13 Trusts with lower the average SHMI in the country. The Trust HSMR is also decreasing, but it is not yet at the target level.

Reports from our Medical examiners show that there has been an uptick of community referrals by 28% since making ME statutory. We are working closely with our ME office to respond proportionately to any emerging themes identified, through appropriate governance structures.

The Mortality Surveillance Group is being restructured. This will require amendments to the current Terms of Reference. There has been much consideration around reporting structures up and down the organisation, with the aim to truly embed learning from deaths within our teams. This is a work in progress and hence this report outlines our proposed structure of report (we would welcome feedback); but it remains incomplete. The report for the next quarter will include a palliative care update, a Care Group Mortality and Morbidity report and a lead ME summary. These sections are included as place holders in this report.

## 1. Introduction

The learning from deaths report sets out to satisfy the requirements within the NHS Learning from Deaths Framework. Data is presented from UHD data sources, NHS England and data collected by the Medical Examiners in UHD.

## 2. Analysis and discussion

### 2.1 Inpatient Deaths at UHD

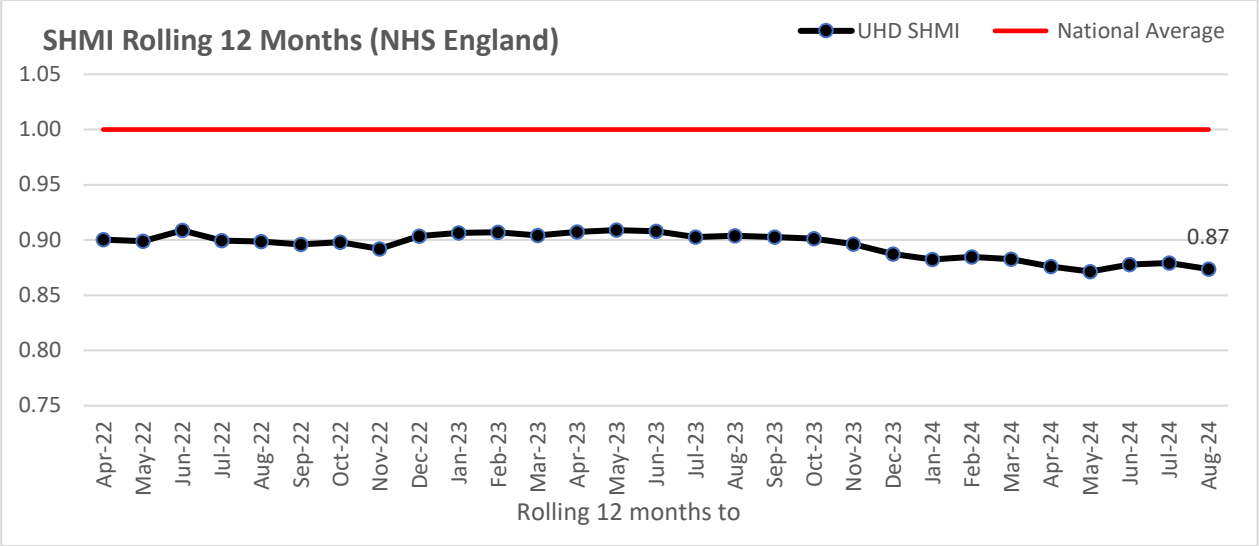
| Quarter | 2019-20 | 2020-21 | 2021-22 | 2022-23 | 2023-24 | 2024-25 |
|---|---|---|---|---|---|---|
| Q1 | 630 | 548 | 522 | 675 | 681 | 682 |
| Q2 | 633 | 575 | 658 | 685 | 623 | 622 |
| Q3 | 765 | 761 | 708 | 807 | 765 | 693 |
| Q4 | 689 | 989 | 715 | 749 | 693 | |
| Total | 2717 | 2873 | 2603 | 2916 | 2762 | |

*Data source is Camis.*

Q3 of 2024-25 saw 693 inpatient deaths at UHD sites, compared to 765 in Q3 2023-24.

### 2.2 SHMI

SHMI (Summary of Hospital Level Mortality Indicator) is the ratio between the number of patients who die up to 30 days following hospitalisation at the Trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated here. Data is provided for rolling 12 months and always in arrears. Covid-19 related activity is included in if the discharge data is on or after 1st September 2021. Hospices are excluded. The national average is 1. UHD's SHMI is in the 'lower than expected' range at 0.87 for the 12 months to August 2024.




NHS England calculate SHMI values and bandings for 10 of the SHMI diagnosis groups. Below is for the latest rolling 12-month period (September 2023 – August 2024)

| Diagnosis group description | Diagnosis group number | Provider spells | Observed deaths | Expected deaths | SHMI value | SHMI banding |
|---|---|---|---|---|---|---|
| Secondary malignancies | 30 | 725 | 135 | 120.00 | 1.12 | As expected |
| Acute myocardial infarction | 57 | 1,030 | 95 | 85.00 | 1.09 | As expected |
| Fluid and electrolyte disorders | 37 | 790 | 50 | 50.00 | 1.01 | As expected |
| Urinary tract infections | 101 | 2,025 | 95 | 100.00 | 0.98 | As expected |
| Cancer of bronchus; lung | 15 | 375 | 105 | 110.00 | 0.98 | As expected |
| Septicaemia (except in labour), Shock | 2 | 735 | 175 | 190.00 | 0.94 | As expected |
| Fracture of neck of femur (hip) | 120 | 1,020 | 75 | 85.00 | 0.90 | As expected |
| Pneumonia (excluding TB/STD) | 73 | 3,355 | 470 | 545.00 | 0.87 | As expected |
| Acute bronchitis | 74 | 2,000 | 60 | 80.00 | 0.72 | Lower than expected |
| Gastrointestinal hemorrhage | 96 | 760 | 35 | 50.00 | 0.69 | Lower than expected |

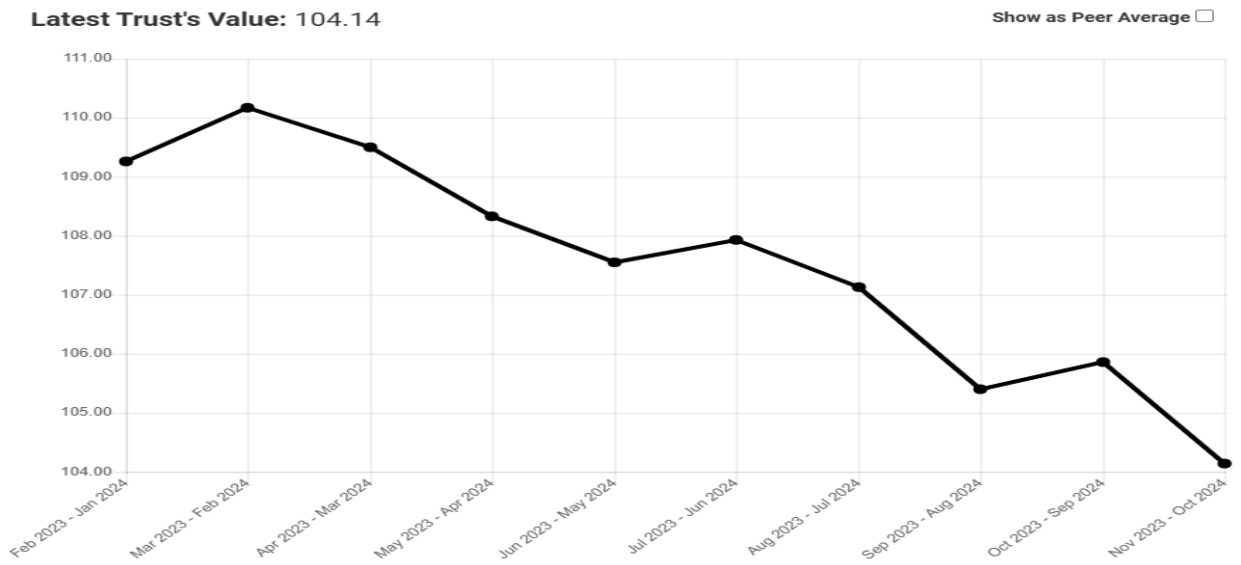
For the 12 months to August 2024, all diagnosis level values are either as expected or lower than expected.

NHS England published the latest monthly statistics on 9th January 2025. **UHD is within the top 13 trusts with 'lower than expected' death outcomes, out of the 119 trusts included.**

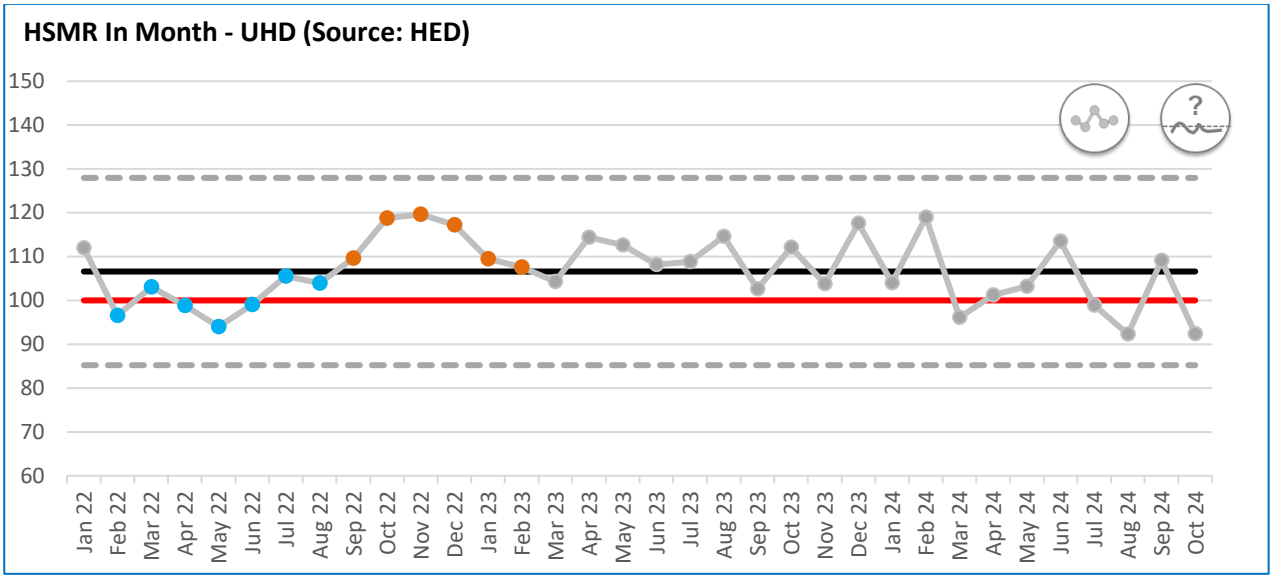
## 2.3 HSMR

HSMR (Hospital Standardised Mortality Ratio) is the ratio of observed number of in-hospital inpatient deaths compared to the expected number of in-hospital deaths. The expected deaths are calculated from logistic regression models with a case-mix of; age band, sex, deprivation, interaction between age band and co-morbidities, month of admission, admission method, source of admission, the presence of palliative care, number of previous emergency admissions and financial year of discharge. UHD report both the in-month and rolling 12-month positions and data is usually a few months in arrears. Data is extracted from HED (Healthcare Evaluation Data) and excludes the latest month which is not yet fully coded. The national average is 100.

HSMR Rolling 12 Month: November 2023 to October 2024 is 104.1. This has steadily been decreasing.




HSMR In Month - Latest fully coded position is October 2024 at 92.4. This is below the national average of 100.




### 2.4.1 Referrals to Clinical Governance Group

There have been no referrals to CGG this quarter. The Learning from Deaths Policy has been in place for 3 months. Work on embedding learning in the Care Groups is ongoing.

### 2.4.2 Care Group Morbidity & Mortality Learning

We will be reporting on learning from Care Group Morbidity and Mortality meetings in future iterations of this report.

## 3 Medical Examiner Service update

### 4.1 Medical Examiner Reviews

In Q3 the East Dorset Medical Examiner Service reviewed 1409 deaths, of which 579 occurred at UHD acute sites and 828 occurred in the community. This compares to 1176 deaths reviewed in Q2. There was an increase of 28% in community referrals compared to Q2. This is due to the medical examining system becoming statutory, whereby all non-coronial deaths must be reviewed by a medical examiner before registration can occur.

91 deaths across both acute and community were referred to the coroner. These figures remain consistent from the previous quarter. 14 ME Medical Certificates of Cause of Death (MCCD) were requested by the Senior Coroner (usually due to no medical practitioner being available) and completed.

There were no deaths where a significant concern was raised by the family and subsequently reported to the Trust via the Learning from Deaths policy, nor were any raised by an ME or MEO. There were 16 learning disability deaths in the quarter which were referred to LeDeR for further review. There were 9 deaths where the patient had not been expected to die (ie following an elective procedure) which were raised via the mortality review system.

### 4.2 Lead ME Report Highlighting Patterns and Trends

There will be a lead Medical Examiner report in the next quarter. This acts as a placeholder.

University Hospitals Dorset
NHS Foundation Trust

# BOARD OF DIRECTORS - PART 1 MEETING

**Meeting Date: 05 March 2025**

**Agenda item: 6.4.1**

| | |
|---|---|
| **Subject:** | Key Issues and Assurance Report to Board of the People and Culture Committee meeting held on 21 February 2025 |
| **Prepared by:** | Sharath Ranjan, Chair of the People and Culture Committee |
| **Presented by:** | Sharath Ranjan, Chair of the People and Culture Committee |

| | |
|---|---|
| **Key Issues/matters discussed by the Committee:** | At its meeting on 21 February 2025, the Committee received the following:<br>• Board Assurance Framework: Breakthrough Objectives & Strategic Initiatives<br>• People Strategy Highlight Report<br>• Chief People Officer's Report including well-led reports<br>• Transforming Care Together "People Ready" Update<br>• Safe Staffing – Maternity<br>• Guardian of Safe Working Hours Report<br>• Education, Learning and Development Review<br>• Pay Gap Reports:<br>  ○ Ethnicity<br>  ○ Disability<br>  ○ Gender<br>• Freedom to Speak Up Report<br>• Staff Survey Update<br>• Equality Delivery System<br>• Assurance/Alerts/Escalations (including from Care Groups)<br>• Integrated Performance Report – People & Culture<br>• Risk Register: risks rated 12-25 (new and current) relating to Workforce and Organisational Development<br>• People and Culture Committee Terms of Reference<br>• People and Culture Committee Governance Cycle<br>The Committee also received various policies for approval. |

| | |
|---|---|
| **Significant issues for escalation to Board for action:** | There were no significant issues noted in the meeting that are being escalated to the Board.<br><br>The Committee in discussion noted the below:<br><br>1. The Committee received and discussed Pay Gap reports for Ethnicity and Disability in addition to the Gender Pay Gap report which is a statutory publishing requirement. There is work to be done to improve representation at higher bands across these reports - the people and culture strategy will be driving some of these objectives.<br>2. The Committee noted the introduction of the highlight reports for the people strategy. It provides oversight of progress against the 10 objectives/programmes of work being delivered this year. The team are looking to introduce a hotspot dashboard (good practice from another trust) to enable targeted intervention and support to teams who may be struggling across a number of metrics in UHD.<br>3. The Committee discussed staff fatigue, with a detailed report being brought back to the Committee in April (post full results of the staff survey).<br>4. Safe Staffing – 0 vacancies noted in Maternity and the team are in a good position with the anticipated move to the BEACH building. There is a plan in relation to the completion of QIS training (expected requirement is 70% completion rate and we are currently at 53%) by the end of the year. |
| **Progress of Board Assurance Key Risks Assigned to Committee:** | BAF Risk 3 – score downgraded to 8 for February 2025 meeting, with a target of 8. |

University Hospitals Dorset
NHS Foundation Trust

**BOARD OF DIRECTORS - PART 1 MEETING**

**Meeting Date: 05 March 2025**

**Agenda item: 6.4.2**

| | |
|---|---|
| **Subject:** | Guardian of Safe Working- Quarterly report |
| **Prepared by:** | Paul Froggatt, Julie Mantell, Nicola Craig |
| **Presented by:** | Paul Froggatt, Peter Wilson |

| | |
|---|---|
| **Strategic themes that this item supports/impacts:** | Population & System ☐<br>Our People ☒<br>Patient Experience ☐<br>Quality Outcomes & Safety ☒<br>Sustainable Services ☐ |
| **BAF/Corporate Risk Register: (if applicable)** | TBC |
| **Purpose of paper:** | Assurance |
| **Executive Summary:** | Good levels of exception reporting, as expected across acute specialties.<br>There has been an increase in safety incident reporting. These are fed back through directorates and no reported safety issues reported. There is ongoing work with directorates and clinicians around support for resident doctors especially out of hours |
| **Background:** | Terms and Conditions of Service 2016 |
| **Key Recommendations:** | Guardian of Safe Working Hours to liaise with RDs & Care Group Leads to ensure timely escalation of any safety concerns. |
| **Implications associated with this item:** | Council of Governors ☐<br>Equality, Equity, Diversity & Inclusion ☐<br>Financial ☐<br>Health Inequalities ☐<br>Operational Performance ☐<br>People (inc Staff, Patients) ☐<br>Public Consultation ☐<br>Quality ☐<br>Regulatory ☐<br>Strategy/Transformation ☐<br>System ☐ |

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

| Report History: Committees/Meetings at which the item has been considered: | Date | Outcome |
|---|---|---|
| People & Culture Committee | 21/02/2025 | Meeting has not yet taken place at the time of submission of this report |

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

University Hospitals Dorset
NHS Foundation Trust

# GUARDIAN OF SAFE WORKING REPORT

## 1st October to 31st December 2024

## UNIVERSITY HOSPITALS DORSET

**CONTENTS:**


| | |
|---|---|
| Poole and RBCH Hospitals GSW Summary…….. | Page 3 |
| Resident Doctor Forum Summary …… | Page 3 |
| Poole Hospital GSW Report …….. | Page 4 - 8 |
| RBCH GSW Report ……... | Page 9 - 13 |
| Poole Hospital and RBCH Visual Comparisons ……... | Page 14 - 16 |
| Resident Doctor Forum Minutes | Page 17 - 19 |

## POOLE & ROYAL BOURNEMOUTH HOSPITALS OVERVIEW

Across both main sites there continues to be a good level of exception reporting and for the main is distributed across directorates with a relatively high proportion of acute patients: general medicine, general surgery and OPS

In addition as in frequently the case the vast majority of reports were submitted by foundation level doctors or an equivalent locally employed doctor and relate to hours worked in excess of their allocated shift.

There have been a large number of reports categorised (by the reporting doctor) as immediate safety concerns (ISCS) this quarter. Often the theme is of a feeling of lacking senior support and/or inadequate staffing; in each of these cases I encourage the reporting doctor to have a face to face meeting with their clinical supervisor, such that they may be able to discuss the event & explore how things might be improved.

However, from it would often appear, from personal experience and colleague feedback, that the reporting doctor doesn't raise their concerns to a responsible consultant contemporaneously. The reasons for this are not clear. In order to try and resolve this issue I will be writing to all resident doctors asking them to inform the relevant consultant at the time of a perceived safety concern and also the care group leads and clinical directors to ensure that a clear pathway for clinical escalation is included at induction.

### Junior Doctor Forums

There were 2 forums during this quarter: 29th October and 18th December 2024. Overview. (Further detail on page 22-23).

29th October 2024:

- GoSW/ER updates:
- Paid breaks for locum shifts:
- ICE filing
- Backdated Pay:
- IMT clerking shifts
- Mailing Lists:
- New bleep system:

18th December 2024:

- Backdated Pay
- Alertive Launch
- ICE Filing
- Criteria Led Discharges
- Car Parking
- Email Lists

**University Hospitals Dorset: Poole Hospital**

## High level data

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

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

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

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

## Exception reports

| Speciality | Exceptions raised 1st October to 31st December 2024 | Exceptions raised outside of 14 days from event | Outcome agreed (*not closed*) | Number of exceptions closed | Number of exceptions outstanding |
|---|---|---|---|---|---|
| **Cardiology** | 1 | 0 | 0 | 1 | 0 |
| **Colorectal** | 3 | 0 | 1 | 2 | 0 |
| **Emergency Medicine** | 12 | 0 | 1 | 10 | 1 |
| **Gastroenterology** | 4 | 0 | 0 | 4 | 0 |
| **General Medicine** | 39 | 2 | 31 | 2 | 6 |
| **General Surgery** | 17 | 0 | 0 | 17 | 0 |
| **Oncology** | 3 | 0 | 2 | 1 | 0 |
| **OPS** | 50 | 0 | 18 | 32 | 0 |
| **Paediatrics** | 5 | 0 | 0 | 5 | 0 |
| **Psychiatry** | 1 | 0 | 0 | 1 | 0 |
| **Respiratory** | 13 | 0 | 0 | 13 | 0 |
| **Upper GI** | 3 | 0 | 2 | 0 | 1 |
| **Vascular** | 0 | 0 | 0 | 0 | 0 |
| **Women's Health** | 7 | 5 | 0 | 7 | 0 |
| **Total** | **158** | **7** | **55** | **95** | **8** |

*(Source: Allocate and HealthRota)*

Two exceptions which were entered in error have been included in the exceptions closed figures (1 for OPS and 1 for Women's Health).

## Overview of Exception Reports Raised

There was a total of 158 exception reports raised for the quarter 1st October to 31st December, this has increased by 89 compared to the last quarter.

There were twenty-six patient safety concerns raised during this quarter, an increase from four raised during the previous quarter.

## Exception Reports – Previous Quarter Comparisons

| Speciality | Exceptions raised 1st July to 30th September 2024 | Exceptions raised 1st October to 31st December | Increase/Decrease |
|---|---|---|---|
| **Cardiology** | 3 | 1 | ↓ |
| **Emergency Medicine** | 6 | 12 | ↓ |
| **Gastroenterology** | 3 | 4 | ↑ |
| **General Medicine** | 12 | 39 | ↑ |
| **General Surgery** | 10 | 23 | ↑ |
| **Haematology** | 2 | 0 | ↓ |
| **Oncology** | 0 | 3 | ↑ |
| **OPS** | 16 | 50 | ↑ |
| **Paediatrics** | 4 | 5 | ↑ |
| **Psychiatry** | 0 | 1 | ↓ |
| **Respiratory** | 12 | 13 | ↑ |
| **Vascular** | 1 | 0 | ↓ |
| **Women's Health** | 0 | 7 | ↑ |
| **Total** | **69** | **158** | ↑ **129%** |

## Reasons for Exceptions Raised

Over 89% of reports raised were in relation to staff working over their contracted hours, this remains as the key reporting reason. These reports were raised by 35 doctors during this period.

| Working over contracted hours | Access to Education | Shift Pattern | Service Support | Natural Breaks/Rest |
|---|---|---|---|---|
| 142 | 4 | 1 | 5 | 6 |

*(Source: Allocate)*

## Reporting Grades for this Period

| FY1 | FY2 | GP/ST1/2 | Trust SHO | IMT1/CT1/ST1 | IMT2/CT2/ST2 | IMT3/ST3 | ST4+ |
|---|---|---|---|---|---|---|---|
| 106 | 4 | 3 | 44 | 0 | 1 | 0 | 0 |

*(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 |
|---|---|---|---|---|---|---|
| 36 | 106 | 6 | 2 | 0 | 0 | 8 |

*(Source: Allocate)*

## Fines

There were no fines this quarter.

## Vacancies – Doctors in Training

| Department | Number of vacancies |
|---|---|
| **Acute Internal Medicine/AMU** | 2 |
| **Anaesthetics** | 1 |
| **Emergency Department/ED** | 2 |
| **Gastroenterology** | 2 |
| **General Surgery** | 1 |
| **Older People Medicine/OPS** | 2 |
| **Oral & Maxillofacial/OMF** | 5 |
| **Paediatrics** | 2 |
| **Rehabilitation** | 1 |
| **Respiratory** | 2 |

*(Source: Medical Staffing)*

**Locum Bookings via Bank**

The below table indicates the number of shifts and hours worked through the bank during this period, identifying whether increase / decrease from the previous quarter.

| Locum bookings (Bank) by department | | | | |
|---|---|---|---|---|
| **Specialty** | **Number of shifts requested** | **Number of shifts worked** | **Number of hours requested** | **Number of hours worked** |
| **Anaesthetics** | 11 ↓ | 9 ↓ | 65 ↓ | 58 ↓ |
| **Emergency Medicine** | 461 ↑ | 365 ↑ | 4,207 ↑ | 3,333 ↑ |
| **ENT** | 116 ↑ | 99 ↑ | 1,074 ↑ | 933 ↑ |
| **General Surgery** | 30 ↓ | 15 ↓ | 311 ↓ | 135 ↓ |
| **Maxillo-facial Surgery** | 2 - | 2 - | 22 ↓ | 22 ↓ |
| **Medicine** | 691 ↓ | 577 ↑ | 6,109 ↓ | 5,047 ↑ |
| **Obstetrics and Gynaecology** | 69 ↓ | 61 ↓ | 582 ↓ | 513 ↓ |
| **Oncology** | 116 ↓ | 92 ↑ | 914 ↓ | 745 ↓ |
| **Orthopaedic Surgery** | 627 ↓ | 549 ↓ | 5,968 ↓ | 5,250 ↓ |
| **Paediatrics** | 68 ↓ | 24 ↓ | 726 ↓ | 227 ↓ |
| **TOTAL** | **2,191** ↓ | **1,793** ↓ | **19,978** ↓ | **16,262** ↓ |

*(Source Temp Staffing Office)*

During this quarter there was a decrease of 14% in the overall number of locum shifts from 2537 to 2191 during this quarter. For the previous two quarters, Emergency Medicine had been decreased the number of shifts requested, however this quarter has seen an increase from 443 to 461 shifts. The most notable decrease this quarter was Obs & Gynae reducing by 58% from 164 to 69 shifts and Paediatrics by 47% from 128 to 68 shifts.

The most unfilled shifts were within General Surgery and Paediatrics which is a theme continued from the previous quarters. Of note, over half of the Paediatric (65%) and General Surgery (50%) shifts requested were unfilled.

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

| Locum bookings (Bank) by Grade | | | | |
|---|---|---|---|---|
| **Grade** | **Number of shifts requested** | **Number of shifts worked** | **Number of hours requested** | **Number of hours worked** |
| **F1** | 6 ↓ | 4 ↓ | 47 ↓ | 22 ↓ |
| **F2** | 40 ↓ | 28 ↑ | 284 ↓ | 154 ↑ |
| **ST/CMT1/2** | 1,795 ↓ | 1,526 ↑ | 16,191 ↓ | 13,819 ↑ |
| **ST3+** | 350 ↓ | 235 ↓ | 3,456 ↓ | 2,267 ↓ |
| **TOTAL** | **2,191** ↓ | **1,793** ↓ | **19,978** ↓ | **16,262** ↓ |

*(Source Temp Staffing Office)*

Once again, the majority of shifts (82%) have been requested at ST/CMT 1/2 level. The decrease in shifts requested compared to this quarter was 14% from 2537 shifts to 2191

shifts. There was an increase in the number of shifts worked, raising from 73% between July and September to 82% between October and December.

The table below provides the aggregation for Reason why locum shifts were requested.

| Locum Bookings (Bank) by Reason | | | | |
|---|---|---|---|---|
| **Reason** | **Number of shifts Requested** | **Number of shifts worked** | **Number of hours Requested** | **Number of hours Worked** |
| **Annual Leave** | 156 ↓ | 135 ↓ | 1,287 ↓ | 1,128 ↓ |
| **Covering Absent Colleagues** | 95 ↑ | 79 ↑ | 748 ↑ | 602 ↑ |
| **Deanery Vacancy** | 271 ↓ | 231 ↓ | 2,470 ↓ | 2,135 ↓ |
| **Escalations** | 12 ↑ | 1 ↓ | 127 ↑ | 11 ↓ |
| **LTFT Cover** | 104 ↓ | 61 ↓ | 1,139 ↓ | 652 ↓ |
| **Maternity/Paternity Leave** | 36 ↑ | 31 ↑ | 281 ↑ | 236 ↑ |
| **Service Demand (e.g winter pressures)** | 350 ↓ | 298 ↑ | 3,304 ↓ | 2,813 ↑ |
| **Sickness** | 201 ↓ | 123 ↑ | 1,727 ↓ | 1,056 ↑ |
| **Study Leave** | 98 ↑ | 89 ↑ | 880 ↑ | 796 ↑ |
| **Trust vacancy** | 747 ↓ | 654 ↑ | 6,899 ↓ | 6,013 ↑ |
| **Urgent Clinical Need** | 121 ↓ | 91 ↑ | 1,116 ↓ | 821 ↑ |
| **TOTAL** | **2,191 ↓** | **1,793 ↓** | **19,978 ↓** | **16,262 ↓** |

*(Source Temp Staffing Office)*

This quarter, the biggest increase has been for Covering Absent Colleagues (increase of 164% from 36 to 95 shifts) and Maternity/Paternity Leave (increase of 89% from 19 to 36 shifts). The highest percentage of shifts worked were for Study Leave, Trust Vacancy and Annual Leave cover.

### Locum Bookings via Agency

| | | |
|---|---|---|
| **Grade** | **Number of shifts requested** | **Number of shifts worked** |
| **Foundation Year 1** | 0 - | 0 - |
| **Foundation Year 2** | 0 ↓ | 0 ↓ |
| **ST1/2 - CT1/2** | 37 ↑ | 37 ↑ |
| **ST3+** | 3 ↓ | 3 ↓ |
| **TOTALS** | **40 ↓** | **40 ↓** |

*(Source Temp Staffing Office)*

**University Hospitals Dorset: Royal Bournemouth Hospital**

## High level data

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

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

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

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

## Exception reports

| Speciality | Exceptions raised 1st October to 31st December 2024 | Exceptions raised outside of 14 days from event | Outcome agreed (not closed) | Number of exceptions closed | Number of exceptions outstanding |
|---|---|---|---|---|---|
| **Acute** | 7 | 0 | 1 | 6 | 0 |
| **Cardiology** | 3 | 1 | 0 | 3 | 0 |
| **Colorectal** | 4 | 0 | 2 | 2 | 0 |
| **Gastroenterology** | 27 | 2 | 1 | 26 | 0 |
| **General Medicine** | 6 | 0 | 3 | 2 | 1 |
| **General Surgery** | 1 | 0 | 1 | 0 | 0 |
| **Obs & Gynae** | 1 | 0 | 0 | 1 | 0 |
| **OPS** | 12 | 0 | 6 | 6 | 0 |
| **Stroke** | 4 | 0 | 1 | 3 | 0 |
| **Upper GI** | 5 | 0 | 0 | 5 | 0 |
| **Urology** | 3 | 0 | 1 | 2 | 0 |
| **Vascular** | 10 | 3 | 7 | 3 | 0 |
| **Total** | **83** | **6** | **23** | **59** | **1** |

*(Source: Allocate and HealthRota)*

## Brief Overview of Exception Reports Raised

There was a total of 83 raised during the quarter 1st October to 31st December, a decrease of 5 compared to the previous quarter.

There were four patient safety concerns raised during this quarter.

Two exceptions which were entered in error have been included in the exceptions closed figures (1 for Vascular and 1 for Urology).

| Speciality | Exceptions raised 1st July to 30th September 2024 | Exceptions raised 1st October to 31st December 2024 | Increase/Decrease |
|---|---|---|---|
| **Acute** | N/A (In Gen Medicine) | 7 |  |
| **A&E** | 0 | 0 |  |
| **Cardiology** | 0 | 3 |  |
| **Colorectal** | N/A (In Gen Surgery) | 4 |  |
| **Diabetes and Endocrine** | 0 | 0 |  |
| **Gastroenterology** | 7 | 27 |  |
| **General Medicine** | 9* | 6 |  |
| **General Surgery** | 33** | 1 |  |
| **Haematology** | 1 | 0 |  |
| **Obs & Gynae** | 0 | 1 |  |
| **OPS** | 7 | 12 |  |
| **Palliative** | 1 | 0 |  |
| **Psychiatry** | 18 | 0 |  |
| **Respiratory** | 4 | 0 |  |
| **Stroke** | 2 | 4 |  |
| **Upper GI** | N/A (In Gen Surgery) | 5 |  |
| **Urology** | N/A (In Gen Surgery) | 3 |  |
| **Vascular** | 6 | 10 |  |
| **Total** | 88 | 83 |  6% |

*also includes Acute
**also includes Colorectal, Upper GI and Urology

## Reasons for Exceptions Raised

The main reason for exceptions being raised during this quarter was for doctors working over their contracted hours totalling 93% of the reports; a theme which follows the pattern of the previous quarter.

| Working over contracted hours | Access to Education | Shift Pattern | Service Support | Natural Breaks/Rest |
|---|---|---|---|---|
| 77 | 3 | 0 | 1 | 2 |

*(Source: Allocate and HealthRota)*

## Reporting Grades for this Period

| FY1 | FY2 | GP/ST1/2 | Trust SHO | IMT1-2 | ST1/ST2/CT1/CT2 | IMT3/ST3/CT3 | ST4+ |
|---|---|---|---|---|---|---|---|
| 54 | 14 | 0 | 9 | 6 | 0 | 0 | 0 |

*(Source: Allocate and HealthRota)*

## 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 |
|---|---|---|---|---|---|---|
| 59 | 18 | 3 | 2 | 0 | 0 | 1 |

*(Source: Allocate and HealthRota)*

## Vacancies

| Department | Number of vacancies |
|---|---|
| **Cardiology** | 2 |
| **Emergency Department/ED** | 1 |
| **Gastroenterology** | 1 |
| **Older People Medicine/OPS** | 3 |
| **Orthodontics** | 1 |
| **Urology** | 1 |

*(Source: Medical Staffing)*

## Fines

There were no fines this quarter.

## Locum Bookings Via Bank

| Locum bookings (Bank) by department | | | | |
|---|---|---|---|---|
| **Specialty** | **Number of shifts requested** | **Number of shifts worked** | **Number of hours requested** | **Number of hours worked** |
| **Anaesthetics** | 10 ↑ | 9 ↑ | 108 ↑ | 95 ↑ |
| **Emergency Medicine** | 604 ↑ | 498 ↑ | 5,485 ↑ | 4,523 ↑ |
| **General Surgery** | 209 ↓ | 179 ↓ | 2,101 ↓ | 1,804 ↓ |
| **Medicine** | 820 ↑ | 613 ↑ | 8,177 ↑ | 6,062 ↑ |
| **Ophthalmology** | 15 ↓ | 15 ↓ | 305 ↓ | 305 ↓ |
| **Orthopaedic Surgery** | 185 ↓ | 156 ↓ | 1,401 ↓ | 1,155 ↓ |
| **Urology** | 35 ↑ | 30 ↓ | 265 ↓ | 232 ↓ |
| **Vascular surgery** | 1 ↓ | 0 ↓ | 10 ↓ | 0 ↓ |
| **TOTAL** | **1,879 ↑** | **1,500 ↑** | **17,850 ↑** | **14,175 ↑** |

*(Source Temp Staffing Office)*

The above table highlights the number of shifts and hours worked, compared to the previous quarter figures.

There was an increase of 8% in the number of shifts requested from 1747 to 1879 with 79% of these worked during the quarter. The highest increases in number of shifts requested have been in Medicine from 611 to 820 (34% rise compared to the decrease noted last quarter) and in Anaesthetics from 4 to 10 shifts. Notable decreases have been seen in Vascular from 51 to 1 shifts requested and a decrease of 20% within Orthopaedic Surgery.

| Locum bookings (Bank) by Grade | | | | |
|---|---|---|---|---|
| **Grade** | **Number of shifts requested** | **Number of shifts worked** | **Number of hours requested** | **Number of hours worked** |
| **F1** | 28 ↑ | 8 ↑ | 296 ↑ | 58 ↑ |
| **F2** | 19 ↑ | 4 - | 201 ↑ | 44 ↑ |
| **ST/CMT1/2** | 1,489 ↓ | 1,240 ↓ | 13,673 ↓ | 11,396 ↓ |
| **ST3+** | 343 ↑ | 248 ↑ | 3,680 ↑ | 2,679 ↑ |
| **TOTAL** | **1,879 ↑** | **1,500 ↑** | **17,850 ↑** | **14,175 ↑** |

*(Source Temp Staffing Office)*

As per the last quarter, the majority of shifts requested has once again been ST/CMT 1/2 grades.

| Locum Bookings (Bank) by Reason | | | | |
|---|---|---|---|---|
| **Reason** | **Number of shifts Requested** | **Number of shifts worked** | **Number of hrs Requested** | **Number of hrs Worked** |
| **Annual Leave** | 161 ↑ | 134 ↑ | 1,525 ↑ | 1,268 ↑ |
| **Civil Duty** | 3 ↑ | 3 ↑ | 27 ↑ | 27 ↑ |
| **Covering Absent Colleagues** | 33 ↓ | 21 ↓ | 352 ↓ | 212 ↓ |
| **Deanery Vacancy** | 58 ↑ | 50 ↑ | 541 ↑ | 458 ↓ |
| **Escalations** | 10 ↑ | 1 - | 90 ↑ | 9 ↓ |
| **Industrial Action** | 1 ↓ | 0 ↓ | 10 ↓ | 0 - |
| **LTFT Cover** | 18 ↑ | 17 ↑ | 201 ↑ | 189 ↑ |
| **Maternity/Paternity Leave** | 11 ↓ | 11 ↓ | 125 ↓ | 125 ↓ |
| **Service Demand (e.g. winter pressures)** | 329 ↑ | 253 ↑ | 3,079 ↑ | 2,315 ↑ |
| **Sickness** | 365 ↑ | 238 ↑ | 3,747 ↑ | 2,514 ↑ |
| **Study Leave** | 37 ↑ | 27 ↑ | 369 ↑ | 264 ↑ |
| **Trust vacancy** | 499 ↓ | 404 ↓ | 4,586 ↓ | 3,711 ↓ |
| **Urgent Clinical Need** | 353 ↑ | 340 ↑ | 3,192 ↑ | 3,078 ↑ |
| **WLI (Waiting List Initiative)** | 1 ↓ | 1 ↓ | 8 ↓ | 8 ↓ |
| **TOTAL** | **1,879 ↑** | **1,500 ↑** | **17,850 ↑** | **14,175 ↑** |

*(Source Temp Staffing Office)*

This quarter, the biggest bank locum bookings increase has been for Escalations rising by 150% from 4 to 10 shifts and Sickness rising by 88% from 194 to 365 shifts. Civil duty shifts and LTFT cover have risen and did not feature in the last quarter. The Waiting List Initiatives have reduced by 89% since the previous quarter.

### Locum Bookings via Agency

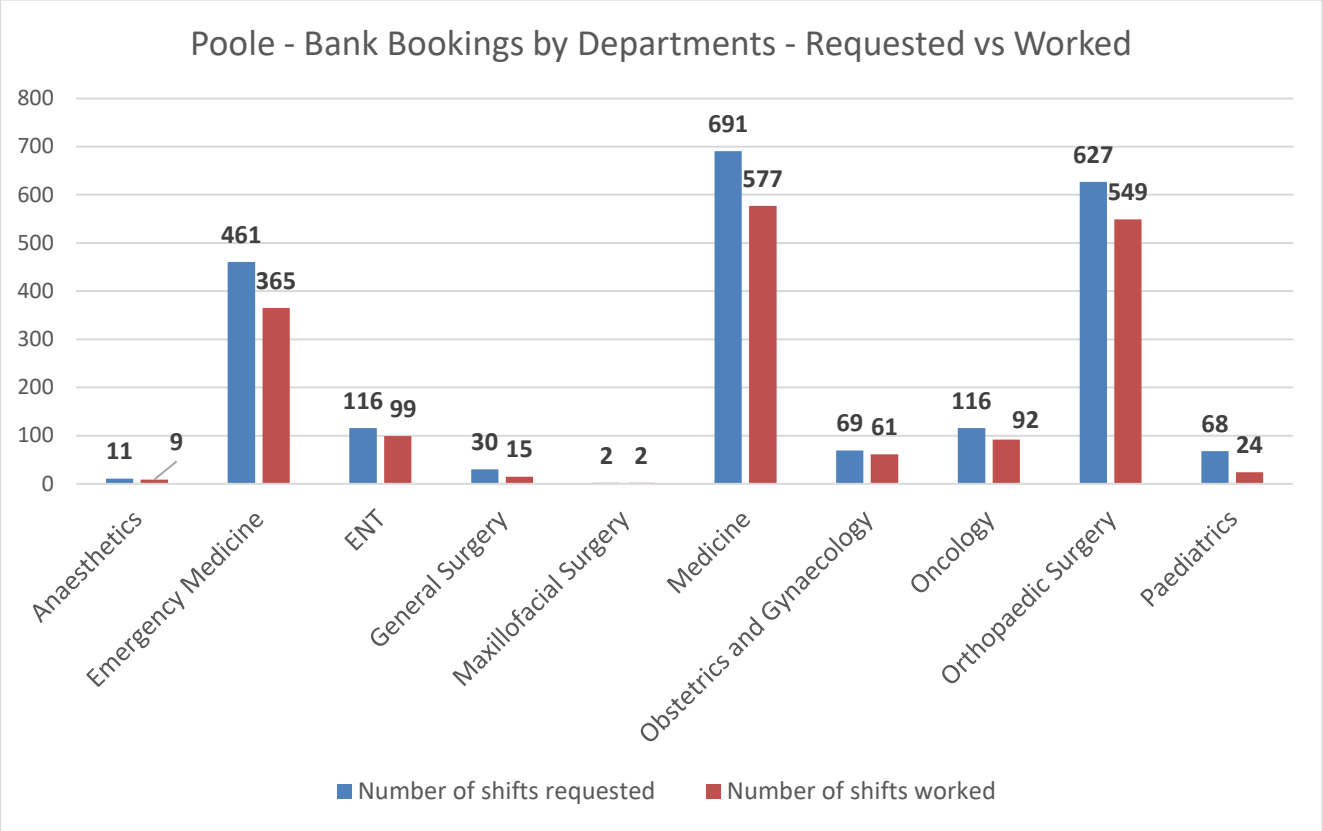
| Locum bookings by Grade | | |
|---|---|---|
| **Grade** | **Number of shifts requested** | **Number of shifts worked** |
| **Foundation Year 1** | 0 - | 0 - |
| **Foundation Year 2** | 0 - | 0 - |
| **ST1/2 - CT1/2** | 0 - | 0 - |
| **ST3+** | 9 ↓ | 9 ↓ |
| **TOTALS** | **9 ↓** | **9 ↓** |

*(Source Temp Staffing Office)*

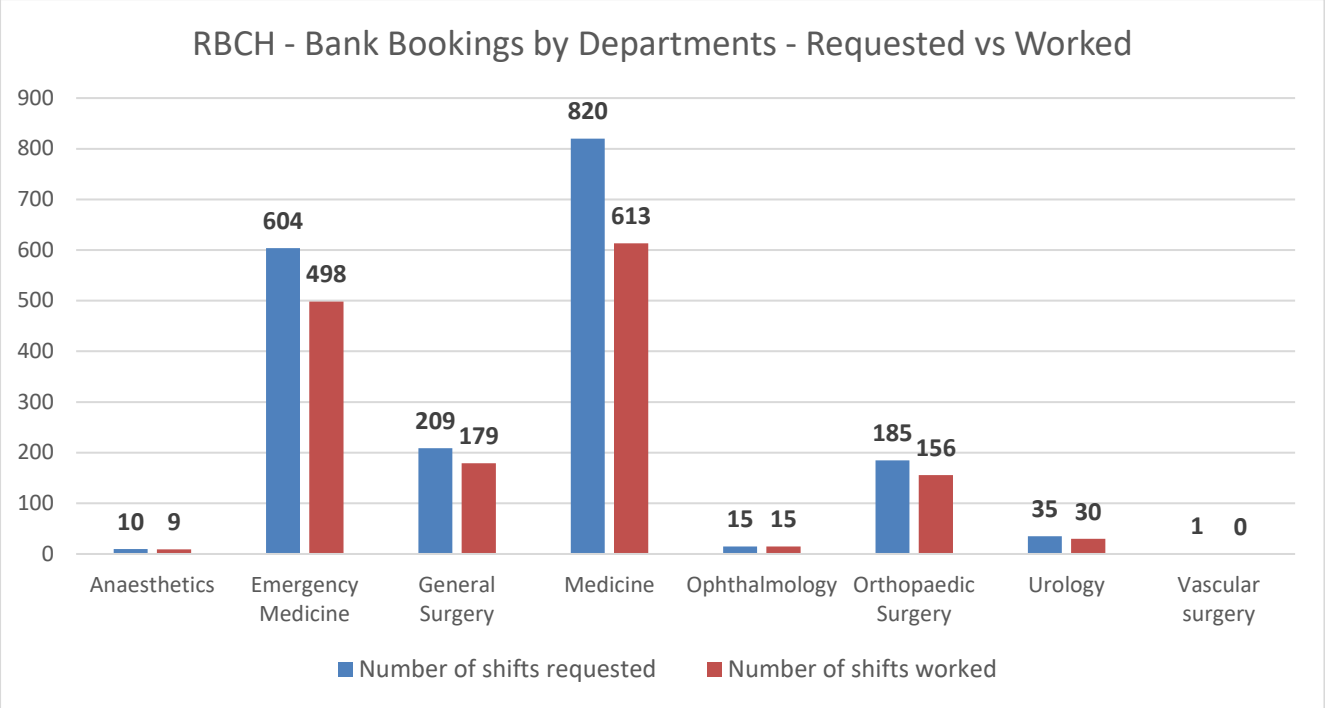
The number of locum bookings via agency has decreased by 71% from 31 to 9 shifts.

## Visual Data Representations

### Poole

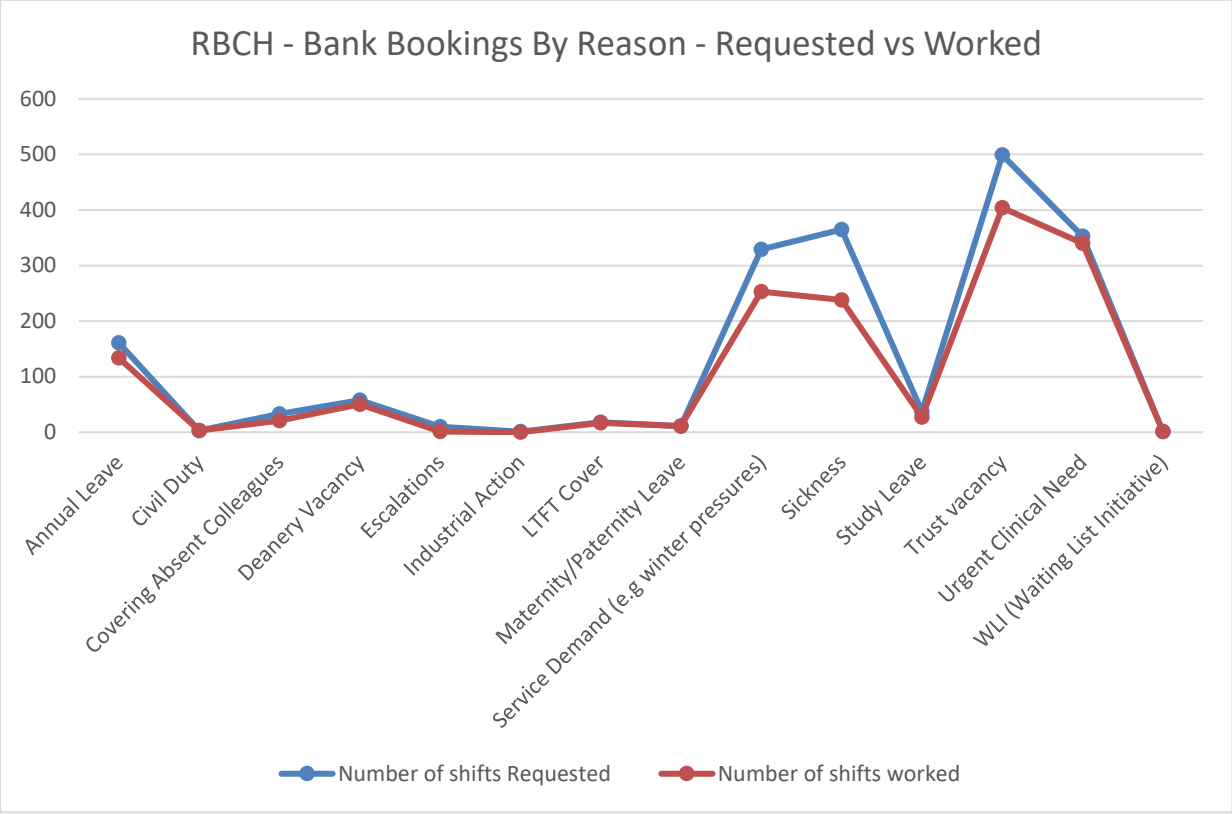



### Bournemouth

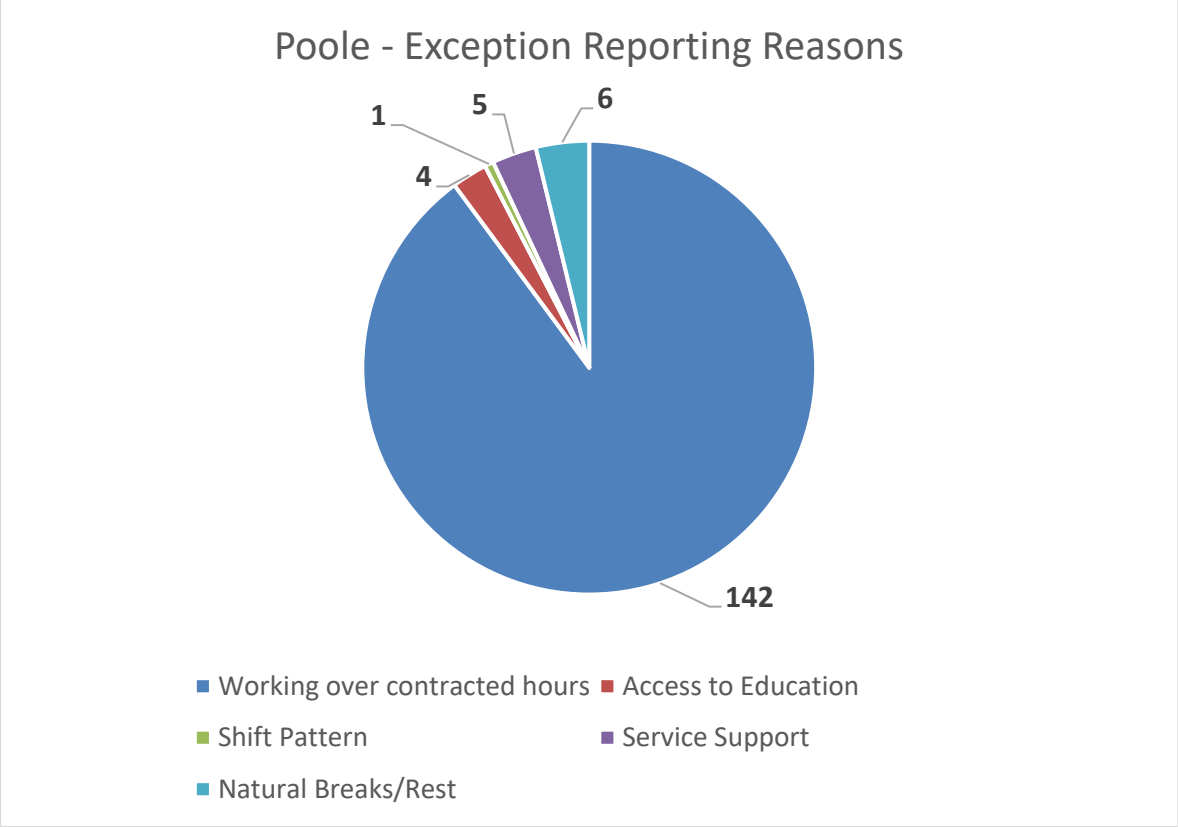


**Poole**

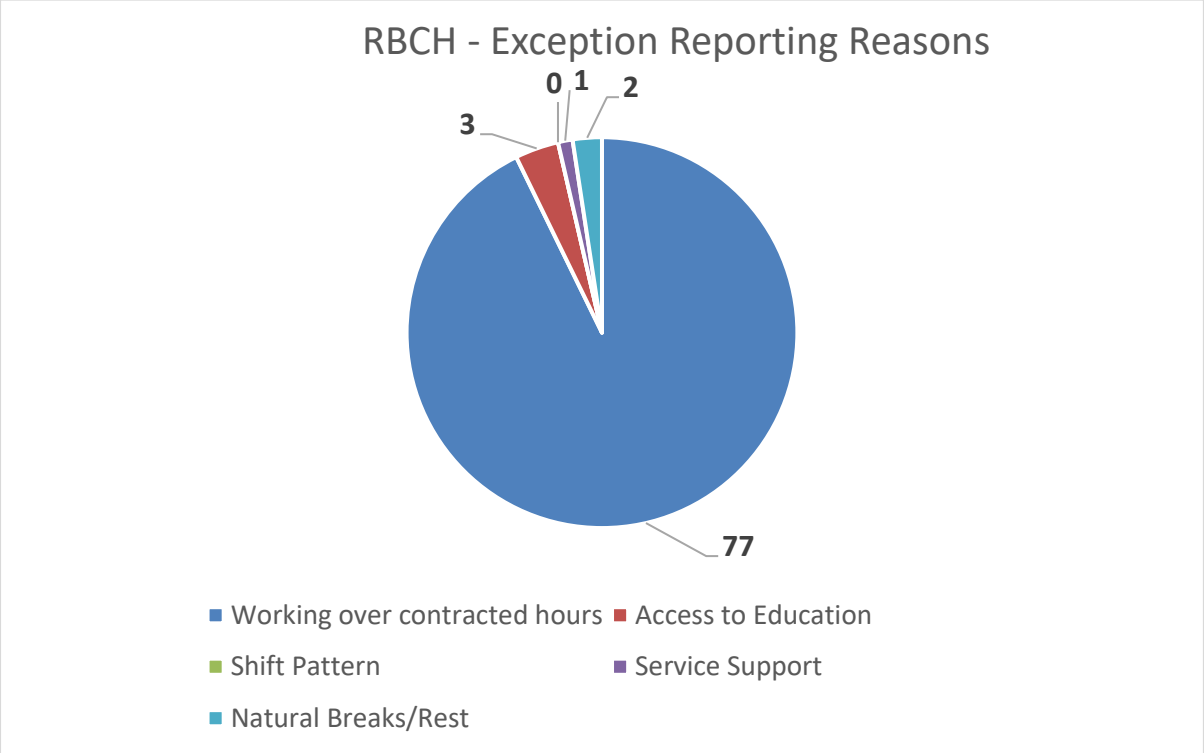

**Bournemouth**



**Poole**




**Bournemouth**



**RESIDENT DOCTOR FORUM**:

**29th October**:

GoSW/ER updates: ERs submitted on HealthRota system more settled. GoSW has full visibility of all ERs and will approve directly if any delays. Repeated ERs from certain rotas due to staffing issues, including UGI surgery at RBH. CD/DME and deputy CMO aware and working to improve situation. **(KH)-** Issues with processing ER on new system, aiming to sort in due course. Certain rotas such as anaesthetics not on HealthRota so ERs are still to be submitted via Allocate system. Aware of BMA's change to ER based on new pay deal. If <2 hours will be approved and paid. **(SF) -** Concern some RDs unaware that ER now submitted via HealthRota.

Paid breaks for locum shifts: Report of pushback from rota coordinators when claiming. **(JM)** reported some newer rota coordinators not aware. Re-iterated if not able to take a break then that time can be claimed whether carrying a bleep or not. If able to take break on shift then time cannot be claimed.

ICE filing: **(MW) -** Concern that the new process for ICE filing is time consuming, doubles workload (having to review EPR and ICE), difficult to coordinate with EPR. Concern that RDs were not consulted before change in system. Multiple RDs have sent feedback/concerns when the original comms email was sent. Also concerned that admitting consultants are signing off result for patients who they have not reviewed for several weeks as results are under their name. **(SF) -** At PGH when requesting bloods on ICE, they are requesting under consultant of the week rather than admitting consultant. RDs at PGH have been told there needs to be a period of engagement to establish issues/whether its working. Future aim is to have a more robust/sophisticated system and the new ICE filing is a temporary stopgap.

Backdated Pay: **(KH) -** Advised not to ring/call payroll. If still working within trust then no action required and payment in November will occur automatically. UHD planning to write out to leavers to ensure correct bank details etc. Leavers from Aug/Sept 2024 will also receive automatic back payment. Advised RDs should contact trusts outside UHD **(SF)** suggested email to be sent out to RDs to inform of above and reduce emails being sent to payroll.

IMT clerking shifts: **(MW) -** Concerns at RBH that IMTs not getting enough clerking shifts rota'd to enable adequate acute take numbers/assessments. Concerns LEDs being prioritised for shifts. When raised with rota coordinators IMTs told their responsibility to swap. **(MS)** reiterated above. Reports raised with educational supervisor who also informed to swap. **(DMW)** has raised this issue with Dr Michelle Dharmasiri (RCP college tutor) who is aware and has been in touch with rota coordinators. DMW will take issue back to Dr Dharmasiri.

Mailing Lists: **(MW)** mailing lists for RDs not consistent. E.g. F2s not getting emails about RDFs. **(JM)** will check mailing lists. Email addresses are cross referenced with details on TIS system. Reports difficult when RDs don't update email addresses (some using old university emails).

New bleep system: **(SH)** asking about new bleep system. Currently delayed until end of Nov. **(SF)** reports PGH told end of Nov too with no further updates. Plan to revisit at next RDF

**18th December 2024**:

Backdated Pay: Ongoing issues with backdate pay for Drs who have previously worked in the trust. Payroll have sent out email. BMA rep unavailable at this RDF.

Alertive Launch: Referrals: some being made via messaging feature rather than bleeped but no notification sound so many being missed. Advised that at present referrals should be made via bleep rather than messages. Some bleeps not on 701 bleep system. E.G. ward 1 SHO bleeps only functional with the Alertive web system. Apparently intentional as per d/w IT by ward 1 SHO. Bleeps also get sent through even if no one assigned to the role on Alertive. Some RDs forgetting to log in and assign themselves to a role.

ICE Filing: **(ST)** encouraged to use ICE rather than EPR to look at and sign off results. Can look at ICE standalone to see all the results for the entire ward rather than opening for each individual patient to reduce clicks. **(ST)** to show RDs present at RDF how to use ICE at end of meeting. Often named consultant on results signing off results for patients they have not been involved in/have not seen for a significant time. If RDs signing off results then this negates the safety issues associated

IMT Clerking Shifts: **(MW)** raised issues with IMT clerking shifts and requirements for 100 patients/year. **(ST)** reports rotas are same pattern for SHOs and clerking shifts etc should be equitable across the board. **(MW)** to have meeting to discuss with college tutor/deputy DME.

Criteria Led Discharges: **(TG)** running project for criteria led discharges especially over weekends and OOH. Allows for discharge without too much clinical involvement to improve flow and reduce delays in discharging. Encouraging band 6+ nurses to lead criteria-based discharge. Keen for RDs to get in contact if they would like to be involved in a QIP – can be done on individual wards.

Car Parking: **(AG)** Issues with car parking at RBH – no increase in car parking planned with the merger. Public transport inaccessible especially if living in Poole. Slip road has been built to come off Wessex Way from Ringwood.

Email Lists: Emailing lists not accurate – most grades not being informed about RDFs.

University Hospitals Dorset
NHS Foundation Trust

**BOARD OF DIRECTORS - PART 1 MEETING**

**Meeting Date: 05 March 2025**

**Agenda item: 6.4.3**

| | |
|---|---|
| **Subject:** | Maternity Bi-Annual Safe Staffing Paper July -December 2024 |
| **Prepared by:** | Lorraine Tonge: Director of Midwifery |
| **Presented by:** | Lorraine Tonge; Director of Midwifery |

| | |
|---|---|
| **Strategic themes that this item supports/impacts:** | Population & System ☒<br>Our People ☒<br>Patient Experience ☒<br>Quality Outcomes & Safety ☒<br>Sustainable Services ☒ |
| **BAF/Corporate Risk Register: (if applicable)** | Previous Risk rating 12: 1642 Midwifery staffing risk closed this reporting period as target met |
| **Purpose of paper:** | Assurance |
| **Executive Summary**: | This report gives a summary of all measures in place to ensure safe midwifery and neonatal staffing.<br>**Midwifery**<br>• We have a fully funded workforce planning in line with birth-rate plus, and a template review has been completed in this reporting period.<br>• The midwife to birth ratio is within expected range.<br>• Vacancies at 0% and sustained below 5%<br>• Turnover 6% which is expected due to moving to new build. Increase in retirements seen. Mitigations in place to reduce risks.<br>• Sickness rates stable at 5.45%- top reason for sickness anxiety and stress.<br>• The midwifery coordinator in charge of the labour ward has supernumerary status and the coordinator was 100% supernumerary at the start of every shift.<br>• 100% of one-to-one care was given in labour.<br>• Red flag incidents and impact have been analyzed and learning shared.<br>• Development of maternity practice development team to provide greater leadership with student learners and implement the student charter, and |

| | |
|---|---|
| | leadership for newly qualified midwives to give them additional support.<br>**Neonatal nursing**<br>• An annual workforce review was completed with the ODN in February 24.<br>• There has been an increase in staffing which was agreed by the trust and staff have recruited into posts and therefore now meeting BAPM Nurse staffing standards however as junior staff appointed level of QIS has fallen now 53% of all staff trained BAPM target 70%<br>• An action plan for newly appointed staff to obtain there QIS training is in place.<br><br>We will continue to ensure safe staffing and our focus is now on retention and supporting our teams as we move to RBCH in April 2025. |
| **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 contents of the report and formally record to the Trust Board minutes |
| **Implications associated with this item:** | Council of Governors ☐<br>Equality, Equity, Diversity & Inclusion ☐<br>Financial ☐<br>Health Inequalities ☐<br>Operational Performance ☐<br>People (inc Staff, Patients) ☐<br>Public Consultation ☐<br>Quality ☐<br>Regulatory ☐<br>Strategy/Transformation ☐<br>System ☐ |
| **CQC Reference:** | Safe ☒<br>Effective ☐<br>Caring ☒<br>Responsive ☐<br>Well Led ☒<br>Use of Resources ☒ |

| **Report History: Committees/Meetings at which the item has been considered:** | **Date** | **Outcome** |
|---|---|---|
| People and Culture Committee | 21/02/2025 | Meeting has not yet taken place at the time of submission of this report. |

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

University Hospitals Dorset
NHS Foundation Trust

# MATERNITY AND NEONATAL SAFE STAFFING REPORT

## JULY-DEC 2024

Author: Lorraine Tonge

Director of Midwifery

## 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 Incentive Scheme (MIS) year 6. Safety action 5 (See appendix 1) a separate paper is now provided for midwifery and neonatal nurse safe staffing.

## 1.0 Executive Summary

This report gives a summary of all measures in place to ensure safe midwifery staffing, including fully funded workforce planning in line with Birthrate 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® (BR+) Workforce Planning

Birthrate Plus® (BR+) is the only recognised national tool for calculating midwifery staffing levels. The Trust report was published in June 2021 (see appendix 2). Compliance with the report is a requirement of Safety Action 5 of the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS).

Birthrate Plus® (BR+) is a clinical workload exercise which calculates the need for clinical midwives in each clinical setting with some 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.

## 3.0 The Birth to Midwife Ratio

The Trust birth to midwife ratio is calculated monthly using Birthrate Plus methodology and the actual monthly delivery rate.

| Month | July | August | September | October | November | December |
|---|---|---|---|---|---|---|
| Actual ratio based on births per month | 1:23 | 1:21.6 | 1:25.6 | 1:22.5 | 1:20.8 | 1:22 |

Table 1: Birthrate Plus births to midwife ratio

To calculate the required whole time equivalent (WTE) midwives the Birthrate Plus reports adds an 22% uplift for annual leave, sickness, and training.

UHD Birthrate Plus assessment 2021 recommended to the Trust a birth to midwife ratio of 1:23.5 midwives per births.

This births to midwife ratio in table 1 shows that our staff ratio to births is better than the expected requirements in all months (except from September).

This ratio reflects UHD's position of decreased birthrate since 2021 from 4301 to 3629 in 2024, however it is expected that the birthrate will again increase as we move into the new facilities in April 2025. Early evidence shows us that this is occurring as December 2024 bookings have increased by 12%.

It also should be noted there has been an increase in the acuity of mothers and babies since 2021 due the decline of health for example an increase in body mass index and diabetes which requires additional care needs.

September birth to midwife ratio was slightly higher than the recommended ratio as vacancy rate was at 6%. To address our vacancy, we have employed 13 newly qualified midwives in October.

With professional judgement our birth to midwife ratios provides a safe position to provide the additional supervision required for newly qualified midwives and meets additional care needs of women. We will await the Birthrate Plus report (a current assessment is occurring- expected to receive final report in March) to be able to advise the board of any staff adjustments.

**4.0 Vacancies**

To maintain the birth rate ratio and provide safe staffing it was important over the last 12 months to reduce the vacancy rate and maintain our rates.

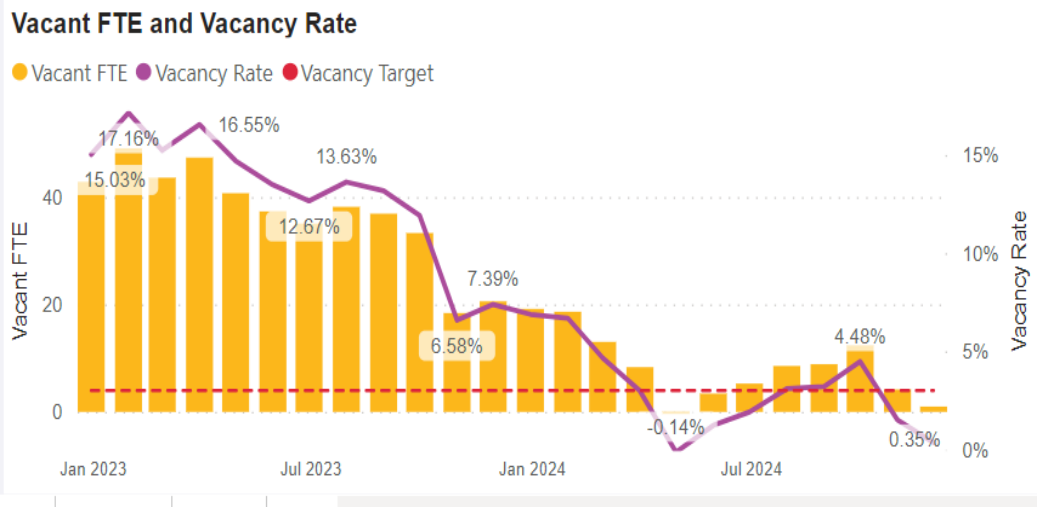



Table 2: Midwifery vacancy rate - data source Cosmos portal 6th of January 2025

From our data on cosmos, (and data is verified through workforce reviews), there is a current vacancy of minus 0.99 WTE This positive position is reflective of a collective responses and actions taken to address the vacancy rate as previously reported in December 2023 of 16.28%.

Actions taken to reduce and sustain vacancies rates in 2024 were:

- We have appointed a fixed term lead midwife for recruitment and retention. This post is essential in sustaining our staff vacancies. The recruitment and retention midwife works closely with the Director of Midwifery and Head of midwifery to deliver the workforce action plan and supports the wellbeing agenda of all staff by providing listening events, a newsletter advertising new development opportunity and exit interviews to understand why staff may leave UHD.

- We have advertised staff vacancies in different ways on social media using different platforms to attract interest in UHD.

- We have provided additional wellbeing support is given to midwives by our Professional advocate midwives (PMA).

- We have held successful recruitment days and developed our preceptorship programme.

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

- We have a fixed term lead midwife for international recruitment and are part of the international recruitment of midwives' programme. (This post will not be continuing after March 2025 as there is no current continuous national funding for this post)

- We have joined the apprentice programme for midwives and training 2 MSW's in training and 2 further MSW's to commence there training in January 2025 with plans of continuing to offer this route of development to our staff.

- We have bank midwives who provide stability to our workforce, and fill shifts at short notice. Bank 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 holiday periods. The school holidays in the summer can be the most challenging to manage with unexpected sickness. Our long-term strategy is to reduce the reliance on bank midwives and work towards more flexible contracts, however the availability of bank midwives will still be required to cover short term sickness.

It is planned to maintain 0% vacancies in midwifery staffing during the maternity transition to the new build which will mitigate an expected increase in turnover.

## 5.0 Turnover

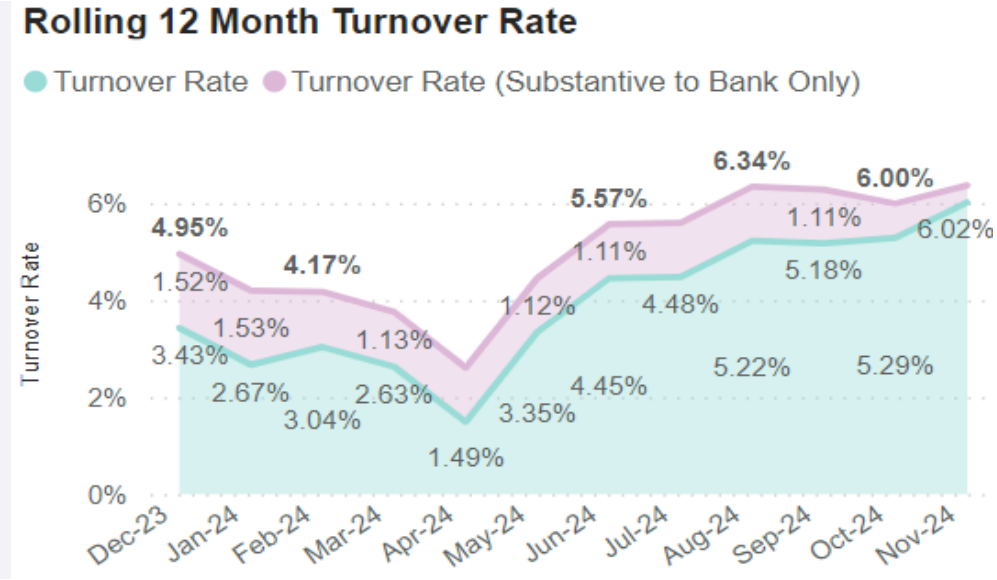



Table 3: Midwifery Turnover rate -data source Cosmos portal 6th of January 2025

We can see from our data that our turnover rate has increased during this reporting period July -December which was expected as we move to the new BEACH building in April 2025. A further rise is expected however we are recruited to our full establishment which will maintain safe staffing.

## 6.0 Sickness

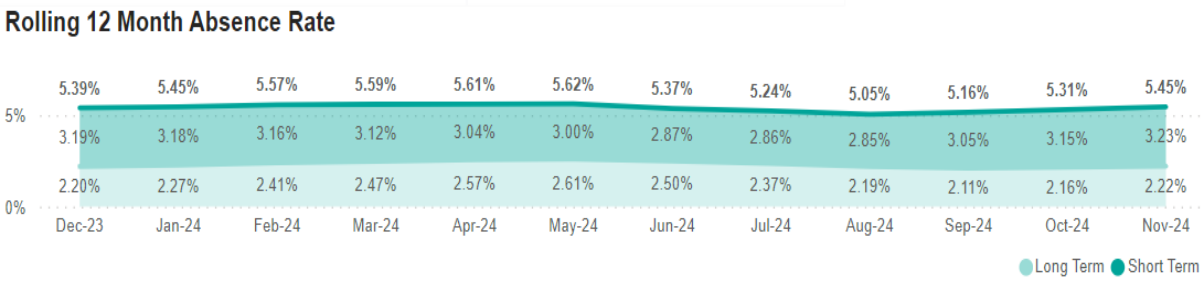



Table 4: Midwifery absence rate - data source Cosmos portal 6th of January 2025

From the data we can see overall sickness rate of greater than 5% although consistent at 5%. This rate above national target of 3% but equal with Trust rates.

Ongoing work continues in supporting staff on return to work by line managers meeting with staff, understanding their absence and sign posting to appropriate well-being services within the trust to offer overall health improvements.

Peer vaccinations ran in November and December aiding staff to have flu and covid vacancies on site in their workplace.

**Top reasons for sickness**

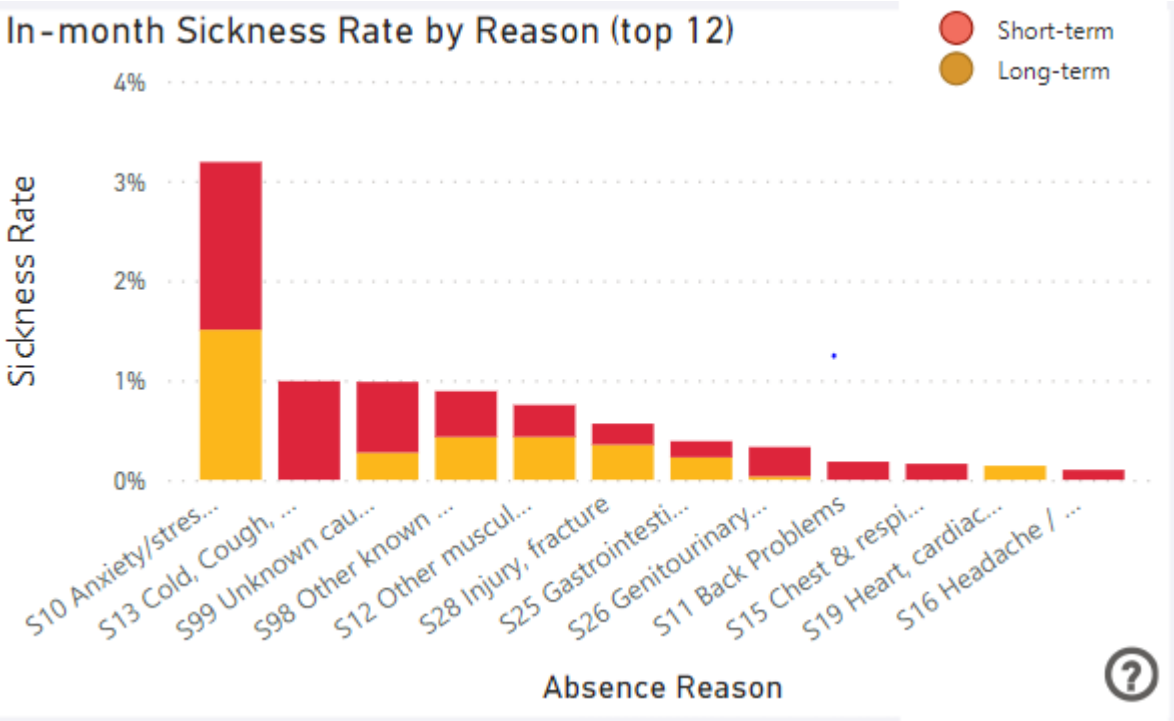



Table 5: Midwifery absence rate top reasons - data source Cosmos portal 13th of January 2025

Anxiety stress and depression remains the overall top reported reason for sickness and this trend fluctuates.

As national media pressures on maternity units are escalated, further work to support our staff to identify work related stress and how we can further support will continue. Prevention of stress may reduce absences from work but also improve the overall health of our workforce.

**7.0 Systematic reviews of implementing Birthrate Plus staffing allocations aligned with safety.**

**7.1**

Band 5-7 clinical midwives staffing templates were completed as part of the maternity workforce transformation by the Director of midwifery, Head of Midwifery, HR, ESR allocate, finance team and rostering team and signed off by Chief Nursing Officer. This was part of the workforce review process in moving to the new build in 2025.

The Director of Midwifery is therefore able to provide assurance to the board of implementation Birthrate Plus staffing allocations in all clinical roles and safe staff planning of the midwifery workforce in the new build.

### 7.2 Funded posts

To calculate the required whole time equivalent (WTE) midwives the Birthrate Plus report 2021 adds an uplift of 22% for annual leave, sickness, and training.

The review can confirm that **all posts are fully funded to Birthrate Plus recommendations.**

| | Band 5-7<br><br>Clinical WTE | Band 3<br><br>providing postnatal care<br><br>10% | Band 7 to 8<br><br>Additional Specialist and management WTE | Total includes all clinical specialists and management roles |
|---|---|---|---|---|
| Birth- rate plus recommendations<br><br>WTE (June 2021) | 174.61 | 19.40 | 21.34 | 215.35 |
| Current Funded WTE (June 2024) | 172.32<br><br>+2.8 externally funded.<br><br>Total 175.12<br><br>*Within this workforce there is a daily board holder overseeing the unit | 17.93<br><br>(Postnatal ward) | 22.31 band 7-8<br><br>9.79 band 6<br><br>Total 32.5 | 222.75 |

Table 6: UHD Birthrate Plus WTE recommendations 2021

**7.3** 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 has worked through this process however our current birth-rate plus does not represent this adjustment.

We are currently participating in implementing the NHS England Workforce, Training and Education MSW framework to enhance the skills of our MSW's and provide development opportunities.

**7.4** Specialist's midwives' roles

The calculations and review of midwifery management and specialist roles of 11% allowance in our Birthrate Plus assessment in 2021 would not be considered sufficient in December 2024 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 lead audit midwife, policy, and guidelines midwife, increase quality and risk midwives, increase Professional midwifery advocate (PMA) support for midwives, and lead fetal monitoring 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 are currently being funded by the ICB and transformation. These roles include Breastfeeding initiative lead (BFI), continuity of care, preterm birth midwife, and Student learner lead.

The current Birthrate Plus 2021 model did not take these the extra requirements into consideration and is undergoing a model review.

A business case for these any additional posts may need to be presented at budget setting for consideration if these posts are not represented in the Birthrate Plus assessment 2025 to enable UHD to maintain assurance standards and not impacting on clinical care.

**7.5** Training requirements

Although Birth-rate Plus allocates an uplift of 22%, 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 6 and core competency framework 2, (CCF2) (see appendix 3).

To achieve the CCF2 standard, a phased approach is being implemented. It is likely that an uplift increase will need to be needed in 2025 and expected increased from 22% to 24%. We are awaiting our current birthrate plus report and expect the recommend training uplifts.

**7.6** Training- Restructure of maternity practice development team

To meet the new training standards as set out in core competency framework 2, (CCF2) we have adjusted our training team structure. This has provided us with leadership for Student midwife lead, implementing the student charter (see appendix 4) and preceptorship midwife lead in advancing our newly qualified midwives and midwife lead ensuring competencies and training standards of midwives are maintained. The team is supported by midwives in practice areas with allocated time in providing relevant training and learning from incidences and complaints and supporting midwives in practice.

## 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 Birthrate Plus Live Acuity Tool

The Birthrate Plus Live Acuity Tool was introduced in the intrapartum areas in April 2023 and a further role out have occurred on the postnatal ward in April 2024.

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 Birthrate Plus.

The Birthrate 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 Birthrate Plus categories and alerts midwives when events during labour move her into a higher category and increased need of midwife support.

The Birthrate Plus acuity tool is now embedded on the intrapartum high risk labour ward. This provides 4-hourly reports on the safety of the staffing and workload, which informs quality and risk reporting.

The labour ward matron oversees this tool and reports monthly through the safety champions report, care group and quality committee for assurance that staff reallocation has occurred to meet the acuity in real time.

### 8.2 Supernumerary Labour Ward Co-ordinator

Availability of a supernumerary labour ward co-ordinator at the start of every shift 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. From July to December there was 100% of an experienced midwife supernumerary as labour ward co-ordinator at the start of each shift.

To support the safety on the labour ward especially overnight, there is now a second band 7 midwife rostered on each shift who can step into the labour ward co-ordinator position should it be required during a shift. For example, should the labour ward co-ordinator become unwell in a shift then a band 7 midwife is immediately available.

### 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.

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

Table 7: One to One in labour - data source Birthrate Plus acuity tool

### 8.4 Red Flags

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 this period July to December 2024 red flags as per NICE recommendations were reported on safe care

| Status | June 24 | July 24 | Aug 24 | Sep 24 | Oct 24 | Nov 24 | December 24 |
|---|---|---|---|---|---|---|---|
| **Resolved** | 47 | 53 | 42 | 66 | 57 | 68 | 51 |
| **Raised in error** | 3 | 4 | 3 | 6 | 4 | 3 | 9 |

Table 8: Nice maternity clinical red flags data source Safe Care.

| Red flag reason | Number |
|---|---|
| Delay in transfer to labour ward for ongoing induction | 297 |
| Delay for epidural | 10 |
| **Time critical delay for LSCS**<br>CAT 1 decision to birth within 30 mins.<br>CAT 2 decision to birth within 75 mins.<br>CAT 3 decision to birth in accordance with clinical condition of woman and baby. | 10 |
| Cancelled Elective LSCS | 15 |
| Delay in obtaining 2nd theatre team | 0 |
| Delay in perineal suturing 3rd degree tear | 0 |
| Delay in manual removal of placenta | 1 |

Table 9: Reasons for red flag - data source safe care

All red flag incidences are reviewed by senior matron for inpatient services, and no care impact was noted.

There were 12 occasions of opal 3 in the six-month period and 2 occasion of opal 4 this was acuity and capacity. No safety incidences were reported during these periods.

## 8.4 Planned versus actual staffing.

Safe Staffing (Rota Fill Rates and CHPPD) - Maternity (Day & Night) Rolling 12 Month Summary

| | January | | | | February | | | | March | | | | April | | | | May | | | | June | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Day | | Night | | Day | | Night | | Day | | Night | | Day | | Night | | Day | | Night | | Day | | Night | |
| Maternity | Registered | Non-Registered | Registered | Non-Registered | Registered | Non-Registered | Registered | Non-Registered | Registered | Non-Registered | Registered | Non-Registered | Registered | Non-Registered | Registered | Non-Registered | Registered | Non-Registered | Registered | Non-Registered | Registered | Non-Registered | Registered | Non-Registered |
| Maternity | 92.6% | 87.8% | 93.9% | 89.5% | 89.4% | 82.4% | 87.2% | 91.6% | 93.0% | 87.9% | 90.1% | 92.9% | 95.2% | 94.1% | 91.8% | 97.3% | 92.2% | 87.2% | 89.5% | 94.4% | 92.8% | 87.3% | 93.6% | 88.8% |
| Maternity Labour Ward | 92.9% | 96.3% | 89.2% | 95.2% | 90.5% | 85.8% | 81.8% | 97.2% | 88.4% | 84.4% | 80.0% | 93.1% | 88.8% | 71.9% | 86.0% | 73.4% | 93.0% | 62.6% | 92.7% | 68.4% | 100.0% | 87.8% | 94.8% | 91.7% |

| | July | | | | Aug | | | | Sep | | | | Oct | | | | Nov | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Day | | Night | | Day | | Night | | Day | | Night | | Day | | Night | | Day | | Night | |
| Maternity | Registered | Non-Registered | Registered | Non-Registered | Registered | Non-Registered | Registered | Non-Registered | Registered | Non-Registered | Registered | Non-Registered | Registered | Non-Registered | Registered | Non-Registered | Registered | Non-Registered | Registered | Non-Registered |
| Maternity | 90.5% | 85.2% | 93.0% | 97.2% | 89.6% | 84.5% | 94.7% | 90.2% | 87.8% | 79.3% | 95.3% | 92.1% | 89.6% | 78.6% | 93.0% | 75.5% | 94.5% | 82.1% | 93.3% | 90.8% |
| Maternity Labour Ward | 92.3% | 77.2% | 88.3% | 79.6% | 78.0% | 65.6% | 80.3% | 76.6% | 80.9% | 94.4% | 82.9% | 97.1% | 88.1% | 81.6% | 83.6% | 99.6% | 94.4% | 81.6% | 85.6% | 90.9% |

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 and request. mutual aid.

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.

## 9.0 Neonatal Services

NHS England – Specialist Commissioning Service Specification for Neonatal Critical Care Review (NCCR, 2024) covers the provision of Neonatal Critical Care, including neonatal intensive care, high dependency care, special care and transitional care.

UHD provides Neonatal Care level 2 Local Neonatal Unit (LNU).

The British Association of Perinatal Medicine (BAPM) and NHS Toolkit for High Quality Neonatal Services provide a framework and calculation tool to determine neonatal nurse staffing depending on cot capacity, acuity and is endorsed by Department of Health (DH) to ensure safe and productive working.

As per MIS safety action 4, the Neonatal Matron with the Southwest ODN conducted an annual review in Q4 (February 24) using the Safer Nursing Care Tool – Shelford Group (2013) using triangulated data sets, inclusive of an annual workforce review, acuity, recruitment, retention, skill mix and Qualification in Speciality (QIS).

A nursing workforce business case was presented to the Board and funding was agreed in February 2024. The substantive nursing WTE increased in budget in April 2024 to meet the standard BAPM and recruitment has occurred and after recruitment standards now met.

The systematic review of nursing review of templates was also repeated in this reporting period as part of the transformation neonatal nursing workforce plans. This review was by the interim neonatal matron, HR, ESR allocate, finance team and rostering team and signed off by Chief Nursing Officer. This was part of the workforce review process in moving to the new build in 2025.

It was identified that the current compliance with QIS Registered Nurse workforce is 53% (against standard requirement of 70%) this has been due to the recruitment of junior band 5 nurses. However, 2 candidates started the course in November 2024 for completion in 12 months with a request to train 7 colleagues in 2025. This reflects the national picture of QIS within Neonatal services.

**10.0 Next steps and actions**

- NICE (2017) recommend that a Birthrate Plus assessment is carried out every three years. The assessment is underway and will take account of the current maternity service model 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.) This assessment is in progress and the findings will be presented to the Board on receipt of the final report.

- As training requirements have increased for midwives in MIS year 6 and expected to increase further in MIS year 7 we will await Birthrate Plus assessment and MIS year 7 requirements and present their recommendations to the Trust board.

- We will continue with the workforce strategy and continue improving recruitment and retention, reducing the reliance on bank staff, understanding, and supporting staff with work stress improving staff wellbeing.
-
- We will continue with the action plan to increase the QIS neonatal nursing staffing to the recommended 70%

**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 6 safety standards.

It also provides assurances of safety measures in place to address midwifery and neonatal 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.

## Appendix

Appendix 1: MIS year 6 guidance

MIS-Year-6-guidanc
e.pdf

Appendix 2: Birth rate plus assessment UHD June 2021

University Hospitals
Dorset Birthrate Plu

Appendix 3: Core competency framework 2

CCF
v2-minimum-standar

University Hospitals Dorset
NHS Foundation Trust

**BOARD OF DIRECTORS - PART 1 MEETING**

**Meeting Date: 05 March 2025**

**Agenda item: 6.4.4**

| | |
|---|---|
| **Subject:** | Equality Delivery System [EDS] report template 2025 |
| **Prepared by:** | Deepa Pappu, Organisational Development Practitioner EDI; Jon Harding, Head of Organisational Development; Deb Matthews, Director of Organisational Development |
| **Presented by:** | Tina Ricketts, Chief People Officer |

| | |
|---|---|
| **Strategic themes that this item supports/impacts:** | Population & System ☒<br>Our People ☒<br>Patient Experience ☒<br>Quality Outcomes & Safety ☒<br>Sustainable Services ☒ |
| **BAF/Corporate Risk Register: (if applicable)** | BAF 3 and 4 |
| **Purpose of paper:** | Decision/Approval |
| **Executive Summary**: | This Equality Delivery System [EDS] evaluation has been taking place since October 2024, during this time more stakeholders both internal and external have been engaged than in previous years.<br><br>The report provides an overview of the actions and activities taken both internal and external to University Hospitals Dorset NHS Foundation Trust.<br><br>The review for Domain 1 was undertaken with the Dorset Integrated Care System and local partners. Services reviewed include Dorset Intelligence and Insight Service, Bagernet [PALs & Friends and Family] & Targeted Lung Health Checks.<br><br>Domain 2 considers Workforce Health & Wellbeing with internal and external stakeholder assessment and an internal survey, with 78 responses. An increase from 28 from 2024, notably the responses were positive.<br><br>Domain 3 is a review of our Inclusive Leadership Capacity.<br><br>The proposed overall assessment for this report is now, Achieving with a combined score of 23, this is an increase in most metrics and an improvement in the developing assessment for 2023. Please see |

| | |
|---|---|
| | comparison of scores for 2023/24 and 2024/5 at the end of the cover sheet, also included in the main report.<br><br>Healthwatch Dorset scored domain 2 and 3, the Health Inequalities Hub scored domain 1.<br><br>The breakdown of the ratings can be seen in the attached document. |
| **Background:** | Implementation of the Equality Delivery System (EDS) is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS in accordance EDS guidance documents.<br><br>The EDS is an improvement tool for patients, staff, and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership.<br><br>It is driven by data, evidence, engagement, and insight. The EDS Report is a template which is designed to give an overview of the organisation's most recent EDS implementation and grade. The report will be submitted via england.eandhi@nhs.net and published on the organisation's website. It will be made available at UHD on the internet and intranet. |
| **Key Recommendations**: | UHD has a contractual obligation to submit this report to NHS England on or before the 28 February 2025.<br><br>A review of progress will be programed in July 2025 ahead of the next engagement round.<br><br>The Board is asked to approve this document for publication. |
| **Implications associated with this item:** | Council of Governors ☐<br>Equality, Equity, Diversity & Inclusion ☒<br>Financial ☐<br>Health Inequalities ☒<br>Operational Performance ☐<br>People (inc Staff, Patients) ☒<br>Public Consultation ☒<br>Quality ☐<br>Regulatory ☐<br>Strategy/Transformation ☐<br>System ☐ |
| **CQC Reference:** | Safe ☐<br>Effective ☐<br>Caring ☐<br>Responsive ☐ |

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| | Well Led<br>Use of Resources | ☒<br>☐ |

| Report History: Committees/Meetings at which the item has been considered: | Date | Outcome |
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| Trust Management Group<br>People and Culture Committee | 18/02/2025<br>21/02/2025 | Outcomes from TMG and PCC pending at the time of submission |

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

2024/25 comparison with 2023/24

| Domain | 2023-24 | | 2024-25 | | Stakeholders |
|---|---|---|---|---|---|
| **Domain 1 Patient services** | *End of Life 9*<br>*Falls 10*<br>*ENT 4* work continued after submission* | 9 | *DiiS 6.5*<br>*Lungs 7* | 7 | Scored through collaboration with ICS colleagues |
| **Domain 2 Workforce Health and Wellbeing** | 6 | | 9 | | • External score#<br>• Stakeholder Survey<br>• Department Leads |
| **Domain 3 Inclusive Leadership** | 3 | | 7 | | • External score# |
| **Overall Assessment** | **18 developing** | | **23 achieving** | | Scoring fluctuations are likely due to improved stakeholder responses and process becoming more established. |

# University Hospitals Dorset NHS Foundation Trust

## NHS Equality Delivery System 2022

# EDS Reporting Template

Version 1, 15 August 2022

Classification: Official
Publication approval reference: PAR1262

## Equality Delivery System for the NHS

***The EDS Reporting Template***

Implementation of the Equality Delivery System (EDS) is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS in accordance EDS guidance documents. The documents can be found at: www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/eds/

The EDS is an improvement tool for patients, staff, and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement, and insight.

The EDS Report is a template which is designed to give an overview of the organisation's most recent EDS implementation and grade. Once completed, the report should be submitted via england.eandhi@nhs.net and published on the organisation's website.

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| **Name of Organisation** | **University Hospitals Dorset NHS Foundation Trust** | **Organisation Board Sponsor/Lead** |
| | | Tina Ricketts, Chief People Officer |
| **Name of Integrated Care System** | Dorset ICB | |

## NHS Equality Delivery System (EDS)

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| **EDS Lead** | Deepa Pappu and Jonathan Harding | | **At what level has this been completed?** | |
| | | | | ***List organisations** |
| **EDS engagement date(s)** | HEALTHWATCH Dorset January 2025 Domain 2 & 3; Dorset Health Inequalities Group January 2025 Domain 1;<br>Stakeholder Survey with 78 responses December 24 – January 25 Domain 2<br>Trust Management Group February 2025 | | **Individual organisation** | University Hospitals Dorset NHS Foundation Trust- Staff Network Leads, Trade Unions, Chaplaincy, Staff Governors, FTSU team, Health and Wellbeing Champions, Culture Champions |
| | | | **Partnership* (two or more organisations)** | Domain 1 –Dorset University Hospital NHS Foundation Trust, Dorset County Hospital, Dorset ICS |
| | | | **Integrated Care System-wide*** | Anita Counsell – Assistant Director, Health Inequalities and Population Health Management |

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| **Date completed** | 18 February 2025 | **Month and year published** | February 2025 |
| **Date authorised** | To be authorised by TMG – 18/01/2025 | **Revision date** | |

| Completed actions from previous year | |
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| **Dorset ICS & UHD combined Action/activity Domain 1** | **Related equality objectives** |
| **1A Palliative Care and End of Life**<br>***Action:*** *Improve the ability to identify where there is real variation between population groups, rather than could be caused by chance by strengthening information on our system DiiS (to be utilised by End-of-Life Care, and other services)*<br><br>**Activity:** Work has been undertaken to improve equality data across the protected characteristics of Age, gender, and race for 19 of 24 NHS health inequalities indicators. With work having been planned to improve the disability dataset. Improvement in equality data continues to be a priority for NHS Dorset. A total of 11 domains, across 24 indicators have been analysed by protected characteristics of age, gender, and ethnicity (segmented by deprivation) at Integrated Care Board (ICB) and where appropriate at Trust level. The data is further strengthened by the addition of confidence Interval functionality to assess random variation. More work is in progress to identify whether disability or an appropriate proxy can be analysed through Dorset Intelligence and Insight Service functionality. Additionally, an Unwarranted Variation System Group has been established to systematically review and prioritise targeted action on the root causes of unfair access, experience, and outcomes from healthcare services across Dorset, in particular responding to variation identified through the Data and intelligence. | Improve collection and use of all EDI data and compliance against national standards.<br><br>Develop patient co-production and engagement to reduce health inequalities.<br><br>Improve capture of information on protected characteristics in healthcare services Review of fields against NHSE health inequalities reporting requirements and equality duties (protected characteristics) Addition of new fields as required/available. |
| **1B Palliative Care and End of Life**<br>***Action:*** *Embed system quality, equality, and health inequality impact assessment (SQEEIA) in new service development and service reviews (for ongoing review of end-of-life care, and other services)– including systematic comparison and review of eligible population and those accessing services*<br><br>**Activity:** The ICB has:<br>Added equality and health inequality principles into Population Health Management (PHM) learning. Co-designed turning the tide – Dorset's health inequalities' engagement tool. Undertaken a rapid review of equality impact assessments. Work is underway to refresh NHS Dorset's approach to equality and health inequality impact assessments. SQEEIA review process including equality and health inequality impact assessment is in place. A panel meets weekly to provide input to SQEEIAs equality and health inequality principles have been added into Population Health Management (PHM) learning. Co-designed a refresh of the 'Turning the | Improve collection and use of all EDI data and compliance against national standards.<br><br>Develop patient co-production and engagement to reduce health inequalities.<br><br>Embed SQEEIA process in Population Health Management approach and resources. |

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| Tide' innovative Board game to increase understanding of the impact of determinants of health-on-health outcomes. Undertaken a rapid review of equality impact assessments. Work is underway to refresh NHS Dorset's approach to equality and health inequality impact assessments.<br><br>The ICB has taken a refresh of its EHIA process. This is to enable systematic assessment of impact of falls and other commissioned services on different population groups within Dorset, and improve service access, user experience and outcomes from services. | |
| **1C Palliative Care and End of Life**<br>***Action:*** *Bring together quality, health inequality impact assessment process to ensure routine consideration of quality aspects of service alongside equality aspects (in future end of life care and other services)*<br><br>**Activity:** The SQEEIA for end-of-life service was completed and presented to the SQEEIA panel on 19/12/2024. With service equity and inclusion health lead providing advice and support on EHIAs. SQEEIA review process including equality and health inequality impact assessment is in place. A panel meets weekly to provide input to SQEEIAs. The Falls Risk Model has been refreshed and tested with DiiS this year and is pending systemwide rollout. EHIA guidance and resources are available to staff via the intranet pages. With advice and support from service equity and inclusion health lead on undertaking EHIAs. | Improve collection and use of all EDI data and compliance against national standards.<br><br>Develop patient co-production and engagement to reduce health inequalities.<br><br>ICB Equity and Inclusion health post holder in place to provide expert input. Update resources published July 2024 to support process. Roll training to support system quality, Equity, Equality impact assessment approach. |
| **1D Palliative Care and End of Life**<br>***Action:*** *Learning from work on end-of-life care, and other reviews ensure service user experience is routinely embedded in service review processes. Continue to review service user experience in End-of-Life Care (and make changes required)*<br><br>**Activity:** Falls and frailty have been identified as a high clinical priority for NHS Dorset and a systemwide working group has been setup to monitor incidence and track improvements within the Falls service. Equality and Health Inequality Impact Assessment is embedded in the ICBs Gateway process (the process through which new services and programmes of work are reviewed, agreed, and overseen) | Improve collection and use of all EDI data and compliance against national standards.<br><br>Develop patient co-production and engagement to reduce health inequalities.<br><br>Embed consideration of service user experience in Population Health Management approach - linking to insight repository in system working with communities workstream. |
| **1A Falls Risk Assessment**<br>***Action:*** *Improve the ability to systematically identify where there is real variation between population groups, rather than could be caused by chance, by strengthening information on our system Intelligence and Insight Service (DiiS) (to be utilised by End-of-Life Care, and all other services)* | Improve collection and use of all EDI data and compliance against national standards.<br><br>Develop patient co-production and engagement to reduce health inequalities. |

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| **Activity:** Work has been undertaken to strengthen the PHM approach and maturity around falls and improve equality data across the protected characteristics of age, gender, and ethnicity for 19 of 24 NHS health inequalities indicators covering Falls admission data. | Improve capture of information on protected characteristics in healthcare services Review of fields against NHSE health inequalities reporting requirements and equality duties (protected characteristics) Addition of new fields to DiiS required/available |
| **1B Falls Risk Assessment**<br>***Action:*** *Embed system approach to quality, equity, equality, and health inequality impact assessment (SQEEIA) in new service development – including systematic comparison and review of eligible population and those accessing services (for Falls and all other services/policies). Periodically review SQEEIA to ensure service continues to meet needs*<br><br>**Activity:** To enable systematic assessment of impact of falls and other commissioned services on different population groups within Dorset, and improve service access, user experience and outcomes from services, the ICB has taken a refresh of its EHIA process. | Improve collection and use of all EDI data and compliance against national standards.<br><br>Develop patient co-production and engagement to reduce health inequalities.<br><br>Embed SQEEIA process in Population Health Management Undertake repeat SQEEIA for Falls services. |
| **1C Falls Risk Assessment**<br>***Action:*** *Bring together quality, health inequality impact assessment process to ensure routine consideration of quality aspects of service alongside equality aspects (in future end of life care and other services) Ensure staff undertaking SQEEIA have the skills to do this*<br><br>**Activity:** The Falls Risk Model has been refreshed and tested with DiiS this year and is pending systemwide rollout, EHIA guidance and resources are available to staff via the intranet pages. With advice and support from service equity and inclusion health lead on undertaking EHIAs. | Improve collection and use of all EDI data and compliance against national standards.<br><br>Develop patient co-production and engagement to reduce health inequalities.<br><br>ICB Equity and Inclusion health post holder in place to provide expert input. Updated resources published to support process. Roll training to support System Quality, Equity, Equality impact assessment approach (SQEEIA) |
| **1D Falls Risk Assessment**<br>***Action:*** *Learning from Falls work, ensure service user experience is routinely embedded in service review processes. Share learning from using service user experience as part of falls review with other services*<br><br>**Activity**: Falls and frailty have been identified as a high clinical priority for NHS Dorset and a systemwide working group has been setup to monitor incidence and track improvements within the Falls service. | Improve collection and use of all EDI data and compliance against national standards.<br><br>Develop patient co-production and engagement to reduce health inequalities.<br><br>Embed consideration of service user experience in Population Health Management approach - linking to insight repository in system working with communities workstream. Include falls service user review in Insight Bank. |
| **1A Ear, Nose and Throat Service Waiting Lists**<br>***Action:*** *To make it easier for children and young people to attend their* | Improve collection and use of all EDI data and compliance against national standards. |

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| *appointments without missing school.*<br><br>**Activity:** Following a deep dive into the variation in DNA rates in ENT services in Quarter 4 2023/24, which highlighted higher rates of DNAs for children from IMD groups 1 and 2 (top 20% most deprived) and in Community minority groups, there has been a positive shift in DNA rates for children in the latest Quarter (Quarter 2, 2024/25). DNA rates for <18-year-olds from IMD 1 and 2 have reduced by 17.4% compared to Quarter 4 and are now lower than IMD groups 3-10. The same is true for DNA rates within community minority groups, DNA rates for this group have reduced by 7.7% and are less than non-community minority groups. | Develop patient co-production and engagement to reduce health inequalities.<br><br>Explore the location of clinics, to make it easier for children and young people to attend appointments. For example, schools or children's centres. Review the evidence of best practice and ensure the ENT service are delivering services in line with recommendations around reducing DNAs. Proactively use DiiS to monitor and identify any groups of people who may be struggling to access services compared to other groups. Targeted initiatives can then be developed. |
| **1B Ear, Nose and Throat Service Waiting Lists**<br>***Action:*** *Personalised care and plans available as required*<br><br>**Activity:** The action to develop a mechanism for offering tailored support to families who may be struggling to attend appointments or access services has been successfully implemented and early data suggests it is effective. Personalised care and plans are now available as required, ensuring families receive the support they need to engage with services effectively. DNA data in under 18's, in the 20% most deprived and community minority groups from Q2 to Q4 indicates that this approach has improved access to ENT services. | Improve collection and use of all EDI data and compliance against national standards.<br><br>Develop patient co-production and engagement to reduce health inequalities.<br><br>Develop a mechanism for offering tailored support to families who may be struggling to attend appointments / access services. |
| **1C Ear, Nose and Throat Service Waiting Lists**<br>***Action:*** *Was Not Brought Policy*<br><br>**Activity:** The Was Not Brought Policy is in place and available to all UHD staff via the intranet. The policy is monitored, reviewed, and updated by the Safeguarding Team. Strong links with safeguarding are in place and clear pathways for referral as needed | Improve collection and use of all EDI data and compliance against national standards.<br><br>Develop patient co-production and engagement to reduce health inequalities.<br><br>Update the ENB policy and ensure awareness and compliance across the trust. |
| **1D Ear, Nose and Throat Service Waiting Lists**<br>***Action:*** *To embed the patient voice into service reviews and development/*<br><br>**Activity:** Through the 100-day project, parents and carers were consulted to discuss reasons and causes of DNAs. Work is ongoing to develop a questionnaire which can be sent to all users of ENT services to capture feedback, as well as consideration of a method of ensuring regular feedback is sought and acted upon. Significant progress has been made, and efforts to address DNA's will remain a key | Improve collection and use of all EDI data and compliance against national standards.<br><br>Develop patient co-production and engagement to reduce health inequalities.<br><br>Through the 100-day project establish a parent / carer focus group to explore reasons and causes of DNAs. Alongside this develop a |

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| focus within the unwarranted variation workstream. | questionnaire which can be sent to all users of ENT services to capture feedback. |
| **Domain 2 Activity/Action** | **Objectives** |
| **Domain 2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD, and mental health conditions**<br>***Action:*** *Staff Health Inequalities data to be collected by Occupational Health (OH) on all protected characteristics. Opportunity for both PSC and OH to consider review utilisation of their services against the overall organisational workforce profile.*<br><br>*Targeted promotion of Psychological Support and Counselling Services (PSC), OH services and Health and Wellbeing offers to staff networks to reach underrepresented staff groups. (Completion date 2024/25).*<br><br>**Activity:** NHS Health Checks were carried out by LiveWell Dorset in UHD and have been offered to staff throughout 2024. Emphasis placed on advertising these sessions for Global Majority colleagues from Diverse Ethnicity Network. Out of 199 health checks, 12% from other ethnic backgrounds and 7% from Global Majority. There will be more targeted promotion of PSC, OH services and Health and Wellbeing offers in 2025.<br><br>The eOPAS OH system collects minimal PC data and is due an upgrade during the next reporting period. Thrive Health & Wellbeing and 80 champions support staff. | Improve employee experience and Improve collection and use of all EDI data and compliance against national standards.<br><br>**The UHD Patient First mission is -**<br>"To provide excellent healthcare for our patients and wider community and to be a great place to work, now and for future generations."<br><br>The strategic People A3 target is "To achieve top decile NHS Staff Survey results for "I would recommend UHD as a great place to work" by 2026/27"<br><br>UHD aim to create a work environment whereby Staff can flourish and achieve their potential. UHD will provide appropriate action wherever possible to support staff and eliminate barriers to staff health inequalities.<br><br>Dignity and respect will underpin our civility agenda and support the reduction of abuse, harassment, bullying and physical violence. |
| **Domain 2B**<br>**When at work, staff are free from abuse, harassment, bullying and physical violence from any source.**<br><br>***Action:*** *Anti-Racism/discrimination guidance to become embedded into UHD inclusive culture and to apply to all underrepresented groups of staff.*<br>*Patient inappropriate behaviour is to proactively be addressed.*<br>*Pink LERN forms are to be evaluated quarterly to identify progress.*<br>*Review of 2023 NHS Staff Survey (NSS) data when available. (completion date 2024/25)*<br><br>**Activity:** Anti-racism guidance for staff, managers, and bystanders addressing racism has been distributed through EDI sessions, managers' meetings, and Conscious Inclusion workshops. Staff are encouraged to address unacceptable | Improve employee experience and Improve collection and use of all EDI data and compliance against national standards.<br><br>**The UHD Patient First mission is -**<br>"To provide excellent healthcare for our patients and wider community and to be a great place to work, now and for future generations."<br><br>The strategic People A3 target is "To achieve top decile NHS Staff Survey results for "I would recommend UHD as a great place to work" by 2026/27"<br><br>UHD aim to create a work environment whereby Staff can flourish and achieve their potential. UHD will provide appropriate action wherever |

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| behaviour from patients and colleagues and seek support if they are unable to challenge it directly.<br><br>LERN- Staff witnessing or experiencing abuse can raise LERN, these are collated, graded, and escalated as appropriate.<br>The 2023 NSS used to inform the Workforce Race Equality Standard (WRES2024) showed significant improvement in indicators 5, 6, and 8, and a reduction in discrimination experienced. However, indicator 7 which measures equal opportunities for BME staff, showed no improvement. [This was not evident in question 24b where outcomes for BME staff were more positive.] Indicator 3 shows that the formal disciplinary actions for BME staff have doubled compared to last year.<br>Speaking up is a core part of our objectives, strategy, and improvement program, and this year, over 5,600 staff, 59% of UHD have shared their views through the staff survey<br>UHD's Freedom to Speak Up Guardian reports annually to the Board, with 44% of cases involving poor behaviour such as abuse, harassment, bullying, and violence, all confidentially recorded along with ethnicity | possible to support staff and eliminate barriers to staff health inequalities.<br><br>Dignity and respect will underpin our civility agenda and support the reduction of abuse, harassment, bullying and physical violence. |
| **Domain 2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source.**<br><br>***Action:*** *The FTSU team are expanding their focus on data collection to enable wider reporting and targeted support as required.*<br><br>**Activity:** There is a well embedded Freedom to Speak Up service which is regularly promoted. In the 2023/24 FTSU Annual Report it confirms that 412 concerns were raised by staff; 44% (188 staff) included an element of inappropriate attitudes and behaviours. | Improve employee experience and Improve collection and use of all EDI data and compliance against national standards.<br><br>**The UHD Patient First mission is -**<br>“To provide excellent healthcare for our patients and wider community and to be a great place to work, now and for future generations.”<br><br>The strategic People A3 target is “To achieve top decile NHS Staff Survey results for “I would recommend UHD as a great place to work” by 2026/27”<br><br>UHD aim to create a work environment whereby Staff can flourish and achieve their potential. UHD will provide appropriate action wherever possible to support staff and eliminate barriers to staff health inequalities.<br><br>Dignity and respect will underpin our civility agenda and support the reduction of abuse, harassment, bullying and physical violence. |

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| **Domain 2D: Staff recommend the organisation as a place to work and receive treatment.**<br><br>***Action:*** *Continue to report on the Workforce Race Equality Standard (WRES) & Workforce Disability Equality Standard (WDES) metrics and develop action plans to address main concerns. (completion date 2024/25)*<br><br>**Activity:** The WRES and WDES) 2024 reports have been approved through Trust Management Group (TMG) and Board. The full reports including action plan are externally published through internet and internally published through intranet. Some of these actions have also been used to inform our Equality objectives and our Patient First priorities.<br><br>Wider patient health inequalities project work to demonstrate organisational commitment to health inequalities. | Improve employee experience and Improve collection and use of all EDI data and compliance against national standards.<br><br>**The UHD Patient First mission is -**<br>"To provide excellent healthcare for our patients and wider community and to be a great place to work, now and for future generations."<br><br>The strategic People A3 target is "To achieve top decile NHS Staff Survey results for "I would recommend UHD as a great place to work" by 2026/27"<br><br>UHD aim to create a work environment whereby Staff can flourish and achieve their potential. UHD will provide appropriate action wherever possible to support staff and eliminate barriers to staff health inequalities.<br><br>Dignity and respect will underpin our civility agenda and support the reduction of abuse, harassment, bullying and physical violence. |
| **Domain 3 Action/Activity** | **Objective** |
| **Domain 3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities.**<br><br>***Action:*** *Increase trust wide communication of Board actions and commitment to Equality and Health Inequalities. (completion date 2024/25)*<br><br>**Activity:** UHD commits to an external EDI maturity audit and actions are monitored. The staff network executive sponsors are board members and are regularly involved in network activities such as Cultural celebration, Trans Remembrance Day, UHD PRIDE event, Purple Light Up and Menopause Awareness Day. The activities have been regularly communicated through Trust staff bulletin and social media to promote an inclusive culture within UHD. | Enhance Staff Network Engagement and Develop Inclusive Leadership Capability<br><br>**Patient First:**<br>There are 5 strategic themes which are our priorities as a Trust, which each have clear breakthrough objectives for the year:<br>1. Population and System – "Seeing patients sooner" (accessible care for patients)<br>2. Our People – "Great place to work" (attracting and retaining staff)<br>3. Patient Experience – "Improving patient experience, listen and act"<br>4. Quality Outcomes and Safety – "Save lives, improve patient safety"<br>5. Sustainable Services – "Use NHS pound wisely" (improve timeliness and quality of care for patients) |
| **Domain 3B Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed.** | Improve employee experience and Improve collection and use of all EDI data and compliance against national standards. |

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| ***Action:*** *All UHD Executive Board members have EDI objectives for appraisal.*<br><br>**Examples:**<br>**CPO- EDI objective for appraisal-** Improvement in WRES scores in staff survey. Support teams to improve the Workforce Race Equality Standards this year. To develop an Equality, Diversity and Inclusion Plan that supports improvement in our Workforce Race Equality Standards this year - as part of the refreshed People & Culture Strategy.<br>**CNO- EDI objective for appraisal-** In conjunction with CPO develop nursing leadership faculty for Nursing, AHP's and BS, with specific focus on a positive action program aimed at band 6/7 based on nursing WRES data.<br>**Chief Strategy and Transformation Officer- EDI objective for appraisal-** Supporting the work of the Population health and inequalities committee, which involves linking to the ICS on the wider agenda and ensuring alignment with our strategic planning and performance. | **Patient First:**<br>There are 5 strategic themes which are our priorities as a Trust, which each have clear breakthrough objectives for the year:<br>1. Population and System – "Seeing patients sooner" (accessible care for patients)<br>2. Our People – "Great place to work" (attracting and retaining staff)<br>3. Patient Experience – "Improving patient experience, listen and act"<br>4. Quality Outcomes and Safety – "Save lives, improve patient safety"<br>5. Sustainable Services – "Use NHS pound wisely"(improve timeliness and quality of care for patients) |
| **Domain 3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients.**<br><br>***Action: Workforce data:*** *EDI metric dashboard to supplement the existing WDES/WDES/Gender Pay Gap will assist in identifying opportunities to increase equality and staff health inequalities.*<br><br>Workforce data including Gender Pay Gap Reporting is now complemented by Ethnicity Pay Gap and Disability Pay Gap reports, EDI metric dashboard on hold at present but clear priorities and driver metrics and actions will ensure progress is reported through SDR and other board committees and reports.<br><br>***Patient Health Inequalities data:*** *The Trust has implemented a Population Health and System Committee (a sub-Committee of the Board) that will have oversight of the Trust's programme of work to contribute to the CORE20PLUS5 approach to addressing Health Inequalities. NHS Dorset has implemented several initiatives to enhance access to population-level health data. Notably, quantitative data on demographic factors such as age, gender, and ethnicity are readily available through the Dorset Intelligence Information System (DiiS).* | Improve employee experience and Improve collection and use of all EDI data and compliance against national standards.<br><br>**Patient First:**<br>There are 5 strategic themes which are our priorities as a Trust, which each have clear breakthrough objectives for the year:<br><br>• Population and System – "Seeing patients sooner" (accessible care for patients)<br>• Our People – "Great place to work" (attracting and retaining staff)<br>• Patient Experience – "Improving patient experience, listen and act"<br>• Quality Outcomes and Safety – "Save lives, improve patient safety"<br>• Sustainable Services – "Use NHS pound wisely" (improve timeliness and quality of care for patients) |

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| **Activity:** Collaboration and oversight ongoing through Population Health and System Committee, Dorset System collaboration evident in Domain 1 EDS reporting.<br><br>The Trust has implemented a Population Health and System Committee (a sub-committee of the Board) that will have oversight of the Trust's programme of work to contribute to the CORE20PLUS5 approach to addressing Health Inequalities. EDI patient dashboard, Dorset Intelligence, and Insight Service [DIIS], Population Health MGT Tool is used to identify variations in patient access outcomes and experience. | |

## Domain 1: Commissioned or provided services

| DIIS Bagernet [PALs & Friends and Family] | | | | | |
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| **Domain** | **Outcome** | **Data sources** | **Evidence** | **Rating** | **Owner (Dept/Lead)** |
| ***Domain 1: Commissioned or provided services*** | **1A: Patients (service users) have required levels of access to the service** | ***DiiS*** ***Bagernet*** | **Required level of activity is taking place –** NHS Dorset has implemented several initiatives to enhance access to population-level health data. Notably, quantitative data on demographic factors such as age, gender, and ethnicity are readily available through the Dorset Intelligence Information System (DiiS). Additionally, a comprehensive assessment of data quality has been undertaken by the Dorset System Intelligence Function, which has identified the need for a greater focus on ethnicity recording and made corresponding recommendations. This initiative is further supported by the Dorset Annual Report 23/24 and the governance framework of the Health Inequalities' Unwarranted Variation programme. Quantitative demographic data, including ethnicity, age, and gender, is accessible via the DiiS and is instrumental in supporting case-finding methodologies. This data facilitates targeted interventions and enhances the capacity for monitoring health disparities at a population level. In some service areas, ethnicity data recording exceeds national benchmarks, with certain services achieving 100% adherence to recommended standards. However, where discrepancies in ethnicity data recording exist within NHS Dorset, targeted efforts are in place to address these gaps. These efforts aim to standardise data capture processes, improve staff training, and engage service users in ensuring the accuracy and completeness of ethnicity information. Continuous work is ongoing to further improve these systems and reduce variations in data collection practices. | 2 | *Katie Lake/ Kerry Rostom* |
| | **1B: Individual patients (service users) health needs are met** | ***DiiS*** ***Bagernet*** | **Required level of activity is taking place –** a range of options have been adopted to include both cultural to technical solutions to improve ethnicity information across a range of protected characteristics. Reviewing these initiatives are suggestive of the possibilities that protected characteristics such as pregnancy, maternity, age, and gender will be captured and recorded. Some interventions are: **(1)** University Hospitals Dorset is working with GPs to pull ethnicity data from patient GP records to update their hospital records but will not capture patients without a Dorset GP. This is in the planning stages. **(2**) Dorset County Hospital is focusing on training staff in the Emergency Department, Same Day Emergency Care unit, and Wards to | 1.5 | *Katie Lake/ Kerry Rostom* |

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| | | | improve ethnicity recording. **(3)** Additionally, work on establishing a direct HL7 feed from DiiS into the Trust's data warehouse is underway, (though technical challenges remain). **(4)** Dorset Healthcare is convening ongoing discussions to address workforce data improvements that could provide opportunities for collaboration, and enhanced service delivery through learning. Previous DHC directed efforts to improve ethnicity recording, such as sending letters to patients lacking ethnicity data, however the approach was ineffective due to low response rates (relative to cost). **The score was reduced (by 0.5) due to variations in ethnicity recording across providers and services, despite sufficient population-level data in DiiS to consider a range of protected characteristics.** | | |
| | **1C: When patients (service users) use the service, they are free from harm** | ***DiiS*** <br><br> ***Bagernet*** <br><br> ***Friends and Family Tests*** <br><br> ***PALS Data*** | **Required level of activity is taking place** – DiiS provides quantitative data by age, gender, and ethnic background. The system is useful for proactive case finding. However, some ethnic groups have opted out for using their data. A preliminary analysis indicates no substantial disparities in opt-out rates by ethnicity. The use of DiiS for case finding and evaluating service outcomes is unlikely to increase inequalities from an ethnicity perspective. However, periodic reviews and targeted analyses will be essential to maintain equitable practices. | 2 | *Katie Lake/ Kerry Rostom* |
| | **1D: Patients (service users) report positive experiences of the service** | ***DiiS*** <br><br> ***Bagernet*** <br><br> ***Friends and Family Tests*** <br><br> ***PALS Data*** | **Minimal level of activity is taking place –** To address the barriers to accurate ethnicity data recording and access to care, NHS Dorset is undertaking a series of targeted initiatives designed to enhance the collection of ethnicity and other protected characteristic data. These efforts focus on engaging both staff and service users to improve data accuracy and inclusivity. Engagement strategies include collaboration with key staff networks, particularly within Maternity and Neonatal Services, as well as outreach to migrant health contacts and responses to inquiries from the Patient Experience Team. These activities aim better understanding and communication regarding the importance of recording ethnicity and other protected characteristics. Additional avenues for engagement are being explored through the Integrated Care Board, which includes health inequalities-focused initiatives, Primary Care Networks, and Health and Wellbeing Events. These efforts aim to expand the reach of data collection and address potential inequities in healthcare delivery. One notable initiative is the Conversation Café, launched by Dorset County Hospital, which is specifically designed to reduce variations in ethnicity data recording. The Conversation Café applies innovative, | 1 | *Katie Lake/ Kerry Rostom* |

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| | | | trauma-informed approaches to engage patients and service users in a supportive environment, where sensitive data collection is prioritised. This initiative is closely aligned with NHS Dorset's organisational objectives, focusing on improving both the quality of data and the delivery of patient care. Central to these efforts is the collection of feedback from both patients and service users. This feedback provides critical insights into barriers to data collection and informs the development of interventions. Furthermore, guide cards are being developed, based on input from individuals with lived experience, to help facilitate more accurate and sensitive data collection. These guide cards will be trialled in specific departments within Dorset County Hospital and, if successful, will be expanded across other areas to standardise and improve ethnicity data collection processes. | | |
| **Domain 1: Commissioned or provided services overall rating** | | | | 6.5 | |

| **Targeted Lung Health Checks (In collaboration with NHS Dorset)** | | | | | |
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| **Domain** | **Outcome** | **Data sources** | **Evidence** | **Rating** | **Owner (Dept/Lead)** |
| ***Domain 1: Commissioned or provided services*** | **1A: Patients (service users) have required levels of access to the service** | ***Radiology and Pharmacy Directorate data (UHD) Internal data from Cosmos Data from Cancer Intelligence*** | Dorset was an early adopter of TLHCs ahead of the National screening programme, prioritising local areas of highest deprivation, where the most minority communities live. The service is delivered from acute hospital sites, well placed to meet needs including reasonable adjustments. Any alternative mobile service would be challenged by rural accessibility and digital network access. From the data available on uptake and experience, people with protected characteristics report good experiences and uptake is in line with expected cohort data, the exception is working-aged people, for whom additional engagement is proposed. There is provision for people who move into Dorset to continue accessing services; a safety net, invites are repeated every two-years, and opt-in anytime or opt-out options. A gap identified is access for people in prison (there are two adult prisons in Dorset) and homeless people, as individuals at higher risk of experiencing health inequalities. | 2 | *Katie Lake/ Kerry Rostom* |
| | **1B: Individual patients (service users) health needs are** | ***Radiology and Pharmacy Directorate data (UHD)*** | Individual needs are collected as part of a risk-scoring profile for the TLHC and LDCT scan, including questions on reasonable adjustments. The TLHC is a first contact digital/telephone offer, however, where requested this can be facilitated face-to-face to meet needs. Impact is demonstrated in Portland where Late-Stage | 2 | *Katie Lake/ Kerry Rostom* |

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| | **met** | ***Internal data from Cosmos Data from Cancer Intelligence*** | diagnoses in 23/24 dropped to 21.4% - meeting the national 25% target and significantly below Dorset average of 65% for Lung Cancers. As with all screening activity there are 'incidental findings' from LDCT scans and the local policy ensures identified health needs are met by GP's and allied specialities. Patient records document signposting to local services e.g. Community Smoke Stop, however, end to end data on uptake is poor. | | |
| | 1C: When patients (service users) use the service, they are free from harm | *Radiology and Pharmacy Directorate data (UHD) Internal data from Cosmos Data from Cancer Intelligence* | TLHCs in a national screening programme, which has met all clinical safety requirements, based on the results of robust clinical trials. The programme has 15 quality standards B1647-quality-assurance-standards-targeted-lung-health-checks-programme-v2.pdf. In Dorset, the service providers have robust policies and procedures for managing adverse incidents and monitoring quality, which can be interrogated at TLHC level. TLHC is on the Trust risk register as data is managed locally until a national data system is implemented. There is a policy and strong pathways for supporting patients where 'incidental findings' are made for non-lung cancer investigations or care. Patient information ensures participants are aware of the risks and benefits of the TLHC, LDCT scans and management of incidental findings. There is a risk from harm, where patients who are referred for LDCT scans Did Not Attend, and it proposed to deep dive to recommend any improvements, including where there are differences by protected characteristics e.g. Sex and Age. | 2 | *Katie Lake/ Kerry Rostom* |
| | 1D: Patients (service users) report positive experiences of the service | | Patients experience data is available through National and local surveys, however, the results are not analysed by protected characteristics. National surveys are limited without TLHC as route of diagnosis as a presentation. National surveys are presented at ICB and Trust level, for the ICB there were no scores below the expected range and there were no significant differences for respondents' experience of care by tumor type, age, sex or ethnicity, all reporting >9 as the average rating. A Dorset patient survey and recent Friends and Family test results reflect positively on their experience of care; however, additional qualitative feedback would provide insights for improvement and better inform commissioning decisions, including plans for the TLHC programme to roll out countywide. Improving communication and engagement is a key recommendation. | 1 | *Katie Lake/ Kerry Rostom* |
| **Domain 1: Commissioned or provided services overall rating** | | | | 7 | |

## Domain 2: Workforce health and well-being

| Domain | Outcome | Data sources | Evidence | Rating | Owner (Dept/Lead) |
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| ***Domain 2: Workforce health and well-being*** | 2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD, and mental health conditions | **UHD NHS Staff Survey 2023**<br><br>•Q9d Immediate Manager takes a positive interest in my health and wellbeing<br><br>•Q11a Organisation takes positive action on health and wellbeing<br><br>Occupational Health data<br><br>Psychological and Counselling services (PSC) data<br><br>UHD Building Healthy Working Lives Strategy<br><br>UHD Managers/Staff Winter Wellbeing guidance document<br><br>Employee Assistance Programme (EAP) | UHD continues to invest in supporting staff health and wellbeing. For UHD NHS staff survey results under the People Promise theme "We are compassionate and inclusive" we maintained a score of 7.38, compared to the national average of 7.24.<br><br>The Healthy Working Lives strategy outlines goals to encourage staff to improve both their physical and mental wellbeing co-led by Occupational Health (OH), the Psychological Support & Counselling Service (PSC) and Organisational Development (OD) and governed by the Healthy Working Lives Governance meeting once a quarter. Updates are fed through to the UHD People and Culture Committee to the Board.<br><br>The Healthy Working Lives working group has been re-energised, is data driven which supports proactive review of internal wellbeing services. Healthy Working Lives strategy will be replaced by the Health and Wellbeing Plan as part of the People and Culture Strategy (approved at Board January 2025).<br><br>The UHD Cosmos system reports sickness absence data, but no option is currently available to review by protected characteristic.<br><br>**Occupational Health Services (OH)**<br>OH, provides a comprehensive range of individual support for staff on health and wellbeing which includes support for obesity, diabetes, asthma, and COPD as well as many other health conditions. The Employee Assistance Programme is managed by OH and provides a health-related portal for staff.<br><br>From April 2024 to November 2024 there were 4488 referrals for staff support to Occupational. Musculoskeletal conditions remain a high percentage of OH utilisation by staff.<br><br>OH, currently only monitors minimal protected characteristics due to the limitations of the current eOPAS(electronic Occupational Health | 3 | Gemma Lynn, Head of Occupational Health<br><br>Dr Lorin Taranis, Head of PSC<br><br>Sorcha Dossitt, Workforce Health and Wellbeing Development Lead |

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| | | | Management System) which is due to be upgraded in February 2025. The current EAP (Employee Assistance Programme) provider does not provide protected characteristic data.<br><br>Onsite, NHS Health Checks, carried out by Livewell Dorset, have been offered to staff throughout 2024. Emphasis placed on advertising these session to our Global Majority workforce; term adopted at UHD and nationally to replace BME (Black and Minority Ethnic) and to avoid negative implications to the term minority by linking with the DEN (Diverse Ethnicity Network) staff network.<br><br>UHD provided access to Interactive Health Kiosks over a 4-month period during 2024. 22% of staff accessing a health MOT from the kiosks were from a diverse ethnic background.<br><br>**Psychological Support and Counselling Service (PSC)**<br>PSC is a specialist service providing totally confidential support for staff affected by stress and mental health. Run by a Consultant Clinical Psychologist with a team of BACP accredited Counsellors and Psychological Support Practitioners, PSC provides assessment and a range of specialist support interventions as well as signposting and referral to external services. Staff can access this service via self-referral and are supported to attend during their working hours where possible. From January 2024 to (18th) December 2024 there were 598 referrals into PSC, in line with the previous year.<br><br>For the period of January to December 2023 a total of 612 staff accessed the service (36% increase)<br><br>PSC collect data on protected characteristics from the self-referral form.<br><br>**UHD Health & Wellbeing Champions**<br>The UHD Health & Wellbeing Champion team remain a positive force for wellbeing influence with over 80 Champions actively promoting and signposting staff to relevant wellbeing offerings and providing feedback on these services.<br><br>UHD Health and Wellbeing has been rebranded as Thrive Wellbeing with | | |

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| | | | a fresh new easy read format to help staff where English is not their first language. A monthly Thrive Hub information poster signposting staff to wellbeing information and services is distributed via the usual communication channels as well as via the Champions.<br><br>Thrive Live UHD Wellbeing Fair took place during March; evidence-based sessions ran over 5 days including seminars, webinars, health assessments and guidance sessions. 3179 staff engaged during the week and an online repository of recordings was curated to facilitate continued utilisation of the resources post-event.<br><br>Livewell Dorset conducted 199 health checks for the staff at UHD sites; of these checks, a majority were for female staff members. 12% of clients were from other ethnic backgrounds and 7% from Global Majority. Live Well Dorset confirmed the overall number of clients from Global Majority communities for health checks has risen significantly this year in Bournemouth Christchurch and Poole area which is reflective of community engagement the wellbeing team has done. The trust organised a health check event for Global Majority staff whilst celebrating Black History Month in October.<br><br>UHD's Wellbeing check-in conversation framework has been launched and promoted to all staff. A supportive, coaching-style one-to-one discussion focused on empowering individuals while also building individual and team resilience.<br><br>UHD Winter Wellbeing guidance for both staff and managers were refreshed and promoted in November 2024.<br><br>The UHD Library service across Bournemouth and Poole commission and promote many staff wellbeing books and regularly promote via display board.<br><br>*Associated 2023 NHS Staff Survey responses*<br>*Q9d – Immediate Manager takes positive interest in my Health & Wellbeing*<br><br>70.6% UHD positive responses – a 2.4% increase with consistent | | |

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| | | | improvement.<br><br>Protected characteristic groups citing less favourable response include male staff 68%, staff identifying as Gay/lesbian 66.4%) and staff over 66 years of age improved to 68.9% compared to 61%last year and age group of 16-20 years of age only 64.7%<br><br>Staff with Disability 70.37%with an improvement of 1.9% | | |
| | 2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source | **UHD NHS Staff Survey 2023**<br><br>• Q13a Not experienced physical violence from patients<br><br>•Q13c Not experienced physical violence from colleagues<br><br>•Q14a Not experienced harassment, bullying, abuse from patients<br><br>•Q14b Not experienced harassment, bullying abuse from managers<br><br>•Q14c Not experienced harassment, bullying or abuse from colleagues<br><br>UHD Civility, Respect and Dignity at Work Policy<br><br>2023 Freedom to Speak Up Report | University Hospitals Dorset is committed to nurturing an inclusive environment where racism, discrimination, or abuse are not tolerated. The trust actively celebrates the diversity of its staff and community ensuring that everyone is treated with dignity and respect regardless of their race, gender, religion, age, disability, and sexual orientation. The trust's LERN reporting form effectively captures individual data on instances of discrimination when reported. Our WRES 2024 shows positive movement across most four metrics and the Global Majority representation is now 23.8%. Our WDES 2024 shows positive movement across some of our metrics and Disability disclosure is now 6.3% compared to 5.6% last year.<br><br>**See ME First** is a staff-led initiative to promote equality, diversity, and inclusivity. It requires colleagues to challenge and work together towards ending racism and discrimination in the workplace. UHD is the first Trust in the Southwest to launch this campaign.<br>The initiative aims to make real change to our organisation's culture, creating a more inclusive, open, and non-judgemental work environment in which all staff are treated with dignity and respect.<br>The 'See ME First' campaign continues to be implemented at the departmental level, through ED& I sessions, Conscious Inclusion workshops and preceptorship programmes to promoting a workplace culture that encourages Listening, Speaking Up, providing support and challenging discrimination and poor behaviours. Around 2000 staff members including senior leaders across UHD sites have committed to this campaign.<br><br>**An Anti-Racism/Discrimination guidance** for staff and managers has been published in 2024 in conjunction with the DEN, including an Anti- | 3 | Deepa Pappu, EDI Lead<br><br>Helen Martin, FTSU Guardian<br><br>Lisa White, Human Resources<br>Stacey Fuszard Head of Security and Portering |

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| | | | Racism and wider Discrimination statement from the Board, improved reporting mechanisms and associated supportive actions.<br><br>The EDI team in collaboration with Dorset ICS, launched '**Conscious Inclusion'** workshops addressing topics such as cultural competence, bias, prejudice, discrimination, racism, microaggressions, power and privilege. Plans are underway to make these sessions mandatory for colleagues involved in recruitment and management.<br><br>Following the success of 2023, a second **Cultural Celebration** event was held in July across three sites, organised by a core committee from diverse cultural and professional backgrounds with support from staff networks and executive sponsorship from trust board member. The event was a tremendous success, attracting over 2,000 colleagues across all sites. Further celebrations will be planned for 2025.<br><br>**Black History** Month was celebrated with key events across sites, featuring a collaboration with an organisation called DEED to educate and highlight Dorset's hidden Black History. Additionally, various departments held smaller events to celebrate diversity, learn about Black heritage from colleagues and promote integration and understanding.<br><br>It has been acknowledged that inappropriate behaviours from staff, patients and visitors occur at UHD. A **Behaviour Charter** is currently being developed (BC) providing explicit messages on the standards we expect at UHD for everyone and contribute to our objectives of being a great place to work, attracting and retaining best talent and delivering excellent care.<br><br>UHD signed the **Sexual safety in healthcare organisational charter** in 2024. The organisation is committed to a zero-tolerance approach to any unwanted, inappropriate sexual behaviours towards to any staff members. The sexual harassment policy and eLearning package is in the final stage of development. The Conscious Inclusion workshops also facilitate discussions on a sexual harassment case study and emphasis on the importance of creating a safe workplace and promote a culture of openness that does not tolerate unwanted harmful and inappropriate sexual behaviour. | | |

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| | | | Infrastructure to support staff experiencing abuse, harassment, bullying, and physical violence includes the Civility, Respect and Dignity at Work Policy. This is changing to resolution policy and Human Resources has adopted a restorative, just and learning cultural approach with respect to staff support and issues.<br><br>The **Violence Prevention and Reduction** Policy 2022 at UHD encourages staff to report inappropriate patient behaviour, supported by a Respect poster campaign aimed at reducing abuse. While feedback indicates the incident reporting system is lengthy and not user-friendly, there has been an increase in reporting, reflecting a positive shift in reporting culture. A review of harassment incidents shows a decline in incidents across various groups, suggesting that staff are more inclined to report violence and aggression, which is a positive outcome. Of all the reported 5744 security, violence, and aggression incidents between 2021-2024, 3222 were attributed to physical or non-physical violence. Engagement with the Communications team has been established and some crime prevention advice shared with plans to provide some additional material highlighting Trust statistics around violence and aggression and relevant updates/articles to help support staff. The team are approached direct from wards and departments to offer ad hoc advice/support. Some of the work at UHD being done to tackle violence ad aggression are as below:<br><br>• **Appointment of Head of Security** and Portering **(HoSP**) on 3rd March 2024<br>• **In House Security**- Currently appointed 20 in house security.<br>• **Monthly incident summary**: Each month, the Head of Security and Protection (HoSP) or deputy summarises of all violence and aggression incidents across the Trust, highlighting top reporting areas and comparing them to the previous period.<br>• **Violence Prevention and Reduction Standards (VPRS):** These standards were reviewed as part of the VPR Group which is chaired by the deputy COO and further review is being undertaken for the October 2024 meeting.<br>• **Work plan for HoSP:** Targeted approach to tackling security issues across UHD. | | |

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| | | | • **Violence and Aggression Risk Assessments (V&A RA):** A comprehensive review of security, violence, and aggression risk assessments identified the top 10 reporting areas across UHD, which have been approached to review and update their assessments.<br>• **Sanctions:** The HoSP ensures all warning letters are logged and sent, ensuring repeat offenders receive appropriate warnings.<br>• **Training- Management of Violence and Aggression:** Apart from the existing Conflict Resolution for all frontline staff, additional Prevention and Management of Violence and Aggression (PMVA) is available to Security, Porters, Clinical Site Management Team as well as all managers in Emergency Department as well as breakaway techniques.<br>• **Police engagement:** Links have been re-established with Dorset Police giving the ability to quickly ascertain an update following an incident or concern being raised.<br>• UHD has a respected **Freedom to Speak Up (FTSU**) Guardian and team. The Freedom to Speak Up Guardian reports annually to the Board on data relating to cases raised via the FTSU team and 44% of cases were related to poor behaviour including abuse, harassment, bullying and physical violence. The FTSU concerns raised are confidentially recorded and include ethnicity.<br><br>The **Mangers' Induction Programme** is designed to promote compassionate leadership and effective management practices, equipping managers to handle a wide range of issues including those highlighted in the Civility and Respect campaign. Our vision is to improve miscommunication and poor behaviour by empowering staff to challenge unacceptable behaviour and support the culture of civility and respect.<br><br>*Associated 2023 NHS Staff Survey responses*<br><br>***Q13c** – In the last 12 months how, many times have you personally experienced physical violence at work from other colleagues (**Never**).*<br>98.6% UHD positive responses, 0.1% increase.<br>Protected characteristic groups citing less positive response for those | | |

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| | | | identifying as Gay/Lesbian 97.7% and BME colleagues especially White and Black Caribbean 90.9% and White and Asian 90.3%<br>***Q14a -*** *In the last 12 months how, many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives, or other members of the public (**Never**)*<br>73.5% UHD positive response, 2.4% increase from last year.<br>Protected characteristic groups citing less positive response include staff 16-20 years of age 41.2% and 21-30 years of age 67.3%<br>Staff with a Disability,74.1%3.1%improvement compared to last year.<br>BME staff 69.7% (last year 65.9%) 3.8% positive response<br><br>***Q14b*** *– Not experienced harassment, bullying or abuse from Managers*. (**Never**)<br>92.5% UHD positive responses, 2.6% increase.<br>Protected characteristic groups citing less positive experience include Age above 66+years 89.3%<br>Disabled staff 93.2% with 3% improvement from last year.<br>Gay/Lesbian groups 89.2%<br><br>***Q14c*** *– Not experienced harassment, bullying or abuse from colleagues (**Never)***<br>83.4% UHD positive responses, increase of 3.2% positive response.<br><br>Protected characteristic groups citing less positive experience include Disabled staff 83.35%, improvement of 3.2% from last year.<br>Gay/Lesbian 78.5% only<br>The positive response of 77.6% for BME colleagues an improvement from 70.9% with an increase of 6.7% from last year. | | |
| | 2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying | **UHD NHS Staff Survey 2023**<br><br>•Q14d – Last experience of harassment/bullying/abuse reported.<br><br>•Q13d – Last experience of physical violence | Options for staff to raise concerns relating to stress, abuse, bullying, harassment, and physical violence include raising with their manager, raising a LERN form via the Risk and Governance directorate, Occupational Health, Human Resources, EDI lead, Staff Network leads, Trade Union representatives as well as the Freedom to Speak up Team. The **LERN** form is amended to capture specific discriminations when reported by staff.<br><br>There is a well embedded **Freedom to Speak Up** service which is regularly promoted. In the 2023/24 FTSU Annual Report it confirms that | 2 | |

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| | harassment and physical violence from any source | reported.<br><br>2023/24 FTSU Annual Report<br><br>TRiM data | 412 concerns were raised by staff; 44% (188 staff) included an element of inappropriate attitudes and behaviours.<br><br>**Staff Networks** including Pride (supporting LGBTQI+ staff), Women's Network, EU Network, Armed Forces Network, Pro- Ability Network and Disability Ethnic Networks all offer signposting and guidance to relevant services. Staff networks play a crucial role in supporting their members by providing guidance, resources, and a sense of community. They also advocate for the needs and concerns of their members, ensuring their voices are heard within the trust. Additionally, these networks collaborate to promote diversity, inclusion, and a supportive work environment for all staff.<br><br>Staff can utilise the Health and Wellbeing Champions and Mental Health First Aiders for confidential support and signposting in addition to self-referring to the UHD Psychological Support and Counselling Service<br><br>**The UHD Trauma Risk Management Programme** (TRiM) supports staff and line managers who have been through a potentially traumatic event. This is a peer-led process facilitated by 19 TRiM Managers. 41 referrals were made for a TRiM intervention (23/24).<br><br>*Associated 2023 NHS Staff Survey responses*<br>***Q14d –*** *The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it? If they said* ***yes.***<br><br>46.6% UHD positive responses, improvement of 2.5%<br>Only 45% White colleagues and colleagues from Mixed ethnicity reporting 42.1% and Black African colleagues reporting 63.9%.<br>Protected characteristic groups citing less favourable response include 21–30-year group with 38.1%. with a 3.6% reduction in reporting.<br>Disabled staff 46.6% with improvement of 2.1%from last year.<br><br>***Q13d*** *– The last time you experienced physical violence at work, did you or your colleague reported? If yes*<br><br>*70.1% UHD positive responses.*<br>*Protected characteristic groups citing less favourable responses include* | | |

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| | | | *21- 30-year age group (64.9.9% with a 3% increase in reporting and Bisexual 65% Mixed ethnic groups reporting only 54.5% Disabled staff 70.1 % compared to 67.26 with an increase of 3.16%* | | |
| | 2D: Staff recommend the organisation as a place to work and receive treatment | **UHD NHS Staff Survey 2023**<br><br>•Q21c – Would recommend the organisation as a place to work<br><br>•Q21d – Would recommend as a place for treatment<br><br>UHD Patient First strategic objectives<br><br>UHD Annual EDI and Workforce Profile Report 2023 | In 2023, UHD launched **Patient First**, a quality management system and a long-term approach to building improvement into everything we do. In 2023, UHD has a People and Culture strategy that will deliver objective 2 and support others. "When staff thrive, our patients thrive. It is a proven fact that patients get better care in hospitals where staff feel able to make a difference."<br>The mission is "To provide excellent healthcare for our patients and wider community and to be a great place to work, now and for future generations."<br><br>There are 5 strategic themes which are our priorities as a Trust, which each have clear breakthrough objectives for the year:<br><br>• Population and System – "Seeing patients sooner" (accessible care for patients)<br>• Our People – "Great place to work" (attracting and retaining staff. This will be monitored and implemented through the new People and Culture Strategy)<br>• Patient Experience – "Improving patient experience, listen and act"<br>• Quality Outcomes and Safety – "Save lives, improve patient safety"<br>• Sustainable Services – "Use NHS pound wisely" (improve timeliness and quality of care for patients)<br><br>There are differing responses for this question in relation to recommendation for a place to work and a place for treatment:<br><br>The UHD Co-ordinated support programme enables a quick pathway to urgent wellbeing support and is promptly reviewed by OH, PSC and FTSU Guardian.<br><br>***Q25c*** *– Would recommend the organisation as a place to work*<br>63.7% UHD favourable responses, 7.4% increase in total. | 1 | |

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| | | | White colleagues 61.7% less than the Trust average, with 6.7% improvement from last year.<br><br>Protected characteristic groups citing less favourable responses include Disabled staff (63.2%, 7.24% increase from last year Gay/Lesbian 61.1%.<br><br>Protected characteristic groups reporting more favourable responses include BME 73.6% with 8% increase and Male staff 61.9% with 2.9% increase from last year)<br><br>***Q25d*** *– Would recommend as a place for treatment*<br>67.4% UHD positive responses with 3.1% increase<br>Only 66.3% White colleagues less than the Trust average.<br>Protected Characteristics groups citing less favourable responses include disabled staff 60.3% and Gay/Lesbian 71.8%, better than the Trust average.<br>Disabled staff –67.33% with 3.1% increase<br>73.9% BME colleagues compared to 71.4% with 2.5%increase. | | |
| | | | **Domain 2: Workforce health and well-being overall rating** | 9 | |

## Domain 3: Inclusive leadership

| Domain | Outcome | Data sources | Evidence | Rating | Owner (Dept/Lead) |
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| ***Domain 3: Inclusive leadership*** | 3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities | UHD Equality Diversity and Inclusion Strategy<br><br>Equality Diversity and Inclusion Group minutes<br><br>People and | **Workforce**<br>**Culture plans**<br>UHD aspires to have culture plans in place at specialty and corporate directorate level, which will be regularly reviewed through Care Group and Corporate Service Board meetings with oversight via Strategic Deployment Review [SDR] meetings by 31st March 2026. These culture plans will include metrics taken from WRES / WDES. This approach will help to create a better understanding on their culture and what improvements can be made. | 3 | For Patient Health Inequalities:<br><br>Dr Peter Wilson, Chief Medical Officer<br><br>Judith May, Director of |

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| | | Culture Committee minutes<br><br>Workforce Race Equality Standard (WRES)<br><br>Workforce Disability Equality Standard (WDES)<br><br>Gender Pay Gap Report | The UHD leadership behaviours have been reviewed to reflect and incorporate the **Patient First** approach whilst aligning to our Trust values and expectations and the aspirations of our leaders. Through the Patient First methodology, one of the key equality objectives for UHD is to have a representative workforce at all levels of the Trust and has been supported by the Trust Board members.<br><br>Three senior leaders in UHD attended the Dorset **Leading for Inclusion Change Agent's Programme** last year. The aim of this bespoke programme was to develop a pool of approximately 25-30 senior leader representatives from all sectors across Dorset in 'Leading for Inclusion.'<br><br>The implementation of the UHD Equality, Diversity and Inclusion Strategy was monitored through an EDI Group (EDIG) in 2021 and now through People and Culture Group, chaired by Chief People's Officer.<br><br>In 2024, EDIG reported to PCC (People and Culture Committee) for assurance or interventions and Trust Management Group (TMG) for approval.<br><br>Within the People and Culture Strategy and the Patient First Programme our EDI objectives are aligned:<br><br>***We aim 'To have a representative workforce at all levels of the Trust.'***<br><br>To do this we will implement our One Team EDI Plan priorities:<br>**To deliver Conscious Inclusion Workshops**<br>**Introduce a more inclusive approach to recruitment.**<br>**Develop a simple and clear approach to reasonable workplace adjustments.**<br>**Consolidate audit review findings of Staff networks and provide greater alignment with UHD objectives while** | | Operational Performance and Oversight<br><br>For Staff Equality and Health Inequalities: Deepa Pappu, EDI Lead<br><br>Deborah Matthews, Director of Organisational Development (Patient First) |

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| | | | **strengthening their roles and purpose.**<br><br>A Board member is also the lead for addressing staff health inequalities. In addition to the existing Board development plan, additional Board development is commissioned through Southwest NHS England.<br><br>The EDI updates are now reported through the UHD People and Culture Committee to the Board of Directors. Reports include:<br><br>**EDI Annual report and workforce plan**<br>**Workforce Race Equality Standard (WRES) Report and Action Plan**<br>**Workforce Disability Equality Standards (WDES) Report and Action Plan**<br>**Gender Pay Gap report**<br>**Modern Slavery Statement**<br><br>**T**rust Board members are also active sponsors of our UHD Staff Network Groups:<br>DEN Network –Sarah Herbert, CNO<br>Women's Network – Peter Wilson, CMO<br>EU Network – Richard Renaut<br>ProAbility Network -Tina Ricketts, CPO<br>Armed Forces – Abigail Daughters<br>Pride Network – Pete Papworth CFO<br><br>Following the success of 2023, a **second UHD-wide Cultural celebration** was in July and was supported by Exec Board sponsors and Exec and Nonexecutive Directors (NED) across all three trust sites and was attended by over 2000 staff members. Several key engagement events supported by the Exec and NED team such as UHD Pride event, Purple Light Up and Menopause Awareness championed inclusion at UHD. This year's Black History Month (BHM) was celebrated extensively in UHD. | | |

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| | | | The Development Education in Dorset (DEED) was commissioned to celebrate and educate the Black History within Dorset.<br><br>During the period of Civil Unrest in the UK, CEO and Exec team led **regular listening events** supported by Communication Team, to support colleagues from Global Majority. This engagement helped to create an awareness of the real impact on Global Majority colleagues and made a noticeable improvement in allyship and support as per the feedback during the last listening event. Some affected colleagues were offered companionship support for activities like shopping, outings, and house visits to promote psychological safety and strengthen community connections. As part of the CPO's initiative to address potential travel risks faced by colleagues from ethnic minority communities, several supportive measures were introduced during this period. Messages were sent out to mangers to specifically check wellbeing of the colleagues from Global Majority and take actions on daily basis and offer shared travel options whenever possible. Additionally, a comprehensive Travel Risk Checklist was developed to help managers identify potential risks, raise awareness, and ensure the necessary support is offered to individuals where risks are present. These steps aim to enhance safety and inclusivity for affected colleagues. There is a plan in place to hold bi-monthly listening events, facilitated by CEO.<br><br>In September 2024, UHD in collaboration with BU, held a **leadership conference**, commissioned through CEO, and supported by our Executive Board. This was attended by Dr Habib Naqvi, the Director, NHS Race Observatory. Health inequalities and race was discussed in the conference. In collaboration with DEN, **Dr Habib Naqvi then facilitated a focus group** in person and on-line to UHD colleagues. The key points from the focus group discussion supported our plan to prioritise the following workstreams.<br><br>**Conscious Inclusion workshop** was launched in Sept 2024 | | |

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| | | | working in collaboration with ICS with Exec sponsorship. The workshop discusses the concept of anti-racism, cultural competency, bias, and discriminations that occurs to protected characteristics. The session encourages attendees to be responsible for their own behaviour and to hold others accountable for inappropriate actions or for failing to take necessary actions when required<br><br>***Patient Health Inequalities-***<br><br>UHD has appointed Dr Peter Wilson, Chief Medical Officer as lead for Patient Health Inequalities supporting Dr Judith May, Director of Operational Performance and Oversight responsible for Patient Health Inequalities linked to the ICS Strategy for Health Inequalities.<br><br>The UHD Health Inequalities Programme Board's vision is to deliver healthcare interventions which support equity of access, experience, and outcomes for people. The objectives being:<br><br>To identify and bring together all existing initiatives regarding health inequalities and enable and support priority areas for interventions<br>To build a community of interest through Trust-wide engagement<br>To normalise and standardise reporting on health inequalities<br>To objectively quantify, characterise and report on access, experience, and outcomes for patients.<br><br>Health inequalities data is now included within the Trust's board reports.<br><br>Population Health and System Committee established with 'quarterly' meetings. Receives update on service equality monitoring in key patient pathways. Integrated Performance Report includes data on elective waits, deprivation, and ethnicity separately. | | |

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| | 3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed | Board minutes<br><br>Equality Diversity and Inclusion Group (EDIG) minutes<br><br>People and Culture Committee minutes<br><br>Workforce Race Equality Standard (WRES)<br><br>Workforce Disability Equality Standard (WDES)<br><br>Gender Pay Gap Report<br><br>NHS Staff Survey<br><br>EDS2<br><br>Occupational Health updates<br><br>Equality Impact Assessments | **Workforce**<br>The Board and People and Culture Committee are provided with reassurance on progress of EDI national compliance requirements such as WRES/WDES/Gender Pay Gap and EDS2, via TMG. Annual report and Modern slavery statement also published annually with the same approach.<br>EIA for policies provide additional reassurance regarding inclusive decision-making.<br><br>Occupational Health regularly provide specific staff risk assessments (Global Majority, disabled, pregnant staff) as appropriate with respect to their campaigns e.g. COVID vaccinations.<br><br>The Binder Dijker Otte (BDO) was commissioned by UHD for an internal audit for maturity assessment completed in 2023 to measure UHD's EDI progress.<br><br>UHD Board Assurance Framework contains a reference to inclusion introduced through the People and Culture strategy.<br><br>**Patient Inequalities**<br>Population Health and System Committee established with 'quarterly' meetings. Receives update on service equality monitoring in key patient pathways. Integrated Performance Report includes data on elective waits dis-aggregated by deprivation and ethnicity.<br>Health Inequalities now form part of the Board Assurance Framework. | 2 | |
| | 3C: Board members and system leaders | Equality Diversity and Inclusion | **Workforce**<br>The Healthy Working Lives Group and EDIG were facilitated by | 2 | |

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| | (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients | Group minutes<br><br>People and Culture Committee minutes<br><br>Workforce Race Equality Standard (WRES)<br><br>Workforce Disability Equality Standard (WDES)<br><br>Gender Pay Gap Report<br><br>NHS Staff Survey<br><br>Patient Health Inequalities Programme updates<br><br>Patient Engagement team updates | either a Non-Executive Director or a Director to ensure that performance was effectively monitored. Performance is reviewed through People and Culture Committee and at the Board.<br><br>National EDI governance frameworks such as WRES/WDES/Gender Pay Gap/EDS2 all provide evidence and action plans to monitor progress and are adopted within the organisation. Assurance updates are provided through NHS England Southwest and Dorset ICS. They include NHS EDI Improvement plan progress and 6 High Impact Actions. This is cited by CPO.<br><br>The Trust executive sponsors are active with the UHD Staff Network Groups and provide additional opportunities for monitoring the effectiveness of equality and health inequalities in practice. Executive sponsors are actively supporting staff network events, including Trust wide Cultural Celebration, UHD Pride event, menopause awareness initiatives, the Purple Light Up event, Transgender Remembrance Day and listening events aimed at supporting colleagues during civil unrest. Executive sponsors actively make efforts to attend network meetings whenever possible and serve as key points of contact for escalation.<br><br>Exec sponsors are engaged with the Reverse Mentoring (RM) programme facilitated by ReMEDI, supported by EDI team, and funded. The 3rd RM programme was successfully completed.<br><br>The ICB are also reviewing equality data, plans and progress at a system level; leverage from collaborative working across Dorset organisations will support the improvement of this data.<br><br>The BDO Auditors undertake periodic reviews of our EDI progress. Actions are monitored through audit committee. In 2024, an additional audit was commissioned to review the alignment of Staff Networks with Trust objectives. Staff Network alignment is one of the EDI objectives. A Project Support Officer | | |

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| | | | has been recently appointed through charity funding to support network activities.<br><br>**Patient Health Inequalities**<br>The Trust has implemented a Population Health and System Committee (a sub-committee of the Board) that will have oversight of the Trust's programme of work to contribute to the CORE20PLUS5 approach to addressing Health Inequalities. EDI patient dashboard, Dorset Intelligence, and Insight Service [DIIS], Population Health MGT Tool is used to identify variations in patient access outcomes and experience. | | |
| | | **Domain 3: Inclusive leadership overall rating** | | 9 | |

| **Third-party involvement in Domain 3 rating and review** | |
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| **Trade Union Rep(s):**<br>Staff Side Representatives | **Independent Evaluator(s)/Peer Reviewer(s):**<br>Dorset Healthwatch<br>Staff Network Leads |

| EDS Organisation Rating (overall rating):<br><br>**Achieving** |
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| Organisation name(s):<br><br>**University Hospitals Dorset NHS Foundation Trust** |
| Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**<br><br>Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**<br><br>Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**<br><br>Those who score **33,** adding all outcome scores in all domains, are rated **Excelling** |

Scoring comparison 2023/24 and 2024/25

| Domain | 2023-24 | | 2024-25 | | Stakeholders |
|---|---|---|---|---|---|
| **Domain 1 Patient services** | *End of Life 9*<br>*Falls 10*<br>*ENT 4* work continued after submission* | 9 | *DiiS 6.5*<br>*Lungs 7* | 7 | • Scored through collaboration with ICS colleagues |
| **Domain 2 Workforce Health and Wellbeing** | 6 | | 9 | | • External score<br>• Stakeholder Survey<br>• Department Leads |
| **Domain 3 Inclusive Leadership** | 3 | | 7 | | • External score |
| **Overall Assessment** | **18 developing** | | **23 achieving** | | Scoring fluctuations are likely due to improved stakeholder responses and process becoming more established. |

| EDS Action Plan | |
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| **EDS Lead** | **Year(s) active** |
| Deepa Pappu, Organisational Development, EDI<br>Jon Harding, Head of Organisational Development | Plan for April 25 – March 26 |
| **EDS Sponsor** | **Authorisation date** |
| Deb Matthews, Director of Organisational Development | 18 February 2025 |

| DIIS Bagernet [PALs & Friends and Family]<br>[note that not all actions will be undertaken at UHD] | | | | |
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| **Domain** | **Outcome** | **Objective** | **Action** | **Completion date** |
| **Domain 1:**<br><br>**Commissioned or provided services** | **1A: Patients (service users) have required levels of access to the service** | Utilise Data for Proactive Case-Finding and Health Inequalities Monitoring. | Continue to leverage ethnicity data for proactive case-finding and health inequalities monitoring, ensuring that missing or incomplete data does not disproportionately affect health outcome evaluations.<br><br>Regularly review ethnicity data capture processes, including opt-out rates, and ensure any missing data does not introduce biases into health outcomes analyses.<br><br>Implement periodic audits to track and address gaps in ethnicity data that could affect decision-making or patient care<br><br>Implement training and awareness campaigns to emphasise the importance of ethnicity data for improving patient outcomes, particularly at the grassroots level. This should be complemented by guidance on how ethnicity recording contributes to better healthcare services and outcomes, helping staff understand its value in clinical and operational contexts. | Q4 2025/26<br><br>Review progress Q2 2025/26 |
| | **1B: Individual patients (service** | Improve Staff Engagement and Ownership of Data Recording | Seek clarification on the difference between clinical system and reportable ethnicity, for the purposes of | Q4 2025/26 |

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| | **users) health needs are met** | | reporting and analysis for service improvement.<br><br>Integrate ethnicity data recording into quality assurance processes to encourage consistent adherence.<br><br>Develop contingency plans to manage periods of increased workload to prevent the decline in data quality due to capacity pressures. | Review progress Q2 2025/26 |
| | **1C: When patients (service users) use the service, they are free from harm** | Enhance Data Quality through Targeted Engagement with Minority Populations | Strengthen engagement with minority ethnic groups, particularly those who have opted out of sharing ethnicity data, to understand and address their concerns.<br><br>Explore opportunities to engage underrepresented groups in feedback surveys to ensure demographic representation aligns with the patient population.<br><br>Use community-based outreach and culturally tailored initiatives to encourage participation in data collection, ensuring that all ethnic groups feel comfortable and valued when providing their information. Consider working with local communities to better reach diverse populations. | Q4 2025/26<br><br>Review progress Q2 2025/26 |
| | **1D: Patients (service users) report positive experiences of the service** | Develop Culturally Sensitive and Trauma-Informed Data Collection Practices | Focus on improving communication strategies and workforce capability and such as knowledge, skills, and attitude) by implementing trauma-informed, culturally sensitive training.<br><br>Incorporate culturally competent communication into training modules, highlighting the ethical and clinical importance of ethnicity data. Consider using patient-facing materials, such as guide cards or patient information sheets, to explain why ethnicity data is collected and reassure patients about its confidentiality and benefits. | Q4 2025/26<br><br>Review progress Q2 2025/26 |

| Targeted Lung Health Checks<br>[In collaboration with Dorset: note that not all actions will be undertaken at UHD] | | | | |
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| **Domain** | **Outcome** | **Objective** | **Action** | **Completion date** |
| **Domain 1: Commissioned or provided services** | 1A: Patients (service users) have required levels of access to the service | Improve public/population awareness of the TLHCs programme. | Develop a communications and engagement plan, which is informed by patients, and increases confidence in the TLHC offer, including for people with protected characteristics. | Q3, 2025/6<br><br>Review progress Q2 2025/26 |
| | | Increase access to TLHC (screening) for working age people. | As part of planned roll out for TLHCs seek feedback from working age people in eligible cohort/localities, to inform the future offer. Consider where future Integrated Neighbourhood Teams can support. | Q2, 2025/6<br><br>Review progress Q2 2025/26 |
| | | Access for Inclusion Health groups (prison/homeless). | Collaborate with system partners on Inclusion Health group to explore / identify opportunities to safely provide access to the TLHC programme | Q4, 2025/6<br><br>Review progress Q2 2025/26 |
| | 1B: Individual patients (service users) health needs are met | Evidence impact of referrals from TLHCs to Community Smoke Stop services. | Collaborate with system working group to develop systematic feedback from referrals to Community Smoke Stop services. | Q4, 2025/6<br><br>Review progress Q2 2025/26 |
| | 1C: When patients (service users) use the service, they are free from harm | Reduce Did Not Attend (DNA) rates. | Collaborate with the System Working Group on Health Inequalities, deep dive DNA rates for Low Dose CT scans to improve uptake from people with protected characteristics, especially working age people. | Q4, 2025/6<br><br>Review progress Q2 2025/26 |
| | 1D: Patients (service users) report positive experiences of the service | Patient feedback informs service design and commissioning decisions e.g. roll-out countywide. | Engagement with service users to qualitatively hear and reflect their experiences and opportunities to improve the programme as part of planning the programme roll out. | Q2, 2025/6<br><br>Review progress Q2 2025/26 |

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| | | Increase insights into the experiences of people with protected characteristics. | Design Dorset patient experience survey to include; access, experience, and outcomes, through the lens of protected characteristics and seek feedback on opportunities to improve the services. | Q2, 2025/6<br><br>Review progress Q2 2025/26 |

| Health & Wellbeing UHD action plan | | | | |
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| **Domain** | **Outcome** | **Objective** | **Action** | **Completion date** |
| **Domain 2: Workforce health and well-being** | **2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions** | **The UHD Patient First mission is:**<br>"To provide excellent healthcare for our patients and wider community and to be a great place to work, now and for future generations."<br>The strategic People A3 target is "To achieve top decile NHS Staff Survey results for "I would recommend UHD as a great place to work" by 2026/27"<br>UHD is committed to creating a work environment where employees can thrive and reach their full potential. UHD will take necessary steps to support staff well-being and actively work to remove obstacles that contribute to health disparities among staff members. | To collect and monitor Staff Health Inequalities data by Occupational Health on all protected characteristics. PSC to continue monitoring services offered to all protected characteristics.<br><br>Targeted promotion of PSC, OH services and Health and Wellbeing offers to staff networks to reach underrepresented staff groups.<br><br>To encourage greater engagement from Wellbeing Champions representing the Global Majority and other underrepresented staff groups.<br>Provide a clear, streamlined approach to reasonable adjustments, ensuring all staff who need support can reach their full potential. | Q4 2025/2026<br><br>Review progress Q2 2025/26 |
| | **2B: When at work, staff are free from abuse, harassment, bullying and physical violence from** | Dignity and respect will underpin our civility agenda and support the reduction of abuse, harassment, bullying and physical violence.<br>*"University Hospitals Dorset will not tolerate* | To publish the behaviour charter, disseminate it at the care group and departmental levels, and monitor its effectiveness.<br>To monitor and analyse LERN reports | |

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| | **any source** | *racism, discrimination, or abuse. We celebrate the diversity of our staff and community. We treat all our staff with dignity and respect, irrespective of their race, gender, religion, age, disability, or sexual orientation."*<br>Statement from the University Hospitals Dorset Board of Directors | quarterly on harassment, bullying, physical violence, and discrimination, and implement a targeted approach to identify hotspots for focused interventions.<br>Promote the See ME First campaign at the Care Group and Department levels, providing guidance and support on Anti-Racism resources to both staff and managers.<br>Deliver Conscious Inclusion workshops across the Trust for managers and all recruitment personnel. Promote leadership training with a focus on inclusive leadership principles.<br>Implement sexual safety training across the Trust, publish the related policy, and raise awareness through Trust communications.<br>Review of 2024 NHS Staff Survey data when available. | Q4 2025/2026<br><br>Review progress Q2 2025/26 |
| | **2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source** | Promote a 'Speak Up' culture, encouraging staff to raise concerns with their managers through LERN, Occupational Health, HR, EDI Lead, Staff Networks, Trade Unions, and the FTSU team. | Organise and facilitate regular listening events for all staff, led by Trust board members, including the CEO and CPO.<br>FTSU will continue to prioritise data collection and provide targeted support for Global Majority colleagues.<br>Promote staff network engagement and ensure alignment with Trust objectives. | Q4 2025/2026<br><br>Review progress Q2 2025/26 |
| | **2D: Staff recommend the organisation as a place to work and receive treatment** | In 2023, UHD launched **Patient First**, a quality management system and a long-term approach to building improvement into everything we do.<br><br>"When staff thrive, our patients thrive. It is a proven fact that patients get better care in | Continue to report on the WRES & WDES metrics and develop action plans to address main concerns.<br><br>Promote wider patient health inequalities project work to demonstrate organisational commitment to health inequalities. | Q4 2025/2026<br><br>Review progress Q2 2025/26 |

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| | | hospitals where staff feel able to make a difference."<br><br>The mission is "To provide excellent healthcare for our patients and wider community and to be a great place to work, now and for future generations." | Analyse the data and focus on the UHD-coordinated support programme, which provides a fast-track pathway to urgent well-being support for all staff. | |

| **Inclusive Leadership UHD action plan** | | | | |
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| | **Outcome** | **Objective** | **Action** | **Completion date** |
| **Domain 3: Inclusive leadership** | 3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities | *We aim: 'To have a representative workforce at all levels of the Trust.'* | To do this we will implement our One Team EDI Plan<br>priorities:<br>• To deliver Conscious Inclusion Workshops<br>• Introduce a more inclusive approach to recruitment.<br>• Develop a simple and clear approach to reasonable workplace adjustments.<br>• Consolidate audit review findings of Staff networks and provide greater alignment with UHD objectives while strengthening their roles and purpose. | Q4 2025/26<br><br>Review progress Q2 2025/26 |
| | *3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed* | *We aim: 'To have a representative workforce at all levels of the Trust.'*<br><br>*Report health Inequalities Elective waits to be included in monthly integrated performance report** | People and Culture BAF statements embedded<br><br>EDI business as usual reporting approved through Board committees, notably Trust Management Group<br><br>Equality Impact Assessment tool widely used within UHD | Q4 2025/26<br><br>Review progress Q2 2025/26 |

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| | | | *Report performance on average weeks wait by deprivation group, comparing variation for adults and children<br><br>*Report performance on average weeks wait by ethnicity group, comparing variation for adults and children | |
| | 3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients | *We aim: 'To have a representative workforce at all levels of the Trust.'* | Public Sector Equality Duty and NHS Contract EDI reporting actioned, assured and actions monitored.<br><br>Named Executive Sponsors support workstreams, programmes of work and our Staff Networks<br><br>UHD Executive and senior leaders active in system leadership interventions and ICB<br><br>EDI patient dashboard, Dorset Intelligence, and Insight Service [DIIS], Population Health MGT Tool is used to identify variations in patient access outcomes and experience. | Q4 2025/26<br><br>Review progress Q2 2025/26 |

Patient Equality Team
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University Hospitals Dorset
NHS Foundation Trust

**BOARD OF DIRECTORS - PART 1 MEETING**

**Meeting Date: 05 March 2025**

**Agenda item: 6.4.5**

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| **Subject:** | Pay Gap Reporting 2025 |
| **Prepared by:** | Jon Harding, Head of Organisational Development<br>Deb Matthews, Director of Organisational Development |
| **Presented by:** | Tina Ricketts, Chief People Officer |

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| **Strategic themes that this item supports/impacts:** | Population & System<br>Our People<br>Patient Experience<br>Quality Outcomes & Safety<br>Sustainable Services | ☐<br>☒<br>☐<br>☐<br>☐ |
| **BAF/Corporate Risk Register: (if applicable)** | BAF 3 & BAF 4 | |
| **Purpose of paper:** | Decision/Approval | |
| **Executive Summary:** | The UHD data presented in the attached reports is sourced from the Electronic Staff Record for the period ending 31 March 2024. The data has been presented along with recommended actions to provide the Trust Board assurance that UHD will continue to work towards a situation without Gender, Ethnicity and Disability pay gaps.<br><br>**Gender Pay Gap**<br>This data demonstrates that there could be greater female representation in senior clinical roles. Similarly, the Trust acknowledges that there could be greater male representation in less senior clinical and non-clinical roles.<br><br>Our headcount sample has increased by 410 to 9849 since last year with 249 more female and 162 more males across UHD (on 31 March 2024 compared to data reported on 31 March 2023).<br><br>The median **Gender Pay Gap is 2.3%** a reduction from the 3.5% reported in 2024. Comparing the median hourly pay gap women earn approximately 97.5p for every £1 that men earn.<br><br>There is an increase in representation at senior Manager level (8a, 8b, 8c, 8d and 9) of female staff. This is a positive move towards equitable representation with our workforce demographics. | |

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| | Due to local intervention the median bonus pay awarded has removed the gender pay gap, however when comparing the mean (average) bonus pay, women's mean bonus pay is 32.79% lower than men's.<br><br>**Ethnicity Pay Gap**<br>Our headcount sample has increased by 411 to 9,576 with 328 more Global Majority staff and 83 more White staff across UHD (31st March 2023 vs. 31st March 2024). Staff without declared ethnicity have been excluded.<br><br>Our **Ethnicity Pay Gap is -1.13%** in favour of Global Majority staff with the comparator White staff. Global Majority Staff earning more than comparable White staff in the sample. Comparing the median hourly pay gap, Global Majority staff earn £1.01 for every £1 that White Staff earn. Their median hourly pay is 1.13% higher than White Staff.<br><br>However, there is a notably static progress at senior level. Appendix 1 shows the Disparity in Career Progression ratios which help to explain the lack of mobility between bandings and grades for Global Majority staff. For lower to upper career progression, whole trust; the ratio is 7.4 or seven times that for White staff. This could be in part due to low representation in the lower bands for Global Majority staff and the international recruitment of graduate nurses at band 5.<br><br>**Disability Pay Gap**<br>Our headcount sample for the purpose of this report is 8,447 with 663 staff declaring a Disability or Long-Term Condition with 7,784 staff declaring to be non-disabled shown in table 5.1 above. A comparison using the same methodology shows an increase in declaration and head count compared to 2022/23.<br><br>Our Disability Pay Gap is 12.29%, showing our staff with a declared Disability earning comparatively less than non-Disabled staff. Comparing the median hourly pay gap, Disabled staff earn £0.88 for every £1 compared to Non-Disabled Staff. The median hourly pay is 12.29% higher than Disabled Staff.<br><br>There is a notable proportion of staff without a Disability declaration. This has affected the data relating to Bonus Pay where 140 of the 447 receiving Bonus Pay have no declaration. |
| **Background:** | The NHS equality, diversity, and inclusion improvement plan was introduced in 2023 with 6 high impact actions, (HIA). The aim of this plan is to improve equality, diversity, and inclusion, and to enhance the sense of belonging for NHS staff to improve their experience.<br><br>While we refer to the protected characteristics as defined in the Equality Act 2010, the HIA were set out to positively |

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| | impact groups and individuals beyond these terms and definitions.<br><br>The attached reports contain our Gender Pay Gap Report and our first annual reports for Ethnicity Pay Gap and Disability Pay Gap.<br><br>Reporting Gender Pay disparity is a statutory requirement as part of the Public Sector Duty within the Equality Act 2010. Gender Pay Gap reporting is a mandatory requirement for all organisations with +250 employees. UHD is required to publish six calculations showing their:<br><br>Reporting Gender Pay disparity is a statutory requirement as part of the Public Sector Duty within the Equality Act 2010. Gender Pay Gap reporting is a mandatory requirement for all organisations with +250 employees. UHD is required to publish six calculations showing their:<br><br>• Average gender pay gap as a mean [average]<br>• Average gender pay gap as a median [average]<br>• Average bonus gender pay gap as a mean [average]<br>• Average bonus gender pay gap as a median [average]<br>• Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment<br>• Proportion of males and females when divided into four groups ordered from lowest to highest pay<br><br>These reports will be uploaded to the Gender Pay Gap service to meet the compliance standard [30 March 2025.] The attached reports will be published on the UHD external internet and internal intranet pending Board approval.<br><br>**To note:** the pay bands VSM and Executive Director presented in section 4 of the reports are due to legacy system Pay entries and could be re-presented as VSM [Very Senior Manager] before publishing the reports. |
| **Key Recommendations**: | The Chief People Officer and Director of OD will continue to work with the Executive team and our UHD Staff Networks to support the implementation of identified actions. Delivery of these actions will be monitored through Trust's People and Culture Strategy and assured through the People and Culture Committee and our Patient First Programme.<br><br>As an aspiring Inclusive Employer our key Equality, Diversity, and Inclusion objective for 2024 and the next 3 years will be: **'To have a representative workforce at all levels of the Trust.'** To do this we will implement our One Team EDI Plan priorities: |

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| | • strengthen our staff networks to work more closely with the UHD strategic needs and provide project support for engagement activity<br>• with our Dorset Partners and our Recruitment Team we will introduce clear guidance and requirements relating to inclusive recruitment<br>• develop a one-stop shop approach to accessing reasonable adjustments<br>• increase cultural awareness and reduce prejudice through the introduction of Conscious Inclusion workshops |
| **Implications associated with this item:** | Council of Governors ☐<br>Equality, Equity, Diversity & Inclusion ☒<br>Financial ☒<br>Health Inequalities ☒<br>Operational Performance ☐<br>People (inc Staff, Patients) ☐<br>Public Consultation ☐<br>Quality ☐<br>Regulatory ☐<br>Strategy/Transformation ☐<br>System ☒ |
| **CQC Reference:** | Safe ☐<br>Effective ☐<br>Caring ☐<br>Responsive ☐<br>Well Led ☒<br>Use of Resources ☐ |

| **Report History: Committees/Meetings at which the item has been considered:** | **Date** | **Outcome** |
|---|---|---|
| Trust Management Group<br>People and Culture Committee | 18/02/2025<br>21/02/2025 | Outcomes for both TMG and PCC pending at the time of submission |

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

## 1. Background

1.1 It became mandatory from 31 March 2017 for public sector organisations with over 250 employees to report annually on their gender pay gap. The results must be published on a government website, as well as the employer's own website (and remain there for 3 years).

1.2 Gender pay reporting presents data on the difference between men and women's average pay within an organisation. It is important to highlight the distinction between this and equal pay reporting, which is instead concerned with men and women earning equal pay for the same (or equivalent) work. Across the country, average pay of women is lower than that of men and this tends to be because there are fewer women in senior high earning positions in organisations than men. Whilst a workforce may be predominantly female, if the most senior positions are taken up by men, the average pay of women in that organisation could well be lower. The Regulations have been brought in to highlight this imbalance, the aim being to enable employers to consider the reasons for any inequality within their organisation and to take steps to address it. (link. NHS Employer Guide to *Gender Pay Gap Reporting retrieved* 2025-02)

1.3 University Hospitals Dorset NHS Trust has consecutively published annual reports since merger, our first report was March 2021. This report was taken from a snapshot date of 31 March 2024 for our March 2025 report.

1.4 The NHS terms and conditions of service handbook contain the national agreements on pay and conditions of service for NHS staff other than very senior managers and medical staff. Job evaluation (JE) enables jobs to be matched to national job profiles or allows Trusts to evaluate jobs locally, to determine in which Agenda for Change pay band a post should sit.

## 2. The Gender Pay Gap Six Indicators

2.1 An employer must publish six calculations showing their:

- Average gender pay gap as a mean [average]
- Average gender pay gap as a median [average]
- Average bonus gender pay gap as a mean [average]
- Average bonus gender pay gap as a median [average]
- Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment
- Proportion of males and females when divided into four groups ordered from lowest to highest pay.

Under national guidance, medical staff clinical excellence awards are included within bonus pay.

## 3. Methodology

3.1 The statutory calculations have been undertaken at the snapshot date of 31 March 2024, using the national Electronic Staff Record (ESR) Business Intelligence standard report. In line with NHS Employers guidance Clinical Excellence Awards and the approach taken to award them at UHD have been categorised as bonuses.

3.2 Pay includes: basic pay, full paid leave including annual, sick, maternity, paternity, adoption or parental leave, bonus pay, area and other allowances and shift premium pay. (Note: bonus pay is included, but only as a separate metric as one of the 6 key indicators we need to produce. The gender pay gap figure is calculated from hourly pay – which can only be ordinary pay, bonus pay is not hourly).

3.3 Pay does not include: overtime pay, expenses (payments made to reimburse expenditure wholly and necessarily incurred in the course of employment, e.g. mileage for use of vehicle), remuneration in lieu of leave, the value of salary sacrifice schemes, benefits in kind (e.g. childcare vouchers), redundancy pay and tax credits.

## 4. UHD Workforce Context

4.1 The gender split within the overall workforce is 74.1% female and 25.9% male. The breakdown of the proportion of females and males in each banding is as set out below:

| | 2023-24 | | | | |
|---|---|---|---|---|---|
| | Female | | Male | | Total |
| Pay Band | Headcount | % | Headcount | % | |
| Band 1 | 14 | 41.2% | 20 | 58.8% | **34** |
| Band 2 | 625 | 63.2% | 364 | 36.8% | **989** |
| Band 3 | 1667 | 81.1% | 388 | 18.9% | **2055** |
| Band 4 | 581 | 83.4% | 116 | 16.6% | **697** |
| Band 5 | 1407 | 79.2% | 370 | 20.8% | **1777** |
| Band 6 | 1239 | 83.7% | 242 | 16.3% | **1481** |
| Band 7 | 839 | 81.4% | 192 | 18.6% | **1031** |
| Band 8a | 177 | 68.1% | 83 | 31.9% | **260** |
| Band 8b | 93 | 67.4% | 45 | 32.6% | **138** |
| Band 8c | 27 | 60.0% | 18 | 40.0% | **45** |
| Band 8d | 12 | 57.1% | 9 | 42.9% | **21** |
| Band 9 | 7 | 58.3% | 5 | 41.7% | **12** |
| VSM | 5 | 45.5% | 6 | 54.5% | **11** |
| Executive Director | 0 | 0.0% | 2 | 100.0% | **2** |
| Non-Executive Director | 3 | 42.9% | 4 | 57.1% | **7** |
| Chair | 0 | 0.0% | 1 | 100.0% | **1** |
| Other | 0 | 0.0% | 2 | 100.0% | **2** |
| Consultant | 199 | 40.1% | 297 | 59.9% | **496** |
| Non-Consultant Career Grade | 64 | 44.1% | 81 | 55.9% | **145** |
| Trainee Grades | 340 | 52.7% | 305 | 47.3% | **645** |
| **Total** | **7299** | **74.1%** | **2550** | **25.9%** | **9849** |

Table 4.1 Gender Split 2023 - 2024

## 5. Gender Pay Gap Reporting Summary

| Gender Pay Gap Reporting<br>University Hospitals Dorset NHS Foundation Trust | | | | | |
|---|---|---|---|---|---|
| | | **2023-24** | *Previous Year (2022-23)* | *Change 23.24 v 22.23* | |
| **Substantive Headcount** | Female | 7299 | *7050* | ↑ | *249* |
| | Male | 2550 | *2388* | ↑ | *162* |
| | **Total** | **9849** | ***9438*** | | |
| | Female | 74.11% | *74.70%* | ↓ | *-0.59%* |
| | Male | 25.89% | *25.30%* | ↑ | *0.59%* |
| **Difference in hourly rate** | Mean Average | 18.37% | *19.63%* | ↓ | *-1.26%* |
| | Median | 2.30% | *3.53%* | ↓ | *-1.24%* |
| **Proportion of females in each pay quartile** | Lower | 75.80% | *77.06%* | ↓ | *-1.26%* |
| | Lower middle | 75.75% | *76.44%* | ↓ | *-0.69%* |
| | Upper middle | 81.16% | *81.85%* | ↓ | *-0.69%* |
| | Top | 65.01% | *65.59%* | ↓ | *-0.59%* |
| **Who received bonus pay** | Female | 2.40% | *2.31%* | ↑ | *0.09%* |
| | Male | 10.67% | *11.01%* | ↓ | *-0.35%* |
| **Difference in bonus pay** | Mean Average | 32.79% | *35.96%* | ↓ | *-3.17%* |
| | Median | 0.00% | *0.00%* | → | *0.00%* |
| **Our Gender Pay Gap is -** | | **2.30%** | ***3.53%*** | | |

*Figure 5.1 Gender Pay Gap Summary*

### 5.1 Gender Pay Gap Results

- Our headcount has increased by 410 to 9,849 since last year with 249 more female and 162 more males across UHD (31st March 2023 vs. 31st March 2024)
- This year our Gender Pay Gap is 2.30%
- This is an improvement on last year's reported figure of 3.53% and continues the positive trend following the organisational merger in 2020
- There is an increase in representation at senior Manager level (8a, 8b, 8c, 8d and 9) of female staff. This is a positive move towards equitable representation with our workforce demographics.

## 5.2 Ordinary Pay

### Ordinary Pay - Trust Summary

| | 2023-24 | | |
|---|---|---|---|
| | Female | Male | *Female change 23.24 v 22.23* |
| Average Hourly Rate | £19.48 | £23.86 | ↑ £1.09 |
| Difference in Average Hourly Rate | £4.38 | | ↓ -£0.11 |
| Average Pay Gap | 18.4% | | ↓ -1.3% |
| Median Hourly Rate | £17.68 | £18.10 | ↑ £0.84 |
| Difference in Median Hourly Rate | £0.42 | | ↓ -£0.20 |
| **Median Pay Gap** | **2.30%** | | **↓ -1.24%** |

- The gender pay gap for the Trust overall, is 2.3%.
  The gap has reduced from 3.53% reported in 2024.
- The mean gender pay gap for the Trust overall is 18.37%.
  This has decreased by 1.26% from 19.63% reported last in 2024.
- The Trust's mean hourly pay for female staff is £19.48 and £23.86 for male staff.
- The Trust's median hourly pay for female staff is £17.68 and £18.10 for male staff.

*See tables 5.2.1 and 5.2.2*

### Average (Mean) Gender Pay Gap - Ordinary Pay

| | 2023-24 | | |
|---|---|---|---|
| | Female | Male | *% difference* |
| All Staff | £19.48 | £23.86 | ***18.37%*** |
| Non-Medical Staff Groups | £18.01 | £17.75 | ***-1.47%*** |
| Medical Staff Group | £36.73 | £41.39 | ***11.27%*** |

| *Previous Year (2022-23)* | | |
|---|---|---|
| **Female** | **Male** | ***% difference*** |
| £18.39 | £22.88 | *19.63%* |
| £17.03 | £16.82 | *-1.26%* |
| £35.03 | £39.41 | *11.10%* |

*Table 5.2.1*

**Median Gender Pay Gap - Ordinary Pay**

| | 2023-24 | | |
|---|---|---|---|
| | Female | Male | *% difference* |
| All Staff | £17.68 | £18.10 | ***2.30%*** |
| Non-Medical Staff Groups | £17.05 | £15.67 | ***-8.84%*** |
| Medical Staff Group | £31.58 | £39.51 | ***20.08%*** |

| *Previous Year (2022-23)* | | |
|---|---|---|
| **Female** | **Male** | ***% difference*** |
| £16.84 | £17.46 | *3.53%* |
| £16.14 | £14.58 | *-10.75%* |
| £29.64 | £39.61 | *25.17%* |

*Table 5.2.2*

## 5.3 Clinical Excellence Awards Bonus Payments

There will be new national awards that will be featured in future reports, and these are expected to have 3 levels.

For 2025, the bonus pay data has been grouped together as there were so few. We are going to see the local CEAs and discretionary points phased out in future reports.

Local Clinical Excellence Award's (LCEA) recognised and rewarded NHS consultants in England, who perform over and above the standard expected of their role. Awards were given for quality and excellence, acknowledging exceptional personal contributions.

**Bonus Pay***

**Bonus Pay includes both local and national awards, and includes Discretionary Points.*

| | 2023-24 | | |
|---|---|---|---|
| | **Female** | **Male** | *Female change 23.24 v 22.23* |
| Number of Staff Receiving Bonus Pay | 175 | 272 | ↑ 12 |
| Proportion of All Staff Receiving Bonus Pay | 2.4% | 10.7% | ↑ 0.1% |
| Proportion of Medical Staff Receiving Bonus Pay | 29.0% | 39.8% | ↓ -0.2% |
| Average (mean) Bonus Pay Received | £5,508.67 | £8,195.65 | ↑ £225.62 |
| Difference in Bonus Pay - Mean Average | £2,686.98 | | ↓ -£279.47 |
| Average Bonus Pay Gap | 32.79% | | ↓ -3.2% |
| Median Bonus Pay Received | £3,503.66 | £3,503.66 | ↑ £330.35 |
| Difference in Bonus Pay - Median | £0.00 | | → £0.00 |
| Median Bonus Pay Gap | 0% | | → 0.0% |
| Minimum Bonus Pay Received | £512.77 | £33.51 | ↓ -£90.47 |
| Maximum Bonus Pay Received | £33,663.62 | £47,582.04 | ↑ £330.35 |

*Table 5.3.1 Bonus Pay*

## 5.4 Proportion of Males and Females in each Quartile Pay Band

At the time the snapshot was taken the percentage of female staff was 74.43% female and 25.57% male. This representing a decrease female staff for the whole trust.

All Staff Groups

| | 2023-24 | | | |
|---|---|---|---|---|
| | Female | | Male | |
| Quartile | Count | Proportion | Count | Proportion |
| 1 (Lower) | 1948 | 75.80% | 622 | 24.20% |
| 2 (Lower middle) | 1946 | 75.75% | 623 | 24.25% |
| 3 (Upper middle) | 2085 | 81.16% | 484 | 18.84% |
| 4 (Top) | 1670 | 65.01% | 899 | 34.99% |
| **Grand Total** | **7649** | **74.43%** | **2628** | **25.57%** |

*Previous Year (2022-23)*

| Female | | Male | |
|---|---|---|---|
| Count | Proportion | Count | Proportion |
| 1891 | 77.06% | 563 | 22.94% |
| 1872 | 76.44% | 577 | 23.56% |
| 2002 | 81.85% | 444 | 18.15% |
| 1607 | 65.59% | 843 | 34.41% |
| **7372** | **75.23%** | **2427** | **24.77%** |

The proportion of **all staff group** females has reduced from 2022-23.
*Table 5.4.1*

Non-Medical Staff Groups

| | 2023-24 | | | |
|---|---|---|---|---|
| | Female | | Male | |
| Quartile | Count | Proportion | Count | Proportion |
| 1 (Lower) | 1948 | 75.83% | 621 | 24.17% |
| 2 (Lower middle) | 1905 | 76.41% | 588 | 23.59% |
| 3 (Upper middle) | 1978 | 82.73% | 413 | 17.27% |
| 4 (Top) | 1220 | 78.86% | 327 | 21.14% |
| **Grand Total** | **7051** | **78.34%** | **1949** | **21.66%** |

*Previous Year (2022-23)*

| Female | | Male | |
|---|---|---|---|
| Count | Proportion | Count | Proportion |
| 1891 | 77.06% | 563 | 22.94% |
| 1832 | 76.94% | 549 | 23.06% |
| 1915 | 84.29% | 357 | 15.71% |
| 1179 | 79.34% | 307 | 20.66% |
| **6817** | **79.33%** | **1776** | **20.67%** |

The proportion of **non-medical** females has reduced from 2022-23.
*Table 5.4.2*

Medical Staff Groups

| | 2023-24 | | | |
|---|---|---|---|---|
| | Female | | Male | |
| Quartile | Count | Proportion | Count | Proportion |
| 1 (Lower) | 0 | 0.00% | 1 | 100.00% |
| 2 (Lower middle) | 41 | 53.95% | 35 | 46.05% |
| 3 (Upper middle) | 107 | 60.11% | 71 | 39.89% |
| 4 (Top) | 450 | 44.03% | 572 | 55.97% |
| **Grand Total** | **598** | **46.83%** | **679** | **53.17%** |

*Previous Year (2022-23)*

| Female | | Male | |
|---|---|---|---|
| Count | Proportion | Count | Proportion |
| 0 | 0.00% | 0 | 0.00% |
| 40 | 58.82% | 28 | 41.18% |
| 87 | 50.00% | 87 | 50.00% |
| 428 | 44.40% | 536 | 55.60% |
| **555** | **46.02%** | **651** | **53.98%** |

The proportion of medical grade females has increased from 2022-23.
*Table 5.4.3*

## 6. Conclusion

6.1 This report provides data from 1 April 2023 to the 31 March 2024. Our data demonstrates that there could be greater female representation in its senior clinical roles.

The position is consistent with previous snapshot data taken from 31 March 2023 data. Similarly, the Trust acknowledges that there could be greater male representation in less senior clinical and non-clinical roles.

6.2 It should be noted that the 2020 data was first published in March 2021, and this latest data snapshot took place on 31 March 2024, as per the regulations.

6.3 Separating the data for Agenda for Change and the Medical/Dental workforce gives a better understanding of where the greatest difference in pay and gender representation.

6.4 Comparing the median hourly pay gap, women earn 97.5p for every £1 that men earn. Their median hourly pay is 2.3% lower than men's.

6.5 There is no median bonus pay gap for 2024. When comparing mean (average) bonus pay, women's mean bonus pay is 32.79% lower than men.

6.6 In addition to the Gender Pay Gap report there are two other reports detailing the Ethnicity Pay Gap and the Disability Pay Gap.

## 7. Previous Action's

7.1 The following actions continue to support closing the gender pay gap:

| | **Action Plan** | **Progress** |
|---|---|---|
| 1. | Share Gender Pay Gap information across the Trust | Published on intranet and internet.<br><br>Shared with Care Groups |
| 2. | Continue the Trust's commitment to an equitable workforce | Demonstrated in our Trust objectives and values and the wider EDI action plan |
| 3. | Continue equitable access to trust leadership training and development | On-going leadership programmes and additional capacity through the Dorset Integrated Care System for underrepresented groups |
| 4. | Support all staff in protected groups through living our Trust values and implementing our People and Culture Strategy | The EDS Assessment identified areas where protected characteristics should be recorded including Occupational Health and Education Continuous Professional Development |
| 8. | Flexible working – Raising the profile of the benefits of Flexible Working across UHD through a range of methods, including communication briefings, inclusive leadership conversations | UHD has a Flexible Working Policy |
| 9 | Career Progression - Accessible bite sized and online training will continue, to ensure development can be accessed by those working part time and flexible work patterns.<br><br>Bias awareness is included in new leadership and development modules. | Increased access to online leadership training modules. These rotate so they are on different days and times to increase accessibility.<br><br>Managers' induction launched introducing compassionate, inclusive leadership and bias awareness. |
| 10 | A Women's network was introduced with interest from staff across the organisation in 2022. | The network is now established and working to expand reach and influence |
| 11 | CEA awards – will be more inclusive, transparent, and fair and will reward excellence and improvement, underpinning the delivery of local priorities. | In the 2022-23 round of Local Clinical Excellence Awards which we implemented in November 2023 salaries, an agreement was reached with the Joint Local Negotiating Committee that there would be an equal distribution of awards. |

## 8. Next Steps

In November 2024 a new People and Culture Strategy was introduced. As an aspiring Inclusive Employer our key Equality, Diversity, and Inclusion objective for the next 3 years is:

**‘To have a representative workforce at all levels of the Trust.’**

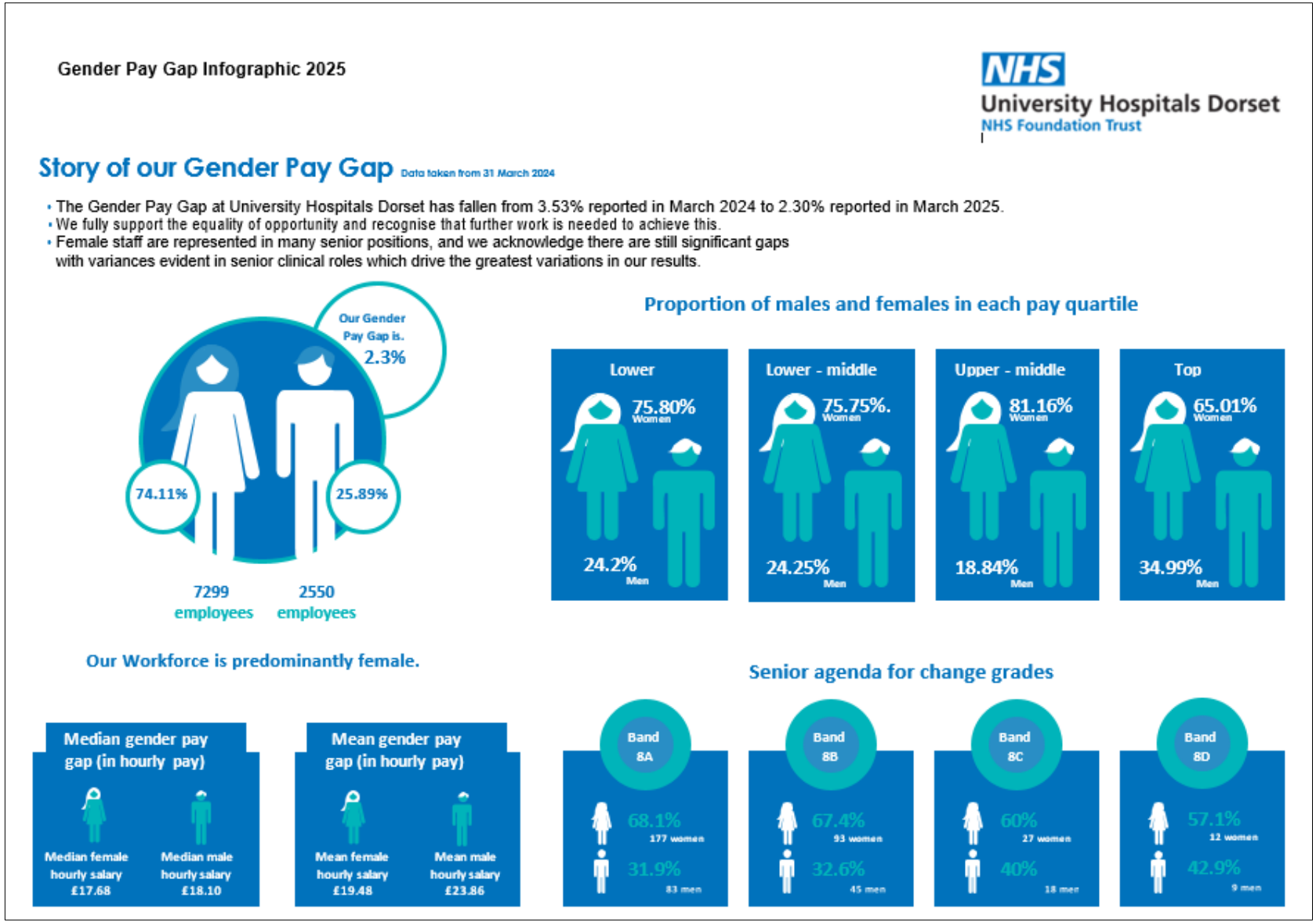
To do this we will implement our One Team EDI Plan priorities:

- strengthen our staff networks to work more closely with the UHD strategic needs and provide project support for engagement activity
- with our Dorset Partners and our Recruitment Team we will introduce clear guidance and requirements relating to inclusive recruitment
- develop a one-stop shop approach to accessing reasonable adjustments
- increase cultural awareness and reduce prejudice through the introduction of Conscious Inclusion workshops

We will further develop and raise the profile of the UHD Women’s network.

The Chief People Officer and Director of OD will continue to work with the Executive team to support the identified actions.

Jon Harding,
Head of Organisational Development
February 2024


Gender Pay Gap Infographic 2025
NHS
University Hospitals Dorset
NHS Foundation Trust
Story of our Gender Pay Gap
Data taken from 31 March 2024
• The Gender Pay Gap at University Hospitals Dorset has fallen from 3.53% reported in March 2024 to 2.30% reported in March 2025.
• We fully support the equality of opportunity and recognise that further work is needed to achieve this.
• Female staff are represented in many senior positions, and we acknowledge there are still significant gaps with variances evident in senior clinical roles which drive the greatest variations in our results.
Our Gender Pay Gap is. 2.3%
74.11%
25.89%
7299 employees
2550 employees
Our Workforce is predominantly female.
Proportion of males and females in each pay quartile
Lower
75.80% Women
24.2% Men
Lower - middle
75.75%. Women
24.25% Men
Upper - middle
81.16% Women
18.84% Men
Top
65.01% Women
34.99% Men
Median gender pay gap (in hourly pay)
Median female hourly salary £17.68
Median male hourly salary £18.10
Mean gender pay gap (in hourly pay)
Mean female hourly salary £19.48
Mean male hourly salary £23.86
Senior agenda for change grades
Band 8A
68.1% 177 women
31.9% 83 men
Band 8B
67.4% 93 women
32.6% 45 men
Band 8C
60% 27 women
40% 18 men
Band 8D
57.1% 12 women
42.9% 9 men

## 1. Background

1.1 It became mandatory from 31 March 2017 for public sector organisations with over 250 employees to report annually on their gender pay gap. The results must be published on a government website, as well as the employer's own website (and remain there for 3 years).

1.2 The NHS equality, diversity, and inclusion improvement plan was introduced in 2023 with 6 high impact actions, (HIA) (link). The aim of this plan is to improve equality, diversity and inclusion, and to enhance the sense of belonging for NHS staff to improve their experience. While we refer to the protected characteristics as defined in the Equality Act 2010, the HIA were set out to positively impact groups and individuals beyond these terms and definitions.

1.3 HIA 3 introduced the need to develop and implement an improvement plan to eliminate pay gaps. This report contains a similar data set as our Gender Pay Gap Report and marks the first annual report for Disability Pay Gap Reporting.

## 2.0 NHS Employer Guide to *Gender Pay Gap Reporting*

The NHS Employer Guide to *Gender Pay Gap Reporting* (link). *retrieved* 2025-02) has Six Indicators and these have been used to provide the framework to present our data.

An employer must publish six calculations showing their:

- Average gender pay gap as a mean [average]
- Average gender pay gap as a median [average]
- Average bonus gender pay gap as a mean [average]
- Average bonus gender pay gap as a median [average]
- Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment
- Proportion of males and females when divided into four groups ordered from lowest to highest pay.

Under national guidance, medical staff clinical excellence awards are included within bonus pay.

## 3. Methodology

3.1 The calculations have been undertaken at the snapshot date of 31 March 2024, using the national Electronic Staff Record (ESR) Business Intelligence standard report. In line with NHS Employers guidance Clinical Excellence Awards and the approach taken to award them at UHD have been categorised as bonuses.

3.2 Pay includes: basic pay, full paid leave including annual, sick, maternity, paternity, adoption or parental leave, bonus pay, area and other allowances and shift premium pay. (Note: bonus pay is included, but only as a separate metric as one of the 6 key indicators we need to produce. The gender pay gap figure is calculated from hourly pay – which can only be ordinary pay, bonus pay is not hourly).

3.3 Pay does not include: overtime pay, expenses (payments made to reimburse expenditure wholly and necessarily incurred in the course of employment, e.g. mileage for use of vehicle), remuneration in lieu of leave, the value of salary sacrifice schemes, benefits in kind (e.g. childcare vouchers), redundancy pay and tax credits.

## 4. UHD Workforce Context

4.1 The overall workforce is 92.2% Non-Disabled and 7.8% Disabled. The breakdown of the proportion of Non-Disable and Disabled staff in each banding is as set out below:

**Pay Band Headcount**

*Staff with no disability declaration on ESR are excluded below*

| | 2023-24 | | | | |
|---|---|---|---|---|---|
| | Disabled | | Non-Disabled | | Total |
| Pay Band | Headcount | % | Headcount | % | |
| Band 1 | 0 | 0.0% | 14 | 100.0% | **14** |
| Band 2 | 80 | 9.9% | 728 | 90.1% | **808** |
| Band 3 | 170 | 9.6% | 1599 | 90.4% | **1769** |
| Band 4 | 50 | 8.3% | 550 | 91.7% | **600** |
| Band 5 | 122 | 7.8% | 1435 | 92.2% | **1557** |
| Band 6 | 80 | 6.1% | 1241 | 93.9% | **1321** |
| Band 7 | 68 | 7.6% | 828 | 92.4% | **896** |
| Band 8a | 23 | 10.3% | 200 | 89.7% | **223** |
| Band 8b | 5 | 4.5% | 107 | 95.5% | **112** |
| Band 8c | 0 | 0.0% | 40 | 100.0% | **40** |
| Band 8d | 0 | 0.0% | 18 | 100.0% | **18** |
| Band 9 | 1 | 9.1% | 10 | 90.9% | **11** |
| VSM | 1 | 12.5% | 7 | 87.5% | **8** |
| Executive Director | 0 | 0.0% | 2 | 100.0% | **2** |
| Non-Executive Director | 1 | 20.0% | 4 | 80.0% | **5** |
| Chair | 0 | 0.0% | 1 | 100.0% | **1** |
| Other | 0 | 0.0% | 1 | 100.0% | **1** |
| Consultant | 6 | 1.7% | 346 | 98.3% | **352** |
| Non-Consultant Career Grade | 5 | 4.9% | 97 | 95.1% | **102** |
| Trainee Grades | 51 | 8.4% | 556 | 91.6% | **607** |
| **Total** | **663** | **7.8%** | **7784** | **92.2%** | **8447** |

table 4.1 Pay Band Headcount spilt 2023/24

As mentioned above, for the purpose of this report we have only used the caregories of Disabled and Non-Disabled thus excluding approximately 14% of staff or 1402 staff from some of the calculations. Our actual ESR declaration rate used for all other purposes is that used in the annual Workforce Disability Equality Report 2024 [6.3%] which is available in both internal intranet and external internet pages for UHD.

## 5. Disability Pay Gap Reporting Summary

| Disability Pay Gap Reporting<br>University Hospitals Dorset NHS Foundation Trust | | 2023-24 | Previous Year (2022-23) | Change 23.24 v 22.23 |
|---|---|---|---|---|
| Substantive Headcount | Disabled | 663 | 614 | 49 |
| | Non-Disabled | 7784 | 7382 | 402 |
| | **Total** | **8447** | **7996** | |
| | Disabled | 7.85% | 7.68% | 0.17% |
| | Non-Disabled | 92.15% | 92.32% | -0.17% |
| Excluded due to no declaration on ESR | Headcount | 1402 | 1442 | -40 |
| | Proportion | 14.23% | 15.28% | -1.04% |
| Difference in hourly rate | Mean Average | 11.73% | 12.35% | -0.61% |
| | Median | 12.29% | 11.83% | 0.46% |
| Proportion of disabled staff in each pay quartile | Lower | 10.90% | 10.30% | 0.60% |
| | Lower middle | 7.71% | 7.73% | -0.01% |
| | Upper middle | 6.36% | 6.38% | -0.03% |
| | Top | 5.68% | 5.51% | 0.17% |
| Who received bonus pay | Disabled | 0.75% | 0.98% | -0.22% |
| | Non-Disabled | 3.88% | 3.75% | 0.13% |
| Difference in bonus pay | Mean Average | -3.42% | 9.45% | -12.88% |
| | Median | 0.00% | 0.00% | 0.00% |
| **Our Disability Pay Gap is -** | | **12.29%** | ***11.83%*** | |

*Table 5.1 Disability Pay Gap Summary*

### 5.1 Disability Pay Gap Results

- Our headcount sample for the purpose of this report is 8,447 with 663 staff declaring a Disability or Long-Term Condition with 7,784 staff declaring to be non-Disabled shown in table 5.1 above, additionally a comparison using the same methodology shows an increase in Declaration and head count compared to 2022-23.

- This year our Disability Pay Gap is 12.29%, showing our staff with a declared Disability earning comparatively less than non-Disabled staff.

- There is a notable proportion of staff without a Disability declaration. This is notably apparent for doctors and consultants receiving Bonus Payments. Notably our key EDI priorities in the next 12 months will include a review of Recruitment practices and access to Reasonable Adjustments and we will also seek to improve declaration rates.

## 5.2 Ordinary Pay

**Ordinary Pay - Trust Summary**

*Staff with no disability delcaration on ESR are excluded on this tab*

| | 2023-24 | | |
|---|---|---|---|
| | **Disabled** | **Non-Disabled** | *Disabled change 23.24 v 22.23* |
| Average Hourly Rate | £17.94 | £20.33 | ↑ £1.12 |
| Difference in Average Hourly Rate | £2.39 | | ↑ £0.02 |
| Average Pay Gap | 11.7% | | ↓ -0.6% |
| Median Hourly Rate | £15.65 | £17.85 | ↑ £0.73 |
| Difference in Median Hourly Rate | £2.19 | | ↑ £0.19 |
| **Median Pay Gap** | **12.29%** | | ↑ **0.46%** |

- The Disability pay gap for the trust in 2023-24 is 12.29%.
  This has increased from the calculated gap for 2023 of 11.83%.
- The mean ethnicity pay gap for the Trust in 2023-4 is 11.73%.
  This has decreased from the calculated gap for 2023 of 12.35%.
- Staff without a declaration for Disability or Non-Disability are excluded from the calculation.
- The Trust's mean Disability hourly pay would be £17.94 compared to £20.33 for non-Disabled staff.
- The Trust's median Disability hourly pay gap would be £15.65 compared to -£17.85 for non-Disabled staff.

*See tables 5.2.1 and 5.2.2*

### Average (Mean) Disability Pay Gap - Ordinary Pay

| | 2023-24 | | |
|---|---|---|---|
| | **Disabled** | **Non-Disabled** | ***% difference*** |
| All Staff | £17.94 | £20.33 | ***11.73%*** |
| Non-Medical Staff Groups | £16.82 | £18.00 | ***6.55%*** |
| Medical Staff Group | £29.47 | £37.00 | ***20.34%*** |

| *Previous Year (2022-23)* | | |
|---|---|---|
| **Disabled** | **Non-Disabled** | ***% difference*** |
| £16.82 | £19.19 | *12.35%* |
| £15.87 | £17.02 | *6.72%* |
| £27.00 | £35.35 | *23.60%* |

*Table 5.2.1*

## Median Disability Pay Gap - Ordinary Pay

| | 2023-24 | | |
|---|---|---|---|
| | Disabled | Non-Disabled | *% difference* |
| All Staff | £15.65 | £17.85 | ***12.29%*** |
| Non-Medical Staff Groups | £14.73 | £16.89 | ***12.80%*** |
| Medical Staff Group | £25.71 | £31.35 | ***17.99%*** |

| *Previous Year (2022-23)* | | |
|---|---|---|
| **Disabled** | **Non-Disabled** | ***% difference*** |
| £14.92 | £16.93 | *11.83%* |
| £14.03 | £15.85 | *11.48%* |
| £23.69 | £29.55 | *19.85%* |

*Table 5.2.2*

### 5.3 Clinical Excellence Awards Bonus Payments

There will be new national awards that will be featured in future reports, and these are expected to have 3 levels. For 2025, the bonus pay data has been grouped together as there were so few. We are going to see the local CEAs and discretionary points phased out in future reports.

Local Clinical Excellence Award's (LCEA) recognised and rewarded NHS consultants in England, who perform over and above the standard expected of their role. Awards were given for quality and excellence, acknowledging exceptional personal contributions.

Please note that 140 of the 447 staff who received bonus pay have no Disability declaration, hence the low numbers in the Disability category.

**Bonus Pay***

**Bonus Pay includes both local and national awards, and includes Discretionary Points.*

| | 2023-24 | | |
|---|---|---|---|
| | **Disabled** | **Non-Disabled** | *Disabled change 23.24 v 22.23* |
| Number of Staff Receiving Bonus Pay | 5 | 302 | -1 |
| Proportion of All Staff Receiving Bonus Pay | 0.8% | 3.9% | -0.2% |
| Proportion of Medical Staff Receiving Bonus Pay | 8.1% | 30.2% | -3.0% |
| Average (mean) Bonus Pay Received | £5,901.70 | £5,706.39 | £717.73 |
| Difference in Bonus Pay - Mean Average | -£195.31 | | -£736.54 |
| Average Bonus Pay Gap | -3.42% | | -12.9% |
| Median Bonus Pay Received | £3,503.66 | £3,503.66 | £330.35 |
| Difference in Bonus Pay - Median | £0.00 | | £0.00 |
| Median Bonus Pay Gap | 0% | | 0.0% |
| Minimum Bonus Pay Received | £3,503.66 | £33.51 | £330.35 |
| Maximum Bonus Pay Received | £12,477.89 | £39,695.66 | £256.58 |
| *Number of Staff Receiving Bonus Pay Excluded Due to No Disability Declaration on ESR* | *140* | | |

*table 5.3.1 Bonus Pay*

## 5.4 Proportion of Males and Females in each Quartile Pay Band

All Staff Groups

| | 2023-24 | | | |
|---|---|---|---|---|
| | Disabled | | Non-Disabled | |
| Quartile | Count | Proportion | Count | Proportion |
| 1 (Lower) | 242 | 10.90% | 1979 | 89.10% |
| 2 (Lower middle) | 170 | 7.71% | 2034 | 92.29% |
| 3 (Upper middle) | 144 | 6.36% | 2121 | 93.64% |
| 4 (Top) | 120 | 5.68% | 1992 | 94.32% |
| **Grand Total** | **676** | **7.68%** | **8126** | **92.32%** |

*Previous Year (2022-23)*

| Disabled | | Non-Disabled | |
|---|---|---|---|
| Count | Proportion | Count | Proportion |
| 216 | 10.30% | 1881 | 89.70% |
| 161 | 7.73% | 1923 | 92.27% |
| 136 | 6.38% | 1994 | 93.62% |
| 108 | 5.51% | 1853 | 94.49% |
| **621** | **7.51%** | **7651** | **92.49%** |

*Table 5.4.1*

The total number of staff making a declaration has increased.

Non-Medical Staff Groups

| | 2023-24 | | | |
|---|---|---|---|---|
| | Disabled | | Non-Disabled | |
| Quartile | Count | Proportion | Count | Proportion |
| 1 (Lower) | 242 | 10.90% | 1978 | 89.10% |
| 2 (Lower middle) | 159 | 7.45% | 1974 | 92.55% |
| 3 (Upper middle) | 130 | 6.21% | 1965 | 93.79% |
| 4 (Top) | 85 | 6.55% | 1213 | 93.45% |
| **Grand Total** | **616** | **7.95%** | **7130** | **92.05%** |

*Previous Year (2022-23)*

| Disabled | | Non-Disabled | |
|---|---|---|---|
| Count | Proportion | Count | Proportion |
| 216 | 10.30% | 1881 | 89.70% |
| 152 | 7.54% | 1865 | 92.46% |
| 126 | 6.37% | 1853 | 93.63% |
| 74 | 6.08% | 1144 | 93.92% |
| **568** | **7.77%** | **6743** | **92.23%** |

*Table 5.4.2*

The percentage of staff making a declaration has increased.

Medical Staff Groups

| | 2023-24 | | | |
|---|---|---|---|---|
| | Disabled | | Non-Disabled | |
| Quartile | Count | Proportion | Count | Proportion |
| 1 (Lower) | 0 | 0.00% | 1 | 100.00% |
| 2 (Lower middle) | 11 | 15.49% | 60 | 84.51% |
| 3 (Upper middle) | 14 | 8.24% | 156 | 91.76% |
| 4 (Top) | 35 | 4.30% | 779 | 95.70% |
| **Grand Total** | **60** | **5.68%** | **996** | **94.32%** |

*Previous Year (2022-23)*

| Disabled | | Non-Disabled | |
|---|---|---|---|
| Count | Proportion | Count | Proportion |
| 0 | 0.00% | 0 | 0.00% |
| 9 | 13.43% | 58 | 86.57% |
| 10 | 6.62% | 141 | 93.38% |
| 34 | 4.58% | 709 | 95.42% |
| **53** | **5.52%** | **908** | **94.48%** |

*Table 5.4.3*

The total number of staff making a declaration has increased.

## 6. Conclusion

6.1 The Trust has voluntarily reported a snapshot of data from 31 March 2024. This data demonstrates that there has been a calculated increase in the Disability Pay Gap in 2023-24.

The Trust acknowledges that we must continue to encourage staff to declare Disability/Non-Disability as we recognise there is a high proportion of staff who have declined the opportunity to make a declaration.

6.2 It should be noted that this report is the first published set of Disability Pay Gap Data, taken on 31 March 2024.

6.3 Separating the data for Agenda for Change and the Medical/Dental workforce gives a better understanding of where the greatest difference in pay and representation exists.

6.4 Comparing the median hourly pay gap, Disabled staff earn £0.88 for every £1 compared to Non-Disabled Staff. Their median hourly pay is 12.29% higher than Disabled Staff.

6.5 There is no median bonus pay gap for 2024. When comparing mean (average) bonus pay, Disabled Staff mean bonus pay is 3.42% higher than Non-Disabled Staff.

6.6 In addition to the Disability Pay Gap report there are two other pay gap report detailing the Gender Pay Gap and the Disability Pay Gap.

## 8. Next Steps – Priorities

UHD commits to the annual NHS Workforce Disability Equality Standard reporting process and publishes data and action plans to support this programme of works and they can be found on both the intranet internally and the external internet portal.

In November 2024 a new People and Culture Strategy was introduced with the aim to enable Global Majority Staff to be represented at all levels of the organisation.

As an aspiring Inclusive Employer our key Equality, Diversity and Inclusion objective for 2024 and the next 3 years will be:

'**To have a representative workforce at all levels of the Trust.'**

To do this we will implement our One Team EDI Plan priorities:

- strengthen our staff networks to work more closely with the UHD strategic needs and provide project support for engagement activity

- with our Dorset Partners and our Recruitment Team we will introduce clear guidance and requirements relating to inclusive recruitment

- develop a one-stop shop approach to accessing reasonable adjustments

- increase cultural awareness and reduce prejudice through the introduction of Conscious Inclusion workshops

Jon Harding
Head of Organisational Development
February 2025

## 1. Background

1.1 It became mandatory from 31 March 2017 for public sector organisations with over 250 employees to report annually on their gender pay gap. The results must be published on a government website, as well as the employer's own website (and remain there for 3 years).

1.2 The NHS equality, diversity, and inclusion improvement plan was introduced in 2023 with 6 high impact actions, (HIA) (link). The aim of this plan is to improve equality, diversity and inclusion, and to enhance the sense of belonging for NHS staff to improve their experience. While we refer to the protected characteristics as defined in the Equality Act 2010, the HIA were set out to positively impact groups and individuals beyond these terms and definitions.

1.3 HIA 3 introduced the need to develop and implement an improvement plan to eliminate pay gaps. This report contains a similar data set as our Gender Pay Gap Report and marks the first annual report for Ethnicity Pay Gap Reporting.

## 2.0 NHS Employer Guide to *Gender Pay Gap Reporting*

The NHS Employer Guide to *Gender Pay Gap Reporting* (link). *retrieved* 2025-02) has Six Indicators and these have been used to provide the framework to present our data.

An employer must publish six calculations showing their:

- Average gender pay gap as a mean [average]
- Average gender pay gap as a median [average]
- Average bonus gender pay gap as a mean [average]
- Average bonus gender pay gap as a median [average]
- Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment
- Proportion of males and females when divided into four groups ordered from lowest to highest pay.

Under national guidance, medical staff clinical excellence awards are included within bonus pay.

## 3. Methodology

3.1 The calculations have been undertaken at the snapshot date of 31 March 2024, using the national Electronic Staff Record (ESR) Business Intelligence standard report. In line with NHS Employers guidance Clinical Excellence Awards and the approach taken to award them at UHD have been categorised as bonuses.

3.2 Pay includes: basic pay, full paid leave including annual, sick, maternity, paternity, adoption or parental leave, bonus pay, area and other allowances and shift premium pay. (Note: bonus pay is included, but only as a separate metric as one of the 6 key indicators we need to produce. The gender pay gap figure is calculated from hourly pay – which can only be ordinary pay, bonus pay is not hourly).

3.3 Pay does not include: overtime pay, expenses (payments made to reimburse expenditure wholly and necessarily incurred in the course of employment, e.g. mileage for use of vehicle), remuneration in lieu of leave, the value of salary sacrifice schemes, benefits in kind (e.g. childcare vouchers), redundancy pay and tax credits.

## 4. UHD Workforce Context

4.1 The overall workforce is 75.5% White and 24.5% BME/Global Majority. The breakdown of the proportion of White and BME/Global Majority staff in each banding is as set out below:

**Pay Band Headcount**

*Staff with no ethnicity recorded on ESR are excluded below*

| | 2023-24 | | | | |
|---|---|---|---|---|---|
| | BME | | White | | Total |
| Pay Band | Headcount | % | Headcount | % | |
| Band 1 | 10 | 31.3% | 22 | 68.8% | **32** |
| Band 2 | 258 | 27.2% | 691 | 72.8% | **949** |
| Band 3 | 362 | 18.0% | 1650 | 82.0% | **2012** |
| Band 4 | 88 | 12.9% | 595 | 87.1% | **683** |
| Band 5 | 771 | 44.3% | 969 | 55.7% | **1740** |
| Band 6 | 252 | 17.4% | 1193 | 82.6% | **1445** |
| Band 7 | 94 | 9.3% | 922 | 90.7% | **1016** |
| Band 8a | 9 | 3.5% | 247 | 96.5% | **256** |
| Band 8b | 5 | 3.7% | 131 | 96.3% | **136** |
| Band 8c | 5 | 11.1% | 40 | 88.9% | **45** |
| Band 8d | 2 | 9.5% | 19 | 90.5% | **21** |
| Band 9 | 1 | 8.3% | 11 | 91.7% | **12** |
| VSM | 1 | 9.1% | 10 | 90.9% | **11** |
| Executive Director | 0 | 0.0% | 2 | 100.0% | **2** |
| Non-Executive Director | 2 | 28.6% | 5 | 71.4% | **7** |
| Chair | 0 | 0.0% | 1 | 100.0% | **1** |
| Other | 0 | 0.0% | 2 | 100.0% | **2** |
| Consultant | 114 | 24.4% | 354 | 75.6% | **468** |
| Non-Consultant Career Grade | 74 | 56.1% | 58 | 43.9% | **132** |
| Trainee Grades | 301 | 49.7% | 305 | 50.3% | **606** |
| **Total** | **2349** | **24.5%** | **7227** | **75.5%** | **9576** |

The use of the abbreviation BME has been used interchangeably with the trust agreed term Global Majority to recognise that this report will be available externally.

table 4.1 Pay Band Headcount split 2023/24

## 5. Ethnicity Pay Gap Reporting Summary

| Ethnicity Pay Gap Reporting<br>University Hospitals Dorset NHS Foundation Trust | | 2023-24 | *Previous Year (2022-23)* | *Change 23.24 v 22.23* |
|---|---|---|---|---|
| **Substantive Headcount** | BME | 2349 | *2021* | ↑ *328* |
| | White | 7227 | *7144* | ↑ *83* |
| | **Total** | **9576** | ***9165*** | |
| | BME | 24.53% | *22.05%* | ↑ *2.48%* |
| | White | 75.47% | *77.95%* | ↓ *-2.48%* |
| **Excluded due to no declaration on ESR** | Headcount | 273 | *273* | → *0* |
| | Proportion | 2.77% | *2.89%* | ↓ *-0.12%* |
| **Difference in hourly rate** | Mean Average | -1.02% | *-3.11%* | ↑ *2.09%* |
| | Median | -1.13% | *-2.34%* | ↑ *1.21%* |
| **Proportion of BME staff in each pay quartile** | Lower | 17.80% | *15.55%* | ↑ *2.25%* |
| | Lower middle | 29.63% | *24.97%* | ↑ *4.66%* |
| | Upper middle | 29.04% | *26.17%* | ↑ *2.87%* |
| | Top | 21.15% | *19.91%* | ↑ *1.25%* |
| **Who received bonus pay** | BME | 4.30% | *4.90%* | ↓ *-0.60%* |
| | White | 4.43% | *4.23%* | ↑ *0.20%* |
| **Difference in bonus pay** | Mean Average | 18.77% | *25.22%* | ↓ *-6.45%* |
| | Median | 0.00% | *0.00%* | → *0.00%* |
| **Our Ethnicity Pay Gap is -** | | **-1.13%** | ***-2.34%*** | |

*Figure 5.1 Ethnicity Pay Gap Summary*

### 5.1 Ethnicity Pay Gap Results

- Our headcount has increased by 411 to 9,576 since last year with 328 more Global Majority staff and 83 more white staff across UHD (31st March 2023 vs. 31st March 2024). Staff without declared ethnicity have been excluded.

- This year our Ethnicity Pay Gap is **-1.13%** in favour of Global Majority staff with the comparator White staff.

- There is a notably static position at senior Manager level.
  Appendix 1 shows the Disparity in Career Progression ratios which help to explain the lack of mobility between bandings and grades for Global Majority staff. For lower to upper career progression, whole trust; the ratio is 7.4 or seven times that for White staff. This could be in part due to lower representation in the lower bands for Global Majority staff and the international recruitment of graduate nurses at band 5.

- Appendix 2 shows that Global Majority staff increasingly report [q24 2023] opportunity to develop their careers.

## 5.2 Ordinary Pay

**Ordinary Pay - Trust Summary**

*Staff with no ethnicity recorded on ESR are excluded on this tab*

| | 2023-24 | | |
|---|---|---|---|
| | **BME** | **White** | *BME change 23.24 v 22.23* |
| Average Hourly Rate | £20.68 | £20.47 | ↑ £0.78 |
| Difference in Average Hourly Rate | -£0.21 | | ↑ £0.39 |
| Average Pay Gap | -1.0% | | ↑ 2.1% |
| Median Hourly Rate | £17.88 | £17.69 | ↑ £0.65 |
| Difference in Median Hourly Rate | -£0.20 | | ↑ £0.19 |
| **Median Pay Gap** | **-1.13%** | | ↑ **1.21%** |

- The ethnicity pay gap for the Trust overall in 2023-24 is -1.13%. The calculated gap for 2022-23 is -2.34%.
- The mean ethnicity pay gap for the Trust is -1.02%. The calculated gap for 2022-23 is -3.11%.
- The Trust's mean Global Majority/BME pay is £20.68 compared to £20.47 for White staff.
- The Trust's median Global Majority/BME pay is £17.88 compared to £17.69 for White Staff.

*See tables 5.2.1 and 5.2.2*

### Average (Mean) Ethnicity Pay Gap - Ordinary Pay

| | 2023-24 | | |
|---|---|---|---|
| | **BME** | **White** | ***% difference*** |
| All Staff | £20.68 | £20.47 | ***-1.02%*** |
| Non-Medical Staff Groups | £17.12 | £18.22 | ***6.00%*** |
| Medical Staff Group | £35.14 | £42.04 | ***16.42%*** |

| *Previous Year (2022-23)* | | |
|---|---|---|
| **BME** | **White** | ***% difference*** |
| £19.90 | £19.30 | *-3.11%* |
| £16.27 | £17.18 | *5.29%* |
| £33.45 | £40.14 | *16.68%* |

*Table 5.2.1*

## Median Ethnicity Pay Gap - Ordinary Pay

| | 2023-24 | | |
|---|---|---|---|
| | BME | White | % difference |
| All Staff | £17.88 | £17.69 | ***-1.13%*** |
| Non-Medical Staff Groups | £16.75 | £16.68 | ***-0.44%*** |
| Medical Staff Group | £30.28 | £44.91 | ***32.58%*** |

| *Previous Year (2022-23)* | | |
|---|---|---|
| **BME** | **White** | ***% difference*** |
| £17.24 | £16.84 | *-2.34%* |
| £16.00 | £15.52 | *-3.08%* |
| £28.47 | £42.37 | *32.80%* |

*Table 5.2.2*

### 5.3 Clinical Excellence Awards Bonus Payments

There will be new national awards that will be featured in future reports, and these are expected to have 3 levels. For 2025, the bonus pay data has been grouped together as there were so few. We are going to see the local CEAs and discretionary points phased out in future reports.

Local Clinical Excellence Award's (LCEA) recognised and rewarded NHS consultants in England, who perform over and above the standard expected of their role. Awards were given for quality and excellence, acknowledging exceptional personal contributions.

**Bonus Pay***

**Bonus Pay includes both local and national awards, and includes Discretionary Points.*

| | 2023-24 | | |
|---|---|---|---|
| | **BME** | **White** | *BME change 23.24 v 22.23* |
| Number of Staff Receiving Bonus Pay | 101 | 320 | ↑ 2 |
| Proportion of All Staff Receiving Bonus Pay | 4.3% | 4.4% | ↓ -0.6% |
| Proportion of Medical Staff Receiving Bonus Pay | 20.6% | 44.6% | ↓ -1.7% |
| Average (mean) Bonus Pay Received | £6,225.98 | £7,664.44 | ↑ £391.49 |
| Difference in Bonus Pay - Mean Average | £1,438.45 | | ↓ -£528.92 |
| Average Bonus Pay Gap | 18.77% | | ↓ -6.4% |
| Median Bonus Pay Received | £3,503.66 | £3,503.66 | ↑ £330.35 |
| Difference in Bonus Pay - Median | £0.00 | | → £0.00 |
| Median Bonus Pay Gap | 0% | | → 0.0% |
| Minimum Bonus Pay Received | £3,503.66 | £33.51 | ↑ £330.35 |
| Maximum Bonus Pay Received | £39,695.66 | £47,582.04 | ↑ £330.35 |
| *Number of Staff Receiving Bonus Pay Excluded Due to No Ethnicity Recorded on ESR* | 26 | | |

*Table 5.3.1 Bonus Pay*

## 5.4 Proportion of Males and Females in each Quartile Pay Band

At the time the snapshot was taken the percentage of Global Majority staff was 24.42% and 75.58% White staff. This representing a decrease in White staff for the whole trust.

All Staff Groups

| | 2023-24 | | | |
|---|---|---|---|---|
| | BME | | White | |
| Quartile | Count | Proportion | Count | Proportion |
| 1 (Lower) | 444 | 17.80% | 2050 | 82.20% |
| 2 (Lower middle) | 741 | 29.63% | 1760 | 70.37% |
| 3 (Upper middle) | 724 | 29.04% | 1769 | 70.96% |
| 4 (Top) | 521 | 21.15% | 1942 | 78.85% |
| **Grand Total** | **2430** | **24.42%** | **7521** | **75.58%** |

*Previous Year (2022-23)*

| BME | | White | |
|---|---|---|---|
| Count | Proportion | Count | Proportion |
| 370 | 15.55% | 2009 | 84.45% |
| 592 | 24.97% | 1779 | 75.03% |
| 622 | 26.17% | 1755 | 73.83% |
| 466 | 19.91% | 1875 | 80.09% |
| **2050** | **21.65%** | **7418** | **78.35%** |

The proportion of **Global Majority staff** has increased in 2024.

*Table 5.4.1*

Non-Medical Staff Groups

| | 2023-24 | | | |
|---|---|---|---|---|
| | BME | | White | |
| Quartile | Count | Proportion | Count | Proportion |
| 1 (Lower) | 443 | 17.77% | 2050 | 82.23% |
| 2 (Lower middle) | 729 | 30.04% | 1698 | 69.96% |
| 3 (Upper middle) | 628 | 27.01% | 1697 | 72.99% |
| 4 (Top) | 150 | 9.91% | 1364 | 90.09% |
| **Grand Total** | **1950** | **22.26%** | **6809** | **77.74%** |

*Previous Year (2022-23)*

| BME | | White | |
|---|---|---|---|
| Count | Proportion | Count | Proportion |
| 370 | 15.55% | 2009 | 84.45% |
| 579 | 25.11% | 1727 | 74.89% |
| 533 | 24.06% | 1682 | 75.94% |
| 134 | 9.26% | 1313 | 90.74% |
| **1616** | **19.36%** | **6731** | **80.64%** |

The proportion of **non-medical Global Majority staff** has increased from 2024.

*Table 5.4.2*

Medical Staff Groups

| | 2023-24 | | | |
|---|---|---|---|---|
| | BME | | White | |
| Quartile | Count | Proportion | Count | Proportion |
| 1 (Lower) | 1 | 100.00% | 0 | 0.00% |
| 2 (Lower middle) | 12 | 16.22% | 62 | 83.78% |
| 3 (Upper middle) | 96 | 57.14% | 72 | 42.86% |
| 4 (Top) | 371 | 39.09% | 578 | 60.91% |
| **Grand Total** | **480** | **40.27%** | **712** | **59.73%** |

*Previous Year (2022-23)*

| BME | | White | |
|---|---|---|---|
| Count | Proportion | Count | Proportion |
| 0 | 0.00% | 0 | 0.00% |
| 13 | 20.00% | 52 | 80.00% |
| 89 | 54.94% | 73 | 45.06% |
| 332 | 37.14% | 562 | 62.86% |
| **434** | **38.72%** | **687** | **61.28%** |

The proportion of medical grade Global Majority staff has increased from in 2024.

*Table 5.4.3*

## 6. Conclusion

6.1 The Trust has voluntarily reported a snapshot of data from 31 March 2024. This data demonstrates that there is an increase in the number of Global Majority staff.

The Trust acknowledges that there could be greater Global Majority representation in more senior roles.

6.2 It should be noted that this report is the first published set of Ethnicity Pay Gap Data, taken on 31 March 2024.

6.3 Separating the data for Agenda for Change and the Medical/Dental workforce gives a better understanding of where the greatest difference in pay and representation exists.

6.4 Comparing the median hourly pay gap, Global Majority staff earn approximately £1.01 for every £1 that White Staff earn. Their median hourly pay is 1.13% higher than White Staff.

6.5 There is no median bonus pay gap for 2024. When comparing mean (average) bonus pay, Global Majority Staff mean bonus pay is 18.77% lower than White Staff.

6.6 In addition the Ethnicity Pay Gap report there are two other reports detailing the Gender Pay Gap and the Disability Pay Gap.

## 8. Next Steps – Priorities

UHD commits to the annual NHS Workforce Race Equality Standard reporting process and publishes data and action plans to support this programme of works and they can be found on both the intranet internally and the external internet portal.

In November 2024 a new People and Culture Strategy was introduced with the aim to enable Global Majority Staff to be represented at all levels of the organisation.

As an aspiring Inclusive Employer our key Equality, Diversity and Inclusion objective for 2024 and the next 3 years will be:

'**To have a representative workforce at all levels of the Trust.'**

To do this we will implement our One Team EDI Plan priorities:

- strengthen our staff networks to work more closely with the UHD strategic needs and provide project support for engagement activity

- with our Dorset Partners and our Recruitment Team we will introduce clear guidance and requirements relating to inclusive recruitment

- develop a one-stop shop approach to accessing reasonable adjustments

- increase cultural awareness and reduce prejudice through the introduction of Conscious Inclusion workshops

Our goal is to increase Global Majority representation in band 8a and above to over 9% within 12–18 months and raise band 6 and above by 3% in 24–36 months.

Jon Harding
Head of Organisational Development
February 2025

## Appendix 1 Disparity Ratios / Whole Trust 31 March 2024

| Bands | White - Current Year | BME - Current Year | Unknown - Current Year |
|---|---|---|---|
| Under Band 1 | 0 | 0 | 0 |
| Band 1 | 22 | 10 | 2 |
| Band 2 | 721 | 270 | 44 |
| Band 3 | 1,645 | 359 | 43 |
| Band 4 | 603 | 95 | 16 |
| Band 5 | 992 | 801 | 39 |
| Band 6 | 1,263 | 255 | 38 |
| Band 7 | 950 | 98 | 15 |
| Band 8a | 251 | 10 | 4 |
| Band 8B | 129 | 5 | 2 |
| Band 8C | 39 | 4 | 0 |
| Band 8D | 20 | 3 | 0 |
| Band 9 | 12 | 1 | 0 |
| VSM | 10 | 1 | 0 |
| **Grand Total** | **6,657** | **1,912** | **203** |

| Bandings | White - Current Year | BME - Current Year | Unknown - Current Year |
|---|---|---|---|
| 1 to 5 | 3,983 | 1,535 | 144 |
| 6 and 7 | 2,213 | 353 | 53 |
| Band 8a+ | 461 | 24 | 6 |
| **Grand Total** | **6,657** | **1,912** | **203** |

| | White | BME |
|---|---|---|
| **Lower to middle** | **1.80** | **4.35** |
| **Middle to upper** | **4.80** | **14.71** |
| **lower to upper** | **8.64** | **63.96** |

| | |
|---|---|
| **Disparity ratio - lower to middle** | **2.42** |
| **Disparity ratio - middle to upper** | **3.06** |
| **Disparity ratio - lower to upper** | **7.40** |

| Total No of Staff | BME representation at trust |
|---|---|
| **8,772** | **21.8%** |

There is a notable representation of Global Majority Staff at band 5, this is in part due to International Nurse Recruitment, this will have affected our data and will have contributed to the reported pay gap. An alternative structure view can be found on page 12.

Programmes of work within the People and Culture Strategy and the supporting Patient First Improvement Programme will introduce Talent Management and career progression.

A review of Recruitment Processes will provide a consistent approach to appointments thereby supporting the progression of all staff and recruitment of external candidates.

## Disparity Ratios / Clinical 31 March 2024

| Bands | White - Current Year | BME - Current Year | Unknown - Current Year |
|---|---|---|---|
| Under Band 1 | 0 | 0 | 0 |
| Band 1 | 8 | 1 | 1 |
| Band 2 | 243 | 137 | 13 |
| Band 3 | 1,028 | 281 | 33 |
| Band 4 | 168 | 58 | 5 |
| Band 5 | 785 | 772 | 34 |
| Band 6 | 1,136 | 233 | 31 |
| Band 7 | 822 | 83 | 12 |
| Band 8a | 169 | 8 | 2 |
| Band 8B | 74 | 3 | 0 |
| Band 8C | 16 | 3 | 0 |
| Band 8D | 9 | 1 | 0 |
| Band 9 | 3 | 0 | 0 |
| VSM | 1 | 1 | 0 |
| **Grand Total** | **4,462** | **1,581** | **131** |

| Bandings | White - Current Year | BME - Current Year | Unknown - Current Year |
|---|---|---|---|
| 1 to 5 | 2,232 | 1,249 | 86 |
| 6 and 7 | 1,958 | 316 | 43 |
| Band 8a+ | 272 | 16 | 2 |
| **Grand Total** | **4,462** | **1,581** | **131** |

| | White | BME |
|---|---|---|
| **Lower to middle** | **1.14** | **3.95** |
| **Middle to upper** | **7.20** | **19.75** |
| **lower to upper** | **8.21** | **78.06** |

| | |
|---|---|
| **Disparity ratio - lower to middle** | **3.47** |
| **Disparity ratio - middle to upper** | **2.74** |
| **Disparity ratio - lower to upper** | **9.51** |

| Total No of Staff | Clinical BME representation at trust |
|---|---|
| **6,174** | **25.6%** |

## Disparity Ratios / Non-Clinical 31 March 2024

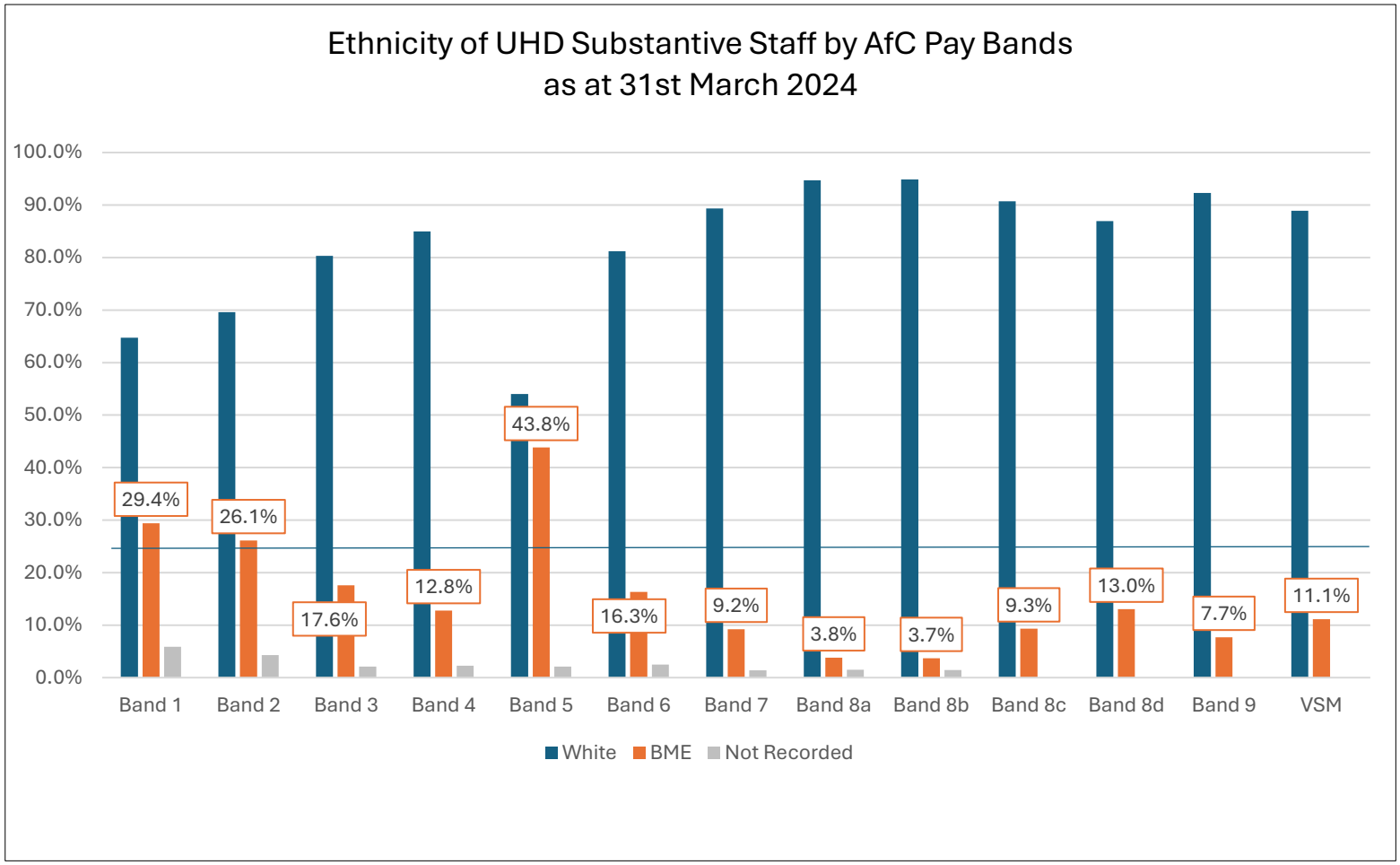
| Bands | White - Current Year | BME - Current Year | Unknown - Current Year |
|---|---|---|---|
| Under Band 1 | 0 | 0 | 0 |
| Band 1 | 14 | 9 | 1 |
| Band 2 | 478 | 133 | 31 |
| Band 3 | 617 | 78 | 10 |
| Band 4 | 435 | 37 | 11 |
| Band 5 | 207 | 29 | 5 |
| Band 6 | 127 | 22 | 7 |
| Band 7 | 128 | 15 | 3 |
| Band 8a | 82 | 2 | 2 |
| Band 8B | 55 | 2 | 2 |
| Band 8C | 23 | 1 | 0 |
| Band 8D | 11 | 2 | 0 |
| Band 9 | 9 | 1 | 0 |
| VSM | 9 | 0 | 0 |
| **Grand Total** | **2,195** | **331** | **72** |

| Bandings | White - Current Year | BME - Current Year | Unknown - Current Year |
|---|---|---|---|
| 1 to 5 | 1,751 | 286 | 58 |
| 6 and 7 | 255 | 37 | 10 |
| Band 8a+ | 189 | 8 | 4 |
| **Grand Total** | **2,195** | **331** | **72** |

| | White | BME |
|---|---|---|
| **Lower to middle** | **6.87** | **7.73** |
| **Middle to upper** | **1.35** | **4.63** |
| **lower to upper** | **9.26** | **35.75** |

| | |
|---|---|
| **Disparity ratio - lower to middle** | **1.13** |
| **Disparity ratio - middle to upper** | **3.43** |
| **Disparity ratio - lower to upper** | **3.86** |

| Total No of Staff | Non- Clinical BME representation at trust |
|---|---|
| **2,598** | **12.7%** |




Target line showing BME/Global Majority representation in UHD at 24%

**Appendix 2 NHS National Staff Survey Data taken for the period covering the report data and the preceding year.**

| | | 2022 | | | 2023 | | |
|---|---|---|---|---|---|---|---|
| | Questions presented comparing BME/White experience; sourced from the NHS Staff Survey 2022 & 2023 heatmaps | UHD (4,167) | White (3,491) | BME (599) | UHD (5,619) | White (4,543) | BME (1,003) |
| Q15 | Does your organisation act fairly with regard, to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age (yes) | 57.8% | 60.1% | 45.7% | 57.7% | 60.7% | 46.1% |
| Q24b | There are opportunities for me to develop my career in this organisation (agree/strongly agree) | 51.1% | 52.0% | 47.6% | 58.2% | 57.2% | 64.3% |
| Q24c | I have opportunities to improve my knowledge and skills (agree/strongly agree) | 58.2% | 59.7% | 50.3% | 71.6% | 71.3% | 74.3% |
| Q24d* | I feel supported to develop my potential (agree/strongly agree) | Q22d 53.9% | 53.7% | 56.1% | Q24d* 57.7% | 57.6% | 59.9% |
| Q24e* | I am able to access the right learning and development opportunities when I need to (agree/strongly agree) | Q22e 55.8% | 55.7% | 57.2% | Q24e* 59.9% | 59.7% | 62.9% |

Q15. is used to inform the Workforce Race quality Standard and shows some improvement for Global Majority Staff.

Q24b. shows a more positive position in relation to career progression.

The NSS conducted in q3 of 2024 will be monitored and included in the WRES 2025 report and the 2026 Ethnicity Pay

University Hospitals Dorset
NHS Foundation Trust

# BOARD OF DIRECTORS - PART 1 MEETING

**Meeting Date: 05 March 2025**

**Agenda item: 6.7**

| | |
|---|---|
| **Subject:** | Key Issues and Assurance Report to Board of the Population Health & System Committee meeting held on 16 January 2025 |
| **Prepared by:** | Helena McKeown, Chair of the Population Health & System Committee |
| **Presented by:** | Helena McKeown, Chair of the Population Health & System Committee |

| | |
|---|---|
| **Key Issues/matters discussed by the Committee:** | The Committee received the following:<br><br>• Equality Delivery System submission report<br>• National Strategy for Elective Care report<br>• NHS Dorset Update. |
| **Significant issues for escalation to Board for action:** | There were no significant issues for escalation to the Board for action.<br><br>The following matters are raised for the Board's awareness: Our Equality Delivery System submission was led by the Quality and Diversity Group including focus on ethnicity recording, targeted lung health checks; and a project by the addiction service focused on high-intensity users of the Emergency Department (ED). Maternity has achieved 100% in ethnicity recording data and the Trust is slightly below the average for ethnicity recording in emergency, inpatients and outpatients. NHS Dorset plans to use the findings from multiple organisations to enhance their understanding of ethnic inequality. Ethnicity recording is currently available as a field but requires a cultural shift to ensure the question is asked.<br><br>UHD's Did Not Attend (DNA) initiative has been a significant contributor to the ICB's health inequalities and prevention programme. |

University Hospitals Dorset
NHS Foundation Trust

**BOARD OF DIRECTORS - PART 1 MEETING**

**Meeting Date: 05 March 2025**

**Agenda item: 7.1**

| | |
|---|---|
| **Subject:** | Risk Register Report - risks rated 15 and above |
| **Prepared by:** | Jo Sims, Associate Director for Quality Governance and Risk<br>Justine George, Risk Register Coordinator |
| **Presented by:** | Sarah Herbert, Chief Nursing Officer |

| | | |
|---|---|---|
| **Strategic themes that this item supports/impacts:** | Population & System | ☐ |
| | Our People | ☐ |
| | Patient Experience | ☐ |
| | Quality Outcomes & Safety | ☒ |
| | Sustainable Services | ☐ |
| **BAF/Corporate Risk Register: (if applicable)** | All | |
| **Purpose of paper:** | Information | |
| **Executive Summary:** | There are 244 approved risks on UHDs Risk register, of which 19 are rated as 15 and above. | |
| **Background:** | The report is provided in accordance with the UHD Risk Management Strategy.<br><br>To provide details of the risks rated 15 and above on the UHD NHS Foundation Trust risk register. | |
| **Key Recommendations:** | To review risks rated 15-25. | |
| **Implications associated with this item:** | Council of Governors | ☐ |
| | Equality, Equity, Diversity & Inclusion | ☐ |
| | Financial | ☐ |
| | Health Inequalities | ☐ |
| | Operational Performance | ☐ |
| | People (inc Staff, Patients) | ☐ |
| | Public Consultation | ☐ |
| | Quality | ☒ |
| | Regulatory | ☐ |
| | Strategy/Transformation | ☐ |
| | System | ☐ |
| **CQC Reference:** | Safe | ☒ |
| | Effective | ☐ |
| | Caring | ☐ |

| | | |
|---|---|---|
| | Responsive | ☐ |
| | Well Led | ☒ |
| | Use of Resources | ☐ |

| Report History: Committees/Meetings at which the item has been considered: | Date | Outcome |
|---|---|---|
| Trust Management Group | 18/02/2025 | Discussion and approval of new risks increased to 15-25 risk rating |

| | | |
|---|---|---|
| **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

# Risk Register Report

The Risk Register report provides details of all current (approved) risks rated 15-25 to be presented at Part 1 of the Board meeting every other month.

**For the period to end January 2025 (as on 03/02/2025)**

# Risk Register Report

## Risk Register

**SUMMARY**
The report details current (approved) risks rated 15-25. 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 244 approved risks on UHDs Risk register, of which 19 are rated as 15 and above.**

**Rating movement key**

- **Stayed the same**
- **Increased**
- **Decreased**
- **New**

| **Population & System Risk** | |
|---|---|
| **Risk ID** | 2052 |
| **Risk Title** | Care of patients in non-clinical areas in the Emergency Department |
| **Date risk raised on the risk register** | 10/04/2024 |
| **Date risk approved as 15+ risk** | 01/07/2024 |
| **Risk Rating** | 20  |
| **Risk Description** | A lack of capacity in the hospital and a requirement to release ambulance crews in a timely manner has led to an increase in the use of non-clinical areas, particularly corridors for patients awaiting a trolley/chair space in both Emergency Departments. This creates a risk of harm to patients, a compromise to privacy and dignity and an increased risk of obstruction of thoroughfares and escape routes. |
| **Executive sponsor** | Chief Operating Officer |
| **Controls in place** | • SOP on corridor use<br>• Ambulance handover SOP<br>• Divert procedures including dynamic conveyancing<br>• Escalation process |
| **Gaps in controls** | • Staffing is reliant on bank and agency workers and therefore levels are not always met<br>• Additionally, where the corridor is under the care of South Western Ambulance Service (SWAST), there is the risk of a lack of clinical oversight from UHD |
| **Action plan(s)** | • Improve the facilities for patient privacy and dignity in Bournemouth corridor<br>• Decompress the Emergency Department to prevent crowding |
| **Risk appetite scale** | Cautious |

# Risk Register Report

| | |
|---|---|
| **Risk tolerance range** | 9-15 |
| **Tolerance breach?** | Yes |
| **Target Risk Rating** | 16 |
| **Progress update** | Updated at UEC Board - Changes to include actions to reduce care in non-clinical area, staffing, THP Timely handover process |

| **Population & System Risk** | |
|---|---|
| **Risk ID** | 2132 |
| **Risk Title** | Cystoscopes issues affecting patients and service provision |
| **Date risk raised on the risk register** | 11/11/2024 |
| **Date risk approved as 15+ risk** | 17/12/2024 |
| **Risk Rating** | 16  |
| **Risk Description** | If we continue with the current arrangement for the provision of cystoscopes with the manufacturer Karl Storz, then UHD will not have enough across the Trust to continue a robust Cystoscopy service. Patients requiring this procedure will need to be cancelled including those on cancer pathways. |
| **Executive sponsor** | Chief Operating Officer |
| **Controls in place** | • Training (handling and usage of cystoscopes) put in place for Theatres and Decon teams<br>• The theatres team record the serial numbers of the cyctoscopes sent for repair to track if we are getting back the scopes<br>• Quick turnaround of the scopes - prioritising the endoscopy service (by SSD team in BH).<br>• Recording the information on why we have sent back the equipment to be able to challenge the decisions re the level of breakage.<br>• Formal issue and concern submitted by Anaesthetics team to supplier (Karl Storz) |
| **Gaps in controls** | • Lack of funding to pay for the scopes currently held by manufacturer<br>• The lack of consistent comms from the Manufacturer re: faulty scopes and reasons of scopes breaking. |
| **Action plan(s)** | • Report to MHRA<br>• To explore other options for scopes repairs (different manufacturer)<br>• To hold the meeting with Karl Storz to discuss the issues |
| **Risk appetite scale** | Cautious |
| **Risk tolerance range** | 9-15 |

# Risk Register Report

| | |
|---|---|
| **Tolerance breach?** | Yes |
| **Target Risk Rating** | 2 |
| **Progress update** | Replacement limit reached with Karl Storz<br>email to clinical leads of Uro and Gynae to discuss options and mitigation (e.g. single use)<br>Theatres continue to experience issues when using the KS flexible cystoscopes - scope not registering when plugged into operating system to ready for use<br>3 scopes returned to KS W/c 13/1/25 - awaiting report<br>Reaching replacement limit (9 replace scopes available in contract year, 6 scopes replaced) |

| **Population & System Risk** | |
|---|---|
| **Risk ID** | 1970 |
| **Risk Title** | Glaucoma Virtual Review Backlog |
| **Date risk raised on the risk register** | 22/09/2023 |
| **Date risk approved as 15+ risk** | 02/05/2024 |
| **Risk Rating** | 16 |
| **Risk Description** | Risk that if the Trust is unable to address glaucoma reviews being done in a timely manner then there is a risk to patients of preventable, irreversible sight loss. |
| **Executive sponsor** | Chief Medical Officer |
| **Controls in place** | • Dept SOP- If a patient's eye pressure is found to be high (more than 30mmHg) then they are prioritised for a review. If the Technicians have any concerns, then they will flag the patient using a separate email account. This is then prioritised.<br>• Patient information - The patient is advised to present to Eye Emergency if the Technicians are really concerned and identify that the patient needs to be reviewed on the same day their pressures have been taken.<br>• SOP - Technicians ask a series of questions which will inform them whether to flag the patient as a concern.<br>• Timetable review for Glaucoma Nurse Specialists to enable them to support with virtual reviews. |
| **Gaps in controls** | • When a patient's pressure is high, but less than 30mmHg, or they have progressive field loss, as the patient is often not aware of the field loss, they can have permanent sight loss. |
| **Action plan(s)** | • To present the plan to set up additional clinics to the directorate<br>• Recruit locum Glaucoma Consultant |
| **Risk appetite scale** | Cautious |

# Risk Register Report

| | |
|---|---|
| **Risk tolerance range** | 9-15 |
| **Tolerance breach?** | Yes |
| **Target Risk Rating** | 6 |
| **Progress update** | Engaged with Insourcing company due to start January to relieve some of the pressure. Work with system partners ongoing to share resource. |

| **Population & System Risk** | |
|---|---|
| **Risk ID** | 1053 |
| **Risk Title** | Lack of capacity for elective & non elective activity and associated risk to patient harm due to LLOS and NCTR patients |
| **Date risk raised on the risk register** | 14/01/2015 |
| **Date risk approved as 15+ risk** | 08/03/2021 |
| **Risk Rating** | 16  |
| **Risk Description** | Risk of potential patient harm to patients who no longer require acute care (have 'No Criteria to Reside') or to elective/non elective patients who cannot access acute beds due to increased occupancy. Associated risks to performance standards and organisational reputation. |
| **Executive sponsor** | Chief Operating Officer |
| **Controls in place** | • Daily monitoring of patients with No Reason to Reside (NRTR) - reported daily via email<br>Daily report sent RS100 3 times a day with all patients recorded on health of the ward as ready to leave with no criteria to reside.<br>There is daily oversight from discharge team of patients with no criteria to reside that are on P1-3.<br>Care groups to confirm strategy of monitoring daily patients with no criteria to reside on P0.<br>• Daily review of all NCTR patients with system partners by site<br>Discharge team support and oversight with daily meetings Monday-Friday I believe.<br>• Complex Care wards established both sites to focus expertise<br>Fayrewood and Lulworth on Poole and ward 5 at RBH. MADE event with partners in May to assist with complex discharges and movement of patients from these wards. Lots of positive learning for ward MDT and partners. OPS plan to rearrange further events like this.<br>Medical specialties looking to establish a similar model in the near future.<br>• Discharge lounges both sites now established and actively pulling patients<br>• Establishment of SPA data to track against<br>• RTL/LLOS >21 LoS standards<br>Weekly reviews of LLOS patients by senior matrons in MCG with Medical director with view of Longest LOS patients by CMO established.<br>• D2A plans and home first principles to support external capacity - Home First Board and Delivery Groups<br>Criteria to Reside internal programme (building on previous initiatives e.g. There's no place like Home, Breaking Barriers weeks, SAFER Care Bundle, EDD, Red/Green Days, Nuggets of Best Practice, Gold and Silver patients) |

# Risk Register Report

| | |
|---|---|
| | • HotW in situ for C2R Local and national reporting - (data completion/accuracy metrics)<br>• HotW in situ for C2R Local and national reporting - (data completion/accuracy metrics)<br>• LERN policy - There is a dashboard on cosmos which identifies any reported harms for patients with No criteria to reside.<br>MCG report this info through quality forum and RAG.<br>KLOE in panel meeting re; at point of incident did patient have a criteria to reside.<br>• UEC performance metrics<br>• Bed occupancy procedures and standards<br>• Delivery of elective activity recovery plans<br>The Transfer of Care Hub (ToC) has started using the Estimated Date Ready (EDR) Weekly system meetings to collaborate with an overarching objective of reducing NCTR<br>Strategic partner (Newton Group) engaged to commence in July a 10-week diagnostic across the Dorset system.<br>Presentation to National Team on system wide approach<br>System commissioned Newton to support ICB in reducing NCTR<br>Trust wide flow initiative scheduled for 11th Sept to pilot schemes with a view to embedding different ways of working. OBD reduction programme in place with robust monitoring. |
| **Gaps in controls** | • Challenges to accommodate patients who require acute medical access to an acute hospital bed<br>• Challenges to accommodate patients who require elective care (due to outlying in elective beds)<br>• Challenges to manage patient flow and bed capacity - getting patients into the right bed at the right time<br>• The requirement and challenge to open and staff escalation capacity safely<br>• Any delay in discharge can impact on flow and the ability to achieve the ED mean time standard and other UEC standards<br>• Within DME/OPS and other areas patients sit outside of specialty and can have delayed clinical review and a reduced specialist knowledge of diagnosis specific care. Within DME/OPS, this will include mental health issues support.<br>• Extended stay can increase the risk of hospital acquired infection and deterioration<br>• Decommissioning of the System non- core offer |
| **Action plan(s)** | • There's no place like home and Discharge to Assess programs to lift barriers to discharge.<br>• Improve hospital flow using NHS ECIST tools.<br>• Joint working with partner agencies and regional DOTC meetings.<br>• System UEC Executive meeting to review current pressures and Q2 plan/in extremis actions, System wide risk assessment and action plan<br>• Support for mental health patients who are medically fit for discharge/transfer<br>• Internal Criteria to Reside Programme<br>• Implementation of system Home First programme and associated pathways<br>• UHD Capacity De-escalation Plan<br>• ECIST CTA plan |
| **Risk appetite scale** | Cautious |
| **Risk tolerance range** | 9-15 |
| **Tolerance breach?** | Yes |
| **Target Risk Rating** | 9 |
| **Progress update** | My care needs launched. Newton admission avoidance work underway. LLOS oversight from exec & DCOO level. |

# Risk Register Report

| Population & System Risk | |
|---|---|
| **Risk ID** | 1784 |
| **Risk Title** | Risk of not integrating teams and services and then reconfiguring to create the planned and emergency hospitals |
| **Date risk raised on the risk register** | 02/08/2022 |
| **Date risk approved as 15+ risk** | 01/09/2022 |
| **Risk Rating** | 16  |
| **Risk Description** | Risk recognises the importance of integrating and operating services as a unified entity at least 6 to 9 months prior to any move. |
| **Executive sponsor** | Chief Strategy and Transformation Officer |
| **Controls in place** | • Prevention Evidence of effective governance workstreams<br>• Speciality level plans in place<br>• Meeting structure, attendance, escalation and resolution from speciality steering groups into CG and then Service Ready Group (SRG)<br>• Service Reviews to assess readiness for moves with actions followed up by Care Groups<br>• Robust critical path timeline that clearly articulates deliverables and interdependencies between specific deliverables<br>• Good and effective management of individual programmes (Beach, NHP, Decants, Clinical Integration)<br>• Focus on Critical Path actions<br>• Detection: Internal Audit, NHP Scrutiny/Governance, external Gateway process, result of Service Review findings and progress on critical path actions. Go/No Go checklist and criteria |
| **Gaps in controls** | • Development and operational use of the integration dashboard<br>• Changes to the build programme and interdependency with the reconfiguration programme<br>• Assurance that actions identified at speciality, CG and during Speciality reviews are completed<br>• Effective Working Groups in place to manage the hygiene factors (e.g. Travel Working Group and Improving Staff Experience Group) |
| **Action plan(s)** | • Demonstrate evidence of good and strengthened governance and a robust critical path |
| **Risk appetite scale** | Cautious |
| **Risk tolerance range** | 9-15 |
| **Tolerance breach?** | Yes |
| **Target Risk Rating** | 8 |
| **Progress update** | Risk remains the same. Review in March 2025. Full report updated and attached |

# Risk Register Report

| Population & System Risk | |
|---|---|
| **Risk ID** | 1395 |
| **Risk Title** | Lack of Capacity in Cellular Pathology Causing a Delay in Processing and Reporting |
| **Date risk raised on the risk register** | 13/11/2020 |
| **Date risk approved as 15+ risk** | 04/08/2023 |
| **Risk Rating** | 15  |
| **Risk Description** | Very significant demand and capacity gap in department exacerbated further by additional elective recovery activity. Insufficient medical, support and scientific staff available to meet service increasing workload and complexity of requests. Risk of delayed reporting of cases, impacting on patient referral-treatment times. |
| **Executive sponsor** | Chief Operating Officer |
| **Controls in place** | • Business case for additional staff and incentive package submitted<br>• Use of bank staff and locums where either are available<br>• Use of overtime & recovery points where available<br>• Monitoring and management of backlog with prioritisation of cases. Please refer to procedure on QPulse [B-CP-P-00043]<br>• Implementation of push system<br>• Review of clinical, scientific and support staff mix with every VRP (TRAC)<br>• Contingency for Moh's, PGH & Cytology<br>• Training for more staff to participate in Endoscopic Ultra-Soundography Fine Needle Aspiration and Endoscopic Broncho Ultra-Soundography Clinics<br>• TAT monitoring – Weekly, monthly – all logged in QPulse<br>• Offsite bank of remote reporting NHS pathologists. Honorary contracts and client agreement in place to ensure clinical continuity |
| **Gaps in controls** | • Business case for additional staff has not yet been approved<br>• Significant gaps in staff structure<br>• Not meeting TAT's, has a significant impact on the rest of the hospital, patient waiting times and potential clinical impact. |
| **Action plan(s)** | • Monitor TATs<br>• Trust to recruit 4 histopathologists to return to steady state<br>• Department to accelerate BMS cut up training programmes<br>• Department to accelerate BMS reporting training programmes<br>• Department to implement order comms<br>• Department to implement digital pathology<br>• Department to implement AI<br>• Trust to support demand management initiative<br>• Funding Stream<br>• Report for Finance committee |

# Risk Register Report

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|---|---|
| | • Report delays in recruitment<br>• Trust to review MDT requirement to reduce commitment from pathology and radiology<br>• Trust to initiate cultural review with a view to optimising productivity in consultant body |
| **Risk appetite scale** | Cautious |
| **Risk tolerance range** | 9-15 |
| **Tolerance breach?** | No |
| **Target Risk Rating** | 4 |
| **Progress update** | Implement digital pathology & AI – BC approved; providers appointed, plan for clinical safety case underway, hazard workshop complete<br>Trust to review MDT requirement – ongoing harmonisation meetings set up<br>Acceleration of BMS pathways – ongoing; monthly tracker. |

| **Population & System Risk** | |
|---|---|
| **Risk ID** | 1502 |
| **Risk Title** | Mental Health Care in a Physical Health environment |
| **Date risk raised on the risk register** | 28/07/2020 |
| **Date risk approved as 15+ risk** | 07/09/2021 |
| **Risk Rating** | 15  |
| **Risk Description** | If mental health patients are cared for in an acute physical health environment not suitable for their needs, then there is an increased risk of harm to self, others and staff. |
| **Executive sponsor** | Chief Operating Officer |
| **Controls in place** | • Safe staffing templates<br>• Staff survey results and action plans<br>• Training compliance<br>• Service provision standards for Psych liaison<br>• NICE standards<br>• HSE standards<br>• LERN policy<br>• Managing challenging behaviour policy |

# Risk Register Report

| | |
|---|---|
| | • Some ligature assessed areas<br>• New beach building has been designed to support appropriate environment |
| **Gaps in controls** | • UHD is an acute physical health setting and is therefore designed and equipped as such.<br>• Staff are physical health trained and not all receive mental health training<br>• staff may not have been trained to risk assess the environment for mental health patients<br>• Not all areas have been risk assessed as a safe environment for mental health patients<br>• Access to systems outside of UHD that contain mental health history |
| **Action plan(s)** | • Early intervention referral<br>• Mental Health Training<br>• RMN usage and requesting<br>• Anti- ligature work<br>• Mental Health Legislation<br>• Section 17 leave<br>• Least restrictive interventions policy<br>• Training and Education Plan<br>• Ligature light Policy and environmental risk factors<br>• Right Care Right Person Trust implementation<br>• To agree Metrics and KPIs in relation to Mental Health |
| **Risk appetite scale** | Cautious |
| **Risk tolerance range** | 9-15 |
| **Tolerance breach?** | No |
| **Target risk rating** | 2 |
| **Progress update** | Mental Health project continues to progress against the project scope. Some early indications around a reduction in LLOS from an average of 10 days to 8, needs further investigation to understand. |

| **Population & System Risk** | |
|---|---|
| **Risk ID** | 1665 |
| **Risk Title** | School age Neurodevelopmental service |
| **Date risk raised on the risk register** | 03/09/2021 |
| **Date risk approved as 15+ risk** | 15/08/2023 |

# Risk Register Report

| | |
|---|---|
| **Risk Rating** | 15  |
| **Risk Description** | The school age neuro-developmental service does not have enough capacity to meet demand for children aged 5-16 yr olds who are:<br>- medicated and monitored to manage neurodevelopment issues<br>- referred to the school age Neurodevelopmental service for advice, guidance and treatment. |
| **Executive sponsor** | Chief Operating Officer |
| **Controls in place** | • National targets in place-RTT zero tolerance 78 week waits, 65 week target from March 2024<br>• Local contractual expectation (provision of service and rejection of referrals) in place<br>• Monitor of patient satisfaction via Complaints and claims<br>• Escalation process in place and compliance monitored<br>• Dorset Pathway in place and compliance monitored<br>• Workforce template agreed<br>• Monitoring of staff wellbeing through Absence, sickness & turnover |
| **Gaps in controls** | • National target achievement<br>• Local contractual expectation (provision of service and rejection of referrals)<br>• Poor patient satisfaction<br>• Poor staff wellbeing |
| **Action plan(s)** | • Dedicated admin support for referral screening process<br>• Reduce backlog of un-triaged referrals<br>• Listening events & senior leadership visibility<br>• Recruitment of nurse specialist to support workforce<br>• Supporting SENCo's with regards to referrals<br>• Medical recruitment<br>• Process mapping exercise<br>• To monitor the CDC School age service transformation plan<br>• Engagement with ICB All Age Autism Pathway review<br>• Medical / AHP recruitment |
| **Risk appetite scale** | Cautious |
| **Risk tolerance range** | 9-15 |
| **Tolerance breach?** | No |
| **Target risk rating** | 3 |
| **Progress update** | Medium term 'recovery plan' being finalised and await agreement as ICS level. |

# Risk Register Report

| Population & System Risk | |
|---|---|
| **Risk ID** | 1303 |
| **Risk Title** | Therapy Staffing impacting on flow |
| **Date risk raised on the risk register** | 10/09/2019 |
| **Date risk approved as 15+ risk** | 17/12/2024 |
| **Risk Rating** | 15  |
| **Risk Description** | If we continue with the current Therapy staffing template and do not increase the number of Physiotherapists & Occupational Therapists across the organisation, then this may affect optimisation of therapy treatments and the flow of patients through the Trust. |
| **Executive sponsor** | Chief Operating Office |
| **Controls in place** | • Staffing template<br>• Recruitment policy<br>• Sickness absence policy and procedures<br>• LERN policy<br>• Regional benchmarking-Critical Care provision standards<br>• GPICS compliance<br>• Provision of 7 day service in Critical Care standards<br>• NICE & CSP guidance on therapy input for fractured neck of femur patient |
| **Gaps in controls** | • Staffing templates not increased in 15+ years despite year on year increased admission rates and increased flow through hospital beds.<br>• Business cases not given financial support - both to increase critical care staffing to meet GPICs standards and to fund the crucial workforce pipeline of apprenticeships.<br>• Additional medical and OPS beds opened without therapy staffing budget or template driving existing demand further beyond capacity. |
| **Action plan(s)** | • Business case to request additional financial support for band 6 roles<br>• Approached DHC and RBCH for additional bank opportunities. Working on possibility of a shared bank across RBCH / PHFT. To agree honorary contracts.<br>• Two locums have been sourced and the third one still being sought: start date of three months each from late July – late October 2019.<br>• To engage with Live Well Dorset to provide insight on how we can support staff and manage turnover<br>• Ensure induction processes and training plans for new graduates is comprehensive and timely.<br>• Seek appropriate funding for therapy establishment<br>• Recruitment<br>• Operational management of therapy demand and capacity |
| **Risk appetite scale** | Cautious |

# Risk Register Report

| | |
|---|---|
| **Risk tolerance range** | 9-15 |
| **Tolerance breach?** | No |
| **Target risk rating** | 6 |
| **Progress update** | Progress in last month to mitigate risk: templates for all in-patient therapy teams completed and sent to finance for review. Templating paper begun to articulate the impact of current templates on standards of care. Therapy activity dashboard now in development - IT changes completed & launched. Trauma team commenced improvement work to improve their initial to follow up patient ratios. Risk impact overall high in January with outliers resulting in increased staffing pressures at RBH particularly. |

| **Population & System Risk** | |
|---|---|
| **Risk ID** | 2070 |
| **Risk Title** | Using multiple UHD Theatres for surgery which currently do not have UPS or IPS |
| **Date risk raised on the risk register** | 15/05/2024 |
| **Date risk approved as 15+ risk** | 18/09/2024 |
| **Risk Rating** | 15  |
| **Risk Description** | Currently multiple theatres across UHD do not have UPS back up and would solely rely on a diesel generator in the event of power failure. If an internal power fault occurred most theatres would lose power from their wall sockets which could result in loss of vital medical equipment such as electro surgical and various laparoscopic/robotic, such delays and loss of equipment could lead to significant harm or death to patient/s. |
| **Executive sponsor** | Chief Strategy and Transformation Officer |
| **Controls in place** | • Poole<br>  ○ Barn and Level 1 theatres have UPS back up - any patients needing to continue surgery will be transferred to these areas safely<br>  ○ Move to open surgery if loss of stack/robotic systems<br>  ○ Patients are to be made safe, woken and taken to recovery area<br>  ○ Anaesthetic machines, theatre lights have approx 30 mins back up<br>  ○ No surgery will continue unless life or limb in Level 1 or barn theatres<br>• RBH<br>  ○ Move to open surgery if loss of stack/robotic systems<br>  ○ Patients are to be made safe, woken and taken to recovery area<br>  ○ Anaesthetic machines, theatre lights have approx 30 mins back up<br>  ○ No Surgery will continue unless life or limb |

# Risk Register Report

| | |
|---|---|
| **Gaps in controls** | • Multiple UHD Theatres do not have UPS or localised UPS |
| **Action plan(s)** | • UHD Theatres Team to investigate if a local UPS solution is available and then put it in place<br>• The Surgical Care Group to escalate the risk to the Trust Board and Clinical Governance Group<br>• The UHD theatre team to liaise with the estates and clinical engineering teams to put in place a permanent UPS solution (battery supplies to be installed in the theatres). |
| **Risk appetite scale** | Cautious |
| **Risk tolerance range** | 9-15 |
| **Tolerance breach?** | No |
| **Target risk rating** | 4 |
| **Progress update** | Date from the supplier TBC |

| **Quality (Outcome and Safety) Risk** | |
|---|---|
| **Risk ID** | 1961 |
| **Risk Title** | Failure of provision of service due to ageing sterilisers |
| **Date risk raised on the risk register** | 24/08/2023 |
| **Date risk approved as 15+ risk** | 21/11/2024 |
| **Risk Rating** | 20 ⟷ |
| **Risk Description** | If the sterilisers are not replaced it will result in disruption of all clinical activity across UHD including theatre, clinics and any service that use sterile equipment |
| **Executive sponsor** | Chief Nursing Officer |
| **Controls in place** | • Weekly testing (pass/fail) recorded in the Quality Management System,<br>• Escalation to Estates and the Estates Team will then investigate the reason for failure.<br>• SOPs and policies are in place to describe the escalation routes in case of failure. |
| **Gaps in controls** | • Any replacement of parts need to be manufactured specifically for the old equipment resulting in delay of getting back into service.<br>• NHP funding no longer available<br>• Funding will now have to be from local budgets but may not include pass through ability. This is a risk in itself and will be added to the risk register if purchase of these machines goes ahead |

# Risk Register Report

| | |
|---|---|
| **Action plan(s)** | • Replacement of sterilisers<br>• Estates action - a technical and economic appraisal<br>• To arrange a meeting with key stakeholders - a decision is required on the development options and future strategic direction of UHD Sterile Services Department (SSD) located at the Alderney Hospital site. |
| **Risk appetite scale** | Minimal |
| **Risk tolerance range** | 6-10 |
| **Tolerance breach?** | Yes |
| **Target risk rating** | 6 |
| **Progress update** | 07/01/25- design kick off meeting held on site at SSD to agree actions project managers/suppliers/contractors<br>30/01/25 - Further meeting held on site to review progress<br>Fortnightly meetings in the diary to review and progress<br>Further meeting held 03/02/25 to look at designs, drawing presented for comment.<br>SSD & DSE Decontamination Manager meeting with estates to review drawing/plans and comment 06/02/24 to enable to feed back |

| **Quality (Outcome and Safety) Risk** | |
|---|---|
| **Risk ID** | 1855 |
| **Risk Title** | Lack of Breast Radiologists |
| **Date risk raised on the risk register** | 23/02/2023 |
| **Date risk approved as 15+ risk** | 21/11/2024 |
| **Risk Rating** | 20  |
| **Risk Description** | If we do not increase the number of breast radiologists, we will be unable to sustain the demands of the service. |
| **Executive sponsor** | Chief Medical Officer |
| **Controls in place** | • Review of Incidents reported<br>• Review of Complaints reported<br>• Known Cancer targets<br>• Recruitment/retention processes<br>• Weekend working and extra clinic in RBH<br>• Waiting list to record backlog |

# Risk Register Report

| | |
|---|---|
| **Gaps in controls** | • Lack of radiology capacity to sustain service.<br>• Lack of suitable applicant for both substantive and locum positions - 2 WTE breast radiologists for which service is funded have not been filled, nor has the WTE consultant radiographer post. |
| **Action plan(s)** | • Increase Radiology capacity DBSU<br>• Reduce Symptomatic Patient Backlog (Jigsaw/LBU) |
| **Risk appetite scale** | Minimal |
| **Risk tolerance range** | 6-10 |
| **Tolerance breach?** | Yes |
| **Target risk rating** | 2 |
| **Progress update** | Reviewed at Radiology Quality and Risk Meeting 02/01/2025. Symptomatic backlog reduced by weekend WLIs, but there is no further funding agreed for these. Risk remains the same. |

| **Quality (Outcome and Safety) Risk** | |
|---|---|
| **Risk ID** | 1994 |
| **Risk Title** | Brachytherapy Low Dose Rate (LDR) and High Dose Rate (HDR) Ultrasound (US) equipment |
| **Date risk raised on the risk register** | 16/11/2023 |
| **Date risk approved as 15+ risk** | 22/10/2024 |
| **Risk Rating** | 16  |
| **Risk Description** | The risk is the loss of the brachytherapy service due clinical equipment being end of life and patients breaching their Cancer Waiting Times (CWT).<br><br>The brachytherapy equipment that is approaching end of life include the LDR Ultrasound, HDR Ultrasound and transabdominal transducer. |
| **Executive sponsor** | Chief Strategy and Transformation Officer |
| **Controls in place** | • Regular quality assurance (QA) testing prior to use of equipment to identify issues. Equipment that fails QA testing is taken out of clinical use.<br>• Business case has been submitted to Care Group Board<br>• SBAR submitted to COO for presentation to Board |
| **Gaps in controls** | • No regular process or arrangement in place to use alternative supply of equipment in the event of a failure<br>• There is currently no funding agreed for sourcing replacement equipment |
| **Action plan(s)** | Await outcome of SBAR presentation to Board and respond accordingly.<br>Await outcome of Business case to secure funding for replacement of Ultrasound (US) equipment and respond accordingly. |

# Risk Register Report

| | |
|---|---|
| | LDR Ultrasound equipment - a tender process with 2 LDR suppliers (BD and BXTA) is currently being undertaken time scale for resolution approx. April 2025 |
| **Risk appetite scale** | Minimal |
| **Risk tolerance range** | 6-10 |
| **Tolerance breach?** | Yes |
| **Target risk rating** | 3 |
| **Progress update** | Equipment ordered. waiting for delivery |

| **Quality (Outcome and Safety) Risk** | |
|---|---|
| **Risk ID** | 1214 |
| **Risk Title** | Risk of misdiagnosis/ incorrect treatment from use of ungoverned Point of Care devices |
| **Date risk raised on the risk register** | 10/11/2017 |
| **Date risk approved as 15+ risk** | 17/02/2023 |
| **Risk Rating** | 16 ⟷ |
| **Risk Description** | There is a risk that mismanaged point of care devices will result in incorrect results, misinforming diagnosis and treatment and leading to patient harm |
| **Executive sponsor** | Chief Medical Officer |
| **Controls in place** | • MHRA standards<br>• Compliance with national standards<br>• Service contracts<br>• Point of Care co-ordinator<br>• Contingency policy for majority tests by sending sample to the laboratory<br>• Incidents<br>• MDI procedures<br>• Medical devices policy |
| **Gaps in controls** | • Ungoverned POCT devices non-compliant with MHRA standards<br>• Non-compliance with national standards |

# Risk Register Report

| | |
|---|---|
| | • Point of Care co-ordinator - single point of failure as insufficient staffing and succession planning not in place<br>• No POC policy and standards<br>• Scope does not include point of care ultrasound |
| **Action plan(s)** | • Quarterly EQA testing of glucose and ketone meters by Pathology<br>• Audit of all Abbott blood sugar glucose and ketone equipment within service contact<br>• Training for glucose and ketone meters provided by Abbott within contract, unable to evidence at trust level staff trained<br>• Issues presented to HEG to raise awareness<br>• Support for ketone monitors training/assurance by Diabetes CNS as time allows<br>• Meeting between pathology diabetes CNS to review issues<br>• Ward management of quality for blood gas analysers |
| **Risk appetite scale** | Minimal |
| **Risk tolerance range** | 6-10 |
| **Tolerance breach?** | Yes |
| **Target risk rating** | 3 |
| **Progress update** | Monthly POC meeting to discuss progress scheduled for 2 January was cancelled due to non-availability. Next meeting scheduled for 6 February. Progress update to be provided post meeting. |

| **Quality (Outcome and Safety) Risk** | |
|---|---|
| **Risk ID** | 1974 |
| **Risk Title** | Significant time delays for macular injection treatment |
| **Date risk raised on the risk register** | 05/10/2023 |
| **Date risk approved as 15+ risk** | 01/07/2024 |
| **Risk Rating** | 16  |
| **Risk Description** | If patients do not receive their macular injection within 2 weeks (NICE guidance), then they may have a deterioration in their vision. The reasons patients are not receiving their appointments in the recommended timeframe include; increased demand, lack of staffing (nursing and medical), lack of suitable environment space. |
| **Executive sponsor** | Chief Medical Officer |
| **Controls in place** | • The team have identified Theatre 3, in Eye Outpatients, to undertake Macular injection lists as required.<br>• Appointed a fourth Macular Nurse Practitioner (training and education will be required to ensure competencies are met and signed off). |

# Risk Register Report

| | |
|---|---|
| | • Additional lists added, when staffing allows<br>• Ophthalmology ED for emergency cases<br>• An email account has been set up for the consultants to review referrals from Opticians, to ensure that only appropriate patients are seen by the macular team.<br>• First appointments are being triaged out to the Health Village where they are seen by an Ophthalmic Technician for imaging and other diagnostic tests, not a clinician. Patients then await virtual review from a clinician.<br>• 2 x macular coordinators reviewing patient wait times and prioritising<br>• Direct line to macular coordinators who can escalate to Clinicians<br>• Spreadsheet available for range of clinicians to review for oversight.<br>• Regular Macular meeting to focus on long waiters and agree actions required (monthly and weekly meetings)<br>• Creating a 'core team' within outpatients to work in macular training needs identified and started to roll out. This will also support retention<br>• contacted reps to identify if they can support training and funding |
| **Gaps in controls** | • Additional sites to be identified to undertake additional lists/ full lists that has a space accessible for staff and patients and large enough waiting area<br>• Budget to be identified to enable estates work to be completed and training to be given<br>• The 4th Macular Nurse Practitioner will require a full training program.<br>• Recruitment for replacement consultant needs to be undertaken (finance agreed) |
| **Action plan(s)** | • Recruitment of consultant<br>• Support recruitment and retention<br>• Identify space for macular service<br>• Recruit additional Health Care Support Workers<br>• Daily review of the waiting lists for macular appointments, undertaken by the Macular coordinators. |
| **Risk appetite scale** | Minimal |
| **Risk tolerance range** | 6-10 |
| **Tolerance breach?** | Yes |
| **Target risk rating** | 9 |
| **Progress update** | Support from outside source (nurse injector) one clinic a week. First clinic Jan 2025 undertaken.<br>Discussions outsourcing in place<br>Extra medical staff support in the clinics.<br>Extra injection room in use<br>Appointment of Macular consultant, Await start date confirmation. |

# Risk Register Report

| Quality (Outcome and Safety) Risk | |
|---|---|
| **Risk ID** | 1378 |
| **Risk Title** | Lack of Electronic results acknowledgement system |
| **Date risk raised on the risk register** | 01/02/2021 |
| **Date risk approved as 15+ risk** | 29/11/2022 |
| **Risk Rating** | 15  |
| **Risk Description** | A lack of an electronic results acknowledgement system for requested clinical tests is a risk to patient safety and could result in missed diagnosis and suboptimal treatment. |
| **Executive sponsor** | Chief Medical Officer |
| **Controls in place** | • Teams based notifications standards<br>• External regulatory compliance standards<br>• Compliance with GMC guidance re: the responsible clinician<br>• Clinical in-patient worklist procedures<br>• Health of the ward procedures<br>• Royal College standard regarding referrers responsibilities<br>• IT strategy<br>• LERN policy |
| **Gaps in controls** | • ICE not fully implemented |
| **Action plan(s)** | • Referrer awareness<br>• ICE App |
| **Risk appetite scale** | Minimal |
| **Risk tolerance range** | 6-10 |
| **Tolerance breach?** | Yes |
| **Target risk rating** | 4 |
| **Progress update** | ICE filing is currently sat at 54% filed but needs attention to ensure that this moves closer to the 90% target that has been given. A review will need to take place in the first quarter of 2025 to see how this can be improved. |

# Risk Register Report

| Sustainable Services | |
|---|---|
| **Risk ID** | 1950 |
| **Risk Title** | The Trust Electronic Patient Record (EPR) will be unsupported from April 2027 and is not fit for purpose |
| **Date risk raised on the risk register** | 01/08/2023 |
| **Date risk approved as 15+ risk** | 04/10/2023 |
| **Risk Rating** | 20  |
| **Risk Description** | There is a risk that the Trust EPR is going to be unsupported with no planned replacement and the current solution is not fit for purpose for UHD and the wider Dorset System. There is a risk that this impacts on patient flow (1872), patient safety and results acknowledgement (1378), clinical engagement and staff morale. |
| **Executive sponsor** | Chief Finance Officer |
| **Controls in place** | • The Electronic Health Record Programme (EHR) is moving forward where UHD will partner with Somerset and Dorset to procure a new system that will replace all the current key IT systems, an update was provided to the Board in January 2024.<br>• The majority of the trust IT systems that make up the EPR ecosystem have the following controls in place:<br>  ○ Underpinning legal contracts with software suppliers<br>  ○ Immutable backups (i.e. cannot be affected by malware)<br>  ○ staff training programmes<br>  ○ Active Information Asset Owners who undertake appropriate audits in line with the Data Security and Protection Toolkit<br>  ○ UHD wide Business Continuity Plan<br>  ○ Dedicated Subject Matter Experts in the clinical applications who maintain them in their optimal state<br>  ○ Teams of people working to ensure that the underlying IT Infrastructure is maintained in an optimal state |
| **Gaps in controls** | • Substantial gaps in the functionality of our EPR ecosystem relating to the management of the workflow of diagnostic results and reports and assured clinical transactions generally (e.g. therapy input and interprofessional referrals).<br>• No effective single user interface for clinicians to manage their core care processes.<br>• Local departmental Business Continuity Plans are not yet in place – these are in development with a plan to develop by March 2024. |
| **Action plan(s)** | • Option appraisal<br>• Business continuity Plan<br>• EPR internal mitigation |
| **Risk appetite scale** | Cautious |
| **Risk tolerance range** | 9-15 |
| **Tolerance breach?** | Yes |
| **Target risk rating** | 6 |

# Risk Register Report

| | |
|---|---|
| **Progress update** | EHR business case is with region for sign off to start to deliver more secure dates for the replacement of the EPR System.<br>Mitigation options being explored within Informatics. |

| **Sustainable Services** | |
|---|---|
| **Risk ID** | 1595 |
| **Risk Title** | Medium Term Financial Sustainability |
| **Date risk raised on the risk register** | 27/05/2021 |
| **Date risk approved as 15+ risk** | 28/06/2021 |
| **Risk Rating** | 16  |
| **Risk Description** | Risk that the Trust will fail to deliver a financial break-even position resulting in regulatory intervention, an unplanned reduction in cash and the inability to afford the medium-term capital programme. |
| **Executive sponsor** | Chief Finance Officer |
| **Controls in place** | • Expenditure management and agreed budget envelopes.<br>• Cost improvement programmes.<br>• Contractual settlement with commissioners.<br>• Standing Financial Instructions and Budget Control |
| **Gaps in controls** | • Weaknesses in temporary staffing controls, Mitigation: External review of TSO commissioned to inform improvement plan (Led = CPO)<br>• Alignment of approved nursing templates, e-roster templates and budgeted establishment. Mitigation; Full safe staffing review including realignment of approved templates, rosters and budgets underway (led =CNO)<br>• Incomplete medical job plans and inconsistent premium medical rates. Mitigation: refreshed job planning policy, use of electronic systems, review of premium rates (Lead=CMO)<br>• Inconsistent approach to the opening of unfunded escalation capacity. Mitigation: New SOP to inform consistent escalation process (Lead = COO) |
| **Action plan(s)** | • Medium Term Financial Sustainability |
| **Risk appetite scale** | Cautious |
| **Risk tolerance range** | 9-15 |
| **Tolerance breach?** | Yes |
| **Target risk rating** | 8 |
| **Progress update** | The Risk was reviewed by FPC as part the financial report, no changes were noted. |

# Risk Register Report

| Sustainable Services | |
|---|---|
| **Risk ID** | 2080 |
| **Risk Title** | Cyber Attack |
| **Date risk raised on the risk register** | 17/06/2024 |
| **Date risk approved as 15+ risk** | 22/01/2025 |
| **Risk Rating** | 15  |
| **Risk Description** | If we fail to implement a cyber improvement plan at UHD to address the gaps in our cyber security, we risk a successful attack that could cause all IT systems to be inaccessible and lead to a substantial impact on patient care. |
| **Executive sponsor** | Chief Digital Officer |
| **Controls in place** | • Regular monitoring and patching of all systems to ensure they are on supported and secure platforms<br>• Password policies accepted and adhered to<br>• Retiring of old systems on time before becoming out of support. Implemented SIEM (Security Information and Event Management)<br>• Next Gen firewalls implemented.<br>• Regular Penetration Tests with action plans.<br>• Cyber Improvement Plan approved and actions in progress |
| **Gaps in controls** | • The Cyber Improvement plan details approx. 40 gaps that require action, 15 have been completed |
| **Action plan(s)** | • Completion of action detailed in the Cyber Improvement plan |
| **Risk appetite scale** | Cautious |
| **Risk tolerance range** | 9-15 |
| **Tolerance breach?** | No |
| **Target risk rating** | 10 |
| **Progress update** | Approved at TMG. Exec lead CIO. CIO noted that specific risk exists in relation to IT purchased outside of IT, risk that external suppliers may not have had sufficient cyber security checks if systems purchased by departments direct. |

# Risk Register Report

**1. Risk Heat Map- UHD**

| Current Risk Grading | | Consequence | | | | |
|---|---|---|---|---|---|---|
| | | No Harm (1) | Minor (2) | Moderate (3) | Major (4) | Catastrophic (5) |
| Likelihood | Almost Certain (5) | 2 | 13 | 5 | 2 | 0 |
| | Likely (4) | 3 | 24 | 28 | 8 | 2 |
| | Possible (3) | 1 | 28 | 56 | 14 | 2 |
| | Unlikely (2) | 0 | 8 | 26 | 12 | 2 |
| | Rare (1) | 0 | 1 | 1 | 5 | 1 |

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

| Current Risk Score– UHD total | Feb 24 | Mar 24 | Apr 24 | May 24 | Jun 24 | Jul 24 | Aug 24 | Sept 24 | Oct 24 | Nov 24 | Dec 24 | Jan 25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Very Low (1-3) | 6 | 6 | 6 | 7 | 5 | 5 | 5 | 5 | 6 | 6 | 4 | 3 |
| Low (4-6) | 76 | 72 | 74 | 70 | 67 | 70 | 72 | 69 | 68 | 73 | 72 | 73 |
| Moderate (8-10) | 97 | 97 | 101 | 100 | 107 | 99 | 98 | 107 | 107 | 105 | 111 | 107 |
| Moderate (12) | 19 | 16 | 15 | 15 | 15 | 24 | 28 | 38 | 44 | 43 | 38 | 42 |
| High (15 -25) | **19** | **19** | **17** | **17** | **17** | **19** | **15** | **16** | **16** | **18** | **20** | 19 |
| **Total number of risks under review** | **217** | **210** | **213** | **210** | **211** | **217** | **218** | **235** | **241** | **245** | **245** | **244** |

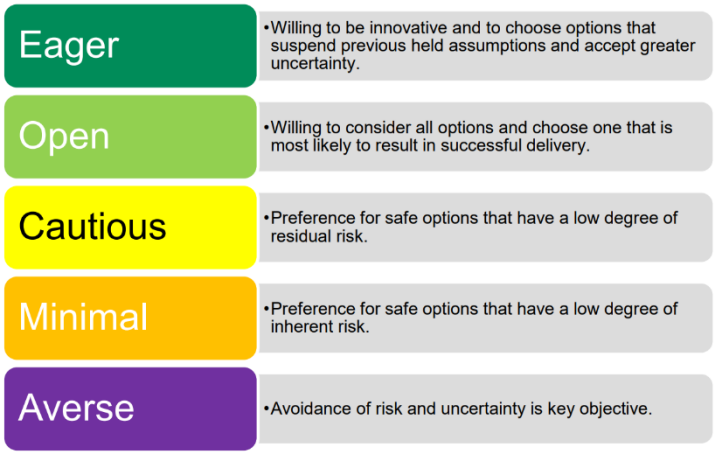
# Risk Register Report

**Appendix A**
**Risk types & categories, appetite scales and tolerances and aligned Executive sponsor**

| Risk Type | Risk Category | Risk Appetite Scale | Risk Appetite score | Risk tolerance | Executive sponsor 15 + risks |
|---|---|---|---|---|---|
| **Workforce Risk** | Staff Experience Risk | Cautious | 1-8 | 9-15 | Chief People Officer |
| **Workforce Risk** | Leadership and Talent Management Risk | Cautious | 1-8 | 9-15 | Chief People Officer |
| **Workforce Risk** | Recruitment and Retention (Staff Offer) Risk | Cautious | 1-8 | 9-15 | Chief People Officer |
| **Workforce Risk** | Workforce Risk | Cautious | 1-8 | 9-15 | Chief People Officer |
| **Workforce Risk** | People Function Risk | Cautious | 1-8 | 9-15 | Chief People Officer |
| **Population and System Risk** | Capacity Planning Risk | Cautious | 1-8 | 9-15 | Chief Operating Officer |
| **Population and System Risk** | Partnership Working Risk | Open | 1-10 | 12-20 | Chief Strategy and Transformation Officer |
| **Quality (Outcome and Safety) Risk** | Infection Prevention and Control Risk | Minimal | 1-5 | 6-10 | Chief Nursing Officer |
| **Quality (Outcome and Safety) Risk** | Patient Safety and Outcome Risk | Minimal | 1-5 | 6-10 | Chief Nursing Officer AND Chief Medical Officer |
| **Quality (Outcome and Safety) Risk** | Research Innovation and Development Risk | Open | 1-10 | 12-20 | Chief Medical Officer |
| **Quality (Outcome and Safety) Risk** | Health and Safety Risk | Averse | 1-3 | 4-6 | Chief People Officer |
| **Quality (Outcome and Safety) Risk** | Legal and Governance Risk | Averse | 1-3 | 4-6 | Chief Executive |
| **Quality (Outcome and Safety) Risk** | Regulatory Risk | Averse | 1-3 | 4-6 | Chief Nursing Officer |
| **Sustainable Services Risk** | Financial Management Risk | Cautious | 1-8 | 9-15 | Chief Finance Officer |
| **Sustainable Services Risk** | Counter Fraud Risk | Averse | 1-3 | 4-6 | Chief Finance Officer |
| **Sustainable Services Risk** | Financial Reporting Risk | Minimal | 1-5 | 6-10 | Chief Finance Officer |
| **Sustainable Services Risk** | Revenue Funding and Cash Management Risk | Cautious | 1-8 | 9-15 | Chief Finance Officer |
| **Sustainable Services Risk** | Information Governance and Security Risk | Cautious | 1-8 | 9-15 | Chief Informatics Officer |
| **Sustainable Services Risk** | Supply Chain Risk | Cautious | 1-8 | 9-15 | Chief Finance Officer |
| **Sustainable Services Risk** | Physical Assets Risk | Cautious | 1-8 | 9-15 | Chief Strategy and Transformation Officer |
| **Sustainable Services Risk** | Business Continuity Risk | Cautious | 1-8 | 9-15 | Chief Operating Officer |
| **Sustainable Services Risk** | Information Technology Risk | Cautious | 1-8 | 9-15 | Chief Informatics Officer |
| **Patient Experience Risk** | Patient Experience Risk | Minimal | 1-5 | 6-10 | Chief Nursing Officer |

# Risk Register Report

## Risk Appetite Scales




## Risk type and category definitions

| | |
|---|---|
| **Workforce Risk** | The risk of unsafe or ineffective patient care resulting from inadequate systems and processes associated with the Trust's workforce supply, skills & capacity, performance and retention, within an appropriate culture. |
| Staff Experience Risk | To ensure the Trust provides a safe environment for staff where all feel respected, valued and included at work |
| Leadership and Talent Management Risk | To ensure that the Trust has processes to support a well led workforce |
| Recruitment and Retention (Staff Offer) Risk | To ensure that the Trust recruits and retains the best people |
| Workforce Risk | To ensure that the Trust maintains a sustainable workforce that is adaptable and organised to meet the needs of our patients |
| People Function Risk | To ensure that there are people processes and systems in place to support care groups and corporate directorates to deliver their priorities |

| | |
|---|---|
| **Population and System Working Risk** | The risk of direct or indirect loss resulting from inadequate or failed internal processes and systems or from external healthcare system process or events. |
| Capacity Planning Risk | To ensure the Trust has effective processes in place for planning and providing capacity to treat elective, non-elective, and clinically urgent patients to maintain patient safety and meet constitutional standards. |
| Partnership Working Risk | To ensure the Trust has effective partnership working arrangements in place, working in conjunction with health, social care, voluntary and private sectors. |

# Risk Register Report

| | |
|---|---|
| **Quality (Outcome and Safety) Risk** | The risk of poor patient outcomes and/or patient harm resulting from inadequate systems and processes associated with the Trust's infection prevention & control, safeguarding, medicines management, patient safety, clinical effectiveness and research & development. The risks of harm to staff as a result of inadequate safe systems of work and compliance with legal requirements for health and safety at work. |
| Infection Prevention and Control Risk | To ensure the Trust has effective processes in place for the management of infection prevention and control to reduce the transmission of infection in hospital and maintain patient safety |
| Patient Safety and Outcome Risk | To ensure the Trust has effective processes in place for monitoring patient safety and outcomes, including learning from patient safety incidents and audit findings |
| Research Innovation and Development Risk | To ensure the Trust has an effective research and innovation strategy and a robust structure in place for research governance |
| Health and Safety Risk | To ensure that the management of Health and Safety and is designed to prevent harm to patients, staff, visitors, and volunteers. |
| Legal and Governance Risk | To ensure that the Trust controls and manages legal risk in accordance with Risk Appetite and operates an effective Corporate Governance Framework |
| Regulatory Risk | To ensure the Trust has effective processes in place for monitoring performance and progress against regulatory quality standards. |

| | |
|---|---|
| **Sustainable Services Risk** | The risk of direct or indirect loss resulting from inadequate systems and processes to the Trust's management of its estate, infrastructure, finances, financial reporting, funding, and cash management. |
| Financial Management Risk | To ensure that financial information reported internally is accurate and complete, including waste reduction programme, and enables the Trust to manage its financial position appropriately, on an ongoing basis |
| Counter Fraud Risk | To ensure that the Trust's Systems and Controls are designed to detect, prevent, and deter organisations and individuals (internal and external) from committing acts of fraud against the Trust and its patients. |
| Financial Reporting Risk | To ensure that financial information reported externally is correct, true, and fair and does not contain material misstatement. Also, to ensure that the tax position of the Trust is understood, appropriately managed, and reported correctly |
| Revenue Funding and Cash Management Risk | To ensure that the Trust's funding sources are adequately managed, held in the required state and available as the business requires |
| Information Governance and Security Risk | To ensure that the Trust has the right processes and systems for collecting, storing, managing, and maintaining information (includes archiving and deletion) in all its forms in order to support business needs and comply with regulations.<br><br>To ensure that the management of information security is designed to protect confidential, private and sensitive information or data from unauthorised access, use, misuse, disclosure, destruction, modification, or disruption. |

# Risk Register Report

| | |
|---|---|
| Supply Chain Risk | To ensure that the selection, ongoing management, and termination of third-party suppliers are managed appropriately to protect the Trust's patients, assets, operations and finances. |
| Physical Assets Risk | To ensure that the management of the Trust's physical assets related to buildings and infrastructure is designed to prevent harm to patients, staff, visitors, volunteers, and property. |
| Business Continuity Risk | To ensure the Trust is able to maintain key patient services during, as well as after, significant failures of systems, cyber-attacks or security breaches, failure of critical and important third-party suppliers or an environmental disaster, such as a fire or flood, impacts to workforce supply |
| Information Technology Risk | To ensure the Trust has appropriate processes in place to manage the use, ownership, operation, involvement, development, and adoption of IT to prevent unplanned business disruption |

| **Patient experience Risk** | The risk of poor patient experience resulting from inadequate systems and processes associated with the fundamentals of care. |
|---|---|
| Patient Experience Risk | To ensure the Trust has effective processes in place to monitor feedback from patients and use this to improve services and patient experience. |

## Appendix B: Matrix and descriptors for Risk Register Assessment

| 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 |

# Risk Register Report

| | | | |
|---|---|---|---|
| **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 |

**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** |

# Risk Register Report

| | | | | | |
|---|---|---|---|---|---|
| • Minimal injury requiring no/minimal intervention or treatment.<br>• Peripheral element of treatment or service suboptimal<br>• Informal complaint/inquiry | • Overall treatment or service suboptimal<br>• Single failure to meet internal standards<br>• Minor implications for patient safety if unresolved<br>• Reduced performance rating if unresolved<br>• Breech of statutory legislation<br>• Elements of public expectation not being met<br>• Loss of 0.1–0.25 per cent of budget<br>• Claim less than £10,000<br>• Loss/interruption of >8 hours<br>• Minor impact on environment | • Treatment or service has significantly reduced effectiveness<br>• Repeated failure to meet statutory or contractual standards<br>• Major patient safety implications if findings are not acted on<br>• Challenging external recommendations/ improvement notice<br>• 5–10 per cent over project budget<br>• Local media coverage – long-term reduction in public confidence<br>• Loss of 0.25–0.5 per cent of budget | • Major injury leading to long-term incapacity/disability<br>• Non-compliance with national standards with significant risk to patients if unresolved<br>• Multiple complaints/ independent review<br>• Low performance rating<br>• Uncertain delivery of key objective/service due to lack of staff<br>• Enforcement action<br>• Multiple breeches in statutory duty<br>• Improvement notices<br>• National media coverage with <3 days service well below reasonable public expectation<br>• Non-compliance with national 10–25 per cent over project budget<br>• Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget<br>• 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<br>• Gross failure to meet national standards<br>• Multiple breeches in statutory or regulatory duty<br>• Prosecution<br>• National media coverage with >3 days service well below reasonable public expectation.<br>• Incident leading >25 per cent over project budget<br>• Non-delivery of key objective/ Loss of >1 per cent of budget<br>• Loss of contract / payment by results<br>• Claim(s) >£1 million<br>• Permanent loss of service or facility<br>• 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**<br>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: 05 March 2025**

**Agenda item: 7.2**

| | |
|---|---|
| **Subject:** | Membership of Board Committees and Terms of Reference |
| **Prepared by:** | Yasmin Dossabhoy, Associate Director of Corporate Governance |
| **Presented by:** | Rob Whiteman, Trust Chair |

| | |
|---|---|
| **Strategic themes that this item supports/impacts:** | Population & System ☐<br>Our People ☐<br>Patient Experience ☐<br>Quality Outcomes & Safety ☐<br>Sustainable Services ☒ |
| **BAF/Corporate Risk Register: (if applicable)** | N/A |
| **Purpose of paper:** | Decision/Approval |
| **Executive Summary**: | From 5 March 2025, the membership of the Board Committees is proposed as follows:<br><br>**Appointments and Remuneration Committee**<br>Rob Whiteman, Trust and Committee Chair<br>Judy Gillow, Non-Executive Director<br>Tracie Langley, Non-Executive Director<br>John Lelliott, Non-Executive Director<br>Femi Macaulay, Non-Executive Director<br>Helena McKeown, Non-Executive Director<br>Sharath Ranjan, Non-Executive Director<br>Cliff Shearman, Non-Executive Director<br>Claire Whitaker, Non-Executive Director<br><br>**Audit Committee**<br>Judy Gillow, Non-Executive Director and Chair<br>Tracie Langley, Non-Executive Director<br>John Lelliott, Non-Executive Director<br>Cliff Shearman, Non-Executive Director<br>Claire Whitaker, Non-Executive Director<br><br>**Charitable Funds Committee** *(addition of Femi Macaulay, Non-Executive Director)*<br>Claire Whitaker, Non-Executive Director and Chair<br>Femi Macaulay, Non-Executive Director<br>Helena McKeown, Non-Executive Director<br>Tina Ricketts, Chief People Officer<br>Pete Papworth, Chief Finance Officer |

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|---|---|
| | **Finance & Performance Committee** *(addition of Beverley Bryant, Chief Digital Officer)*<br>John Lelliott, Non-Executive Director and Chair<br>Beverley Bryant, Chief Digital Officer<br>Tracie Langley, Non-Executive Director<br>Sharath Ranjan, Non-Executive Director<br>Claire Whitaker, Non-Executive Director<br>Mark Mould, Chief Operating Officer<br>Pete Papworth, Chief Finance Officer<br>Richard Renaut, Chief Strategy & Transformation Officer<br>Andrew Doe, Associate Non-Executive Director to be a standing invitee to the Committee<br><br>**Quality Committee**<br>Cliff Shearman, Non-Executive Director and Chair<br>Judy Gillow, Non-Executive Director<br>Femi Macaulay, Non-Executive Director<br>Helena McKeown, Non-Executive Director<br>Mark Mould, Chief Operating Officer<br>Sarah Herbert, Chief Nursing Officer<br>Peter Wilson, Chief Medical Officer<br>Beverley Bryant, Chief Digital Officer will be a standing invitee to the Committee<br><br>**People & Culture Committee**<br>Sharath Ranjan, Non-Executive Director and Chair<br>Judy Gillow, Non-Executive Director<br>Femi Macaulay, Non-Executive Director<br>Tina Ricketts, Chief People Officer<br>Mark Mould, Chief Operating Officer<br><br>**Population Health & System Committee**<br>Helena McKeown, Non-Executive Director and Chair<br>Sharath Ranjan, Non-Executive Director<br>Richard Renaut, Chief Strategy & Transformation Officer<br>Andrew Doe, Associate Non-Executive Director to be a standing invitee to the Committee<br><br>**Transforming Care Together Steering Group** *(addition of Tina Ricketts, Chief People Officer)*<br>Rob Whiteman, Trust and Steering Group Chair<br>John Lelliott, Chair of Finance and Performance Committee<br>Cliff Shearman, Chair of Quality Committee<br>Sharath Ranjan, Chair of People and Culture Committee<br>Helena McKeown, Chair of Population Health and System Committee<br>Judy Gillow, Chair of Audit Committee<br>Siobhan Harrington, Chief Executive Officer<br>Richard Renaut, Chief Strategy and Transformation Officer<br>Mark Mould, Chief Operating Officer<br>Pete Papworth, Chief Finance Officer<br>With Beverley Bryant, Chief Digital Officer as a standing invitee to the Committee |

| | |
|---|---|
| **Background:** | Under the Constitution, the Board shall approve the appointments to each of the Committees which it has formally constituted. |
| **Key Recommendations**: | To approve, with effect from 5 March 2025, the Board Committee membership as outlined above and the amended Terms of Reference for:<br>• Audit Committee<br>• Finance and Performance Committee<br>• People and Culture Committee<br>• Population Health Committee; and<br>• Quality Committee<br>• Transforming Care Together Group |
| **Implications associated with this item:** | Council of Governors ☒<br>Equality, Equity, Diversity & Inclusion ☒<br>Financial ☒<br>Health Inequalities ☒<br>Operational Performance ☒<br>People (inc Staff, Patients) ☒<br>Public Consultation ☒<br>Quality ☒<br>Regulatory ☒<br>Strategy/Transformation ☒<br>System ☒ |
| **CQC Reference:** | Safe ☐<br>Effective ☐<br>Caring ☐<br>Responsive ☐<br>Well Led ☒<br>Use of Resources ☐ |

| **Report History: Committees/Meetings at which the item has been considered:** | **Date** | **Outcome** |
|---|---|---|
| Finance and Performance Committee (FPC Terms of Reference) | 27/01/2025 | Endorsed with a recommendation to the Board to approve |
| People and Culture Committee (PCC Terms of Reference) | 21/02/2025 | Endorsed with a recommendation to the Board to approve |
| Quality Committee | 26/02/2025 | Endorsed with a recommendation to the Board to approve. Terms of Reference subsequently amended to include “in public” in paragraph 6.3 |
| Transforming Care Together | 25/02/2025 | Endorsed with a recommendation to the Board to approve. Updates subsequently made to distinguish members from attendees. |

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

# TERMS OF REFERENCE

## for the

## University Hospitals Dorset NHS Foundation Trust

# Audit Committee

**July 2024**

# DOCUMENT DETAILS

| | |
|---|---|
| **Author:** | Yasmin Dossabhoy |
| **Job Title:** | Associate Director of Corporate Governance |
| **Signed:** | |
| **Date:** | ~~July~~ January ~~2024~~2025 |
| **Version No:** (Author Allocated) | 3.2 |
| **Next Review Date:** | July 2025 |

| | |
|---|---|
| **Approving Body/Committee:** | Board of Directors |
| **Chair:** | Rob Whiteman |
| **Signed:** | |
| **Date Approved:** | [To be inserted once 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 |
|---|---|---|---|---|---|
| October 2020 | 1 | October 2021 | July 2020 | Company Secretary | New Document |
| October 2021 | 1.1 | October 2022 | | Company Secretary | Deleted 9.1 Requirement for Committee minutes to be reported to the Trust Board<br><br>Added 9.1 These minutes will be available to the Board fo Directors<br><br>Remove a phrase at 11.4 i)<br><br>Amend 11.6, |
| January 2023 | 2 | January 2024 | 25 January 2023 | Associate Director of Corporate Governance | Alignment of formatting with other Committee ToR; full review and update. |
| September 2023 | 2.1 | July 2024 | 27 September 2023 | Associate Director of | Amended 3.3 to remove Senior Independent Director from those |

| | | | | | |
|---|---|---|---|---|---|
| | | | | Corporate Governance | ineligible to be Committee Chair. |
| July 2024 | 3 | July 2025 | 4 September 2024 | Associate Director of Corporate Governance | Annual review and update to take account of HMFA NHS Audit Committee Handbook March 2024 – Appendix A Example Terms of Reference |
| January 2025 | 3.2 | July 2025 | | Associate Director of Corporate Governance | Off-cycle review to reflect expanded membership |

## TABLE OF CONTENTS

1. PURPOSE.....
2. RESPONSIBILITIES .....
3. MEMBERSHIP & ATTENDANCE .....
4. AUTHORITY.....
5. CONDUCT OF BUSINESS .....
6. RELATIONSHIPS & REPORTING.....
7. MONITORING.....
8. REVIEW.....

| | | | |
|---|---|---|---|
| **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 | ~~4 September 2024~~[ ] 2025 |
| Print Name | Rob Whiteman | Signature of Chair | |

# UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

# AUDIT COMMITTEE

# TERMS OF REFERENCE

## 1. PURPOSE

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

The Committee will contribute to the overall delivery of the Trust's objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the Trust.

- The duties of the Committee will be driven by the Trust's objectives and the associated risks. An annual programme of business will be agreed each financial year; however this will be flexible to new and emerging priorities and risks.

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

## 2. RESPONSIBILITIES

**Governance, risk management and internal control**

2.1 To review the adequacy and effectiveness of the system of governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical) that supports the achievement of the organisations' objectives. In particular, the Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the annual governance statement together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the Board;
- The underlying assurance processes that indicate the degree of the achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications, including the NHS Code of Governance for Provider Trusts and NHS Provider Licence;
- The policies and procedures for all work related to counter fraud, bribery and corruption as required by the NHS Counter Fraud Authority (NHSCFA).
-

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers, as appropriate, concentrating on the over-arching systems of

governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key Committees (for example, the Quality Committee) so that it understands processes and linkages. However, those other Committees must not usurp the Committee's role.

**Counter-fraud**

2.2.1 To satisfy itself that the Trust has adequate arrangements in place for counter fraud, bribery and corruption that meet the NHSCFA standards and the Committee shall review the outcomes of work in these areas.

2.2.2 In relation to the local counter fraud specialist, to review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans and discuss NHSCFA quality assessment reports.

**Internal Audit**

2.3 To ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive officer (in their capacity as Accounting Officer) and Board. This will be achieved by:

2.3.1 Considering the provision of the internal audit service and the costs involved;

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

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

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

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

**External Audit**

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

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

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

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

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

2.4.5 Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services.

**Other assurance functions**

2.5 To review the findings of other significant assurance functions, both internal and external to the organisation, where relevant to the governance, risk management and assurance of the organisation.

These may include, but will not be limited to, any reviews by Department of Health and Social Care arm's length bodies or regulators/ inspectors (for example, the Care Quality Commission, NHS Resolution) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies).

In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the audit Committee's own areas of responsibility. In particular, this will include any committees covering safety/ quality, for which assurance from clinical audit can be assessed, and risk management.

**Management**

2.6 To request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the organisation (for example, compliance reviews or accreditation reports).

**Financial reporting**

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

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

2.7.3 To review the annual report, and annual financial statements before these are presented to the Board focusing particularly on:

2.7.3.1 The wording in the annual governance statement and other disclosures relevant to the work of the Committee;

2.7.3.2 Areas where judgment has been exercised;

2.7.3.3 Changes in, and compliance with, accounting policies, practices and estimation techniques;

2.7.3.4 Unadjusted misstatements in the financial statements;

2.7.3.5 Significant judgements in the financial statements;

2.7.3.6 Letters of representation; and

2.7.3.7 Explanations for significant variances.

Where requested by the Board, the Committee shall provide advice on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy

**System for raising concerns**

2.8 To review the effectiveness of the arrangements in place for allowing staff (and contractors) to raise (in confidence) concerns about possible improprieties in any area of the organisation (financial, clinical, safety or workforce matters) and ensure that any such concerns are investigated proportionately and independently and in line with the relevant policies.

**Governance regulatory compliance**

2.9 To review the Trust's reporting on compliance with the NHS Provider Licence, NHS Code of Governance for Provider Trusts and the fit and proper persons test.

The committee shall satisfy itself that the Trust's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest.

**Emergency Preparedness, Resilience and Response (EPRR)**

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

## 3. MEMBERSHIP & ATTENDANCE

3.1 Membership of the Committee comprises of ~~four~~ five independent Non-Executive Directors (other than the Trust Chair), one of whom will be a qualified accountant with recent and relevant financial experience and one of whom will also be a member of the Quality Committee. Membership of the Committee as a whole should comprise of members with competence relevant to the sector in which the Trust operates.

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

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

and others will attend as invited by the Committee Chair.

3.3 The Committee will be chaired by a Non-Executive Director of the Trust (not the Trust Chair or Trust Vice-Chair), appointed by the Board. A Non-Executive Deputy Chair should be nominated (not the Trust Chair). In the absence of the

Committee Chair and/or any appointed Deputy, the remaining members shall elect one of the Non-Executive Directors present to chair the meeting.

3.4 Subject to paragraphs 3.2 above and 3.6 below, only members of the Committee have the right to attend Committee meetings. The Chair may ask any or all of those who attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

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

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

3.7 Governor(s) may be invited by the Chair to attend meetings of the Committee as observer(s). Observers are not members of the Committee.

## 4. AUTHORITY

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

4.2 The Committee is authorised to approve its own governance cycle

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

4.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions and all employees are directed to co-operate with any request made by the Committee.

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

## 5. CONDUCT OF BUSINESS

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

5.2 The Committee will meet at least four times in each financial year and at such other times as the Committee Chair shall require. The Committee Chair, Board, Chief Executive Officer, external auditors or head of internal audit may request an additional meeting if they consider that one is necessary.

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

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

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

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

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

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

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

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

5.11 At each meeting, there will be an opportunity for the Committee to meet with representatives of external and internal auditors without management being present to discuss their remit and any issues arising from their audits. At least once a year the Committee should meet privately with the internal auditors, external auditors and local counter fraud specialist either separately or together.

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

5.13 Members will be expected to conduct business in line with the Trust's values and objectives.

5.14 Members of, and those attending, the Committee shall behave in accordance with the Trust's Constitution, Standing Orders, and Codes of Conduct (including, but not limited to, observing confidentiality).

5.15 Members must demonstrably consider the equality and diversity implications of decisions they make.

## 6. RELATIONSHIPS & REPORTING

6.1 The Committee shall be accountable to the Board and shall report to the Board on how it discharges its responsibilities.

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

6.3 The Committee Chair shall present a report summarising the proceedings of each Committee meeting at the next meeting in public of the Board, including drawing to the Board's attention that require disclosure to the full Board, or require executive action. For the avoidance of doubt, where practicable, this shall be a written report, with a verbal update being presented as necessary.

6.4 The committee will report to the Board at least annually on its work in support of the annual governance statement, specifically commenting on the:

- fitness for purpose of the assurance framework
- completeness and 'embeddedness' of risk management in the organisation
- effectiveness of governance arrangements
- appropriateness of the evidence that shows that the organisation is fulfilling regulatory requirements relating to its existence as a functioning business.

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

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

## 7. MONITORING

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

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

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

7.2.2 An explanation of how the Committee has assessed the effectiveness of the external audit process and the approach taken to the appointment or reappointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm, when a tender was last conducted and advanced notice of any retendering plans; and

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

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

## 8. REVIEW

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

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

**APPENDIX A**

## ATTENDANCE AT AUDIT COMMITTEE MEETINGS

| **NAME OF COMMITTEE:** | Audit Committee | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Present** ***(including names of members present at the meeting)*** | **Meeting Dates** | | | | | | | | | | | |
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| Was the meeting quorate? Y/N<br><br>*(Please refer to Terms of Reference)* | | | | | | | | | | | | |

# TERMS OF REFERENCE

## for the

## University Hospitals Dorset NHS Foundation Trust

# Finance & Performance Committee

**August 2024**

## DOCUMENT DETAILS

| | |
|---|---|
| **Author:** | Yasmin Dossabhoy |
| **Job Title:** | Associate Director of Corporate Governance, |
| **Signed:** | |
| **Date:** | ~~August 2024~~January 2025 |
| **Version No:** (Author Allocated) | 3.2~~1~~ |
| **Next Review Date:** | July 2025 |

| | |
|---|---|
| **Approving Body/Committee:** | Board of Directors |
| **Chair:** | Rob Whiteman |
| **Signed:** | |
| **Date Approved:** | [5 March 2025] |
| **Target Audience:** | Board of Directors |

**Document History**

| Date of Issue | Version No: | Next Review Date: | Date Approved: | Director responsible for Change | Nature of Change |
|---|---|---|---|---|---|
| 2020 | 1 | 2021 | 29 07 2020 | Company Secretary | New Document |
| 2021 | 1.1 | Oct 2021 | 26 05 2021 | Assistant Company Secretary | Removed CEO as member of the committee at section 2.1<br>Added the CEO's attendance at section 2.3<br>Added CEO's receipt of papers at section 4.2 |
| October 2021 | 1.2 | October 2022 | | Company Secretary | 'Excluding VAT' added to 8.3 |
| January 2023 | 2.0 | January 2024 | 25 January 2023 | Company Secretary | Full review and redraft. |
| May 2023 | 2.1 | January 2024 | 24 May 2023 | Company Secretary | Membership increased from three to four Non-Executive Directors |
| September 2023 | 2.2 | July 2024 | 27 September 2023 | Company Secretary | Updated strategic objectives in 1.2 |
| August 2024 | 3.1 | July 2025 | 4 September 2024 | Company Secretary | Annual review |

| | | | | | |
|---|---|---|---|---|---|
| January 2025 | 3.2 | July 2025 | | Company Secretary | Off cycle review to amend Committee membership |

## TABLE OF CONTENTS

1. PURPOSE.....
2. RESPONSIBILITIES .....
3. MEMBERSHIP & ATTENDANCE .....
4. AUTHORITY.....
5. CONDUCT OF BUSINESS .....
6. RELATIONSHIPS & REPORTING.....
7. MONITORING.....
8. REVIEW.....

| **INDIVIDUAL APPROVAL** | | | |
|---|---|---|---|
| Job Title | N/A | Date | N/A |
| Print Name | N/A | Signature | |
| **BOARD OF DIRECTORS / COMMITTEE APPROVAL** | | | |
| If the Board / Committee has approved this document, please sign and date it and forward copies for inclusion on the Intranet. | | | |
| Name of approving body | Board of Directors | Date | ~~4 September 2024~~[5 March 2025] |
| Print Name | Rob Whiteman | Signature of Chair | |

**UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST**

**FINANCE & PERFORMANCE COMMITTEE**

**TERMS OF REFERENCE**

## 1. PURPOSE

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

1.2 The purpose of the Finance and Performance Committee is to support the Trust in achieving its strategic objectives: "**See our patients sooner"** and **"Use every NHS pound wisely".**

1.3 The Finance and Performance Committee will do this including through:

- Providing input and recommendations to the Board for the development of the Annual Operating Plan, Productivity and Efficiency Plan (including savings opportunities and merger benefits realisation), Estates Strategy (Masterplan), Sustainability Strategy (Green Plan), Digital Strategy and Private Patients Strategy;
- Assisting the Trust's Board of Directors (Board) in its oversight of achievement of breakthrough objectives and strategic initiatives relating to finance, performance, digital and sustainability;
- Obtaining assurance on the implementation of the Annual Operating Plan, the Productivity and Efficiency Plan, Estates Strategy (Masterplan), Sustainability Strategy (Green Plan), Digital Strategy and Private Patients Strategy;
- Monitoring risks relating to the efficient use of resources (physical and financial, but excluding workforce which shall be reviewed by the People and Culture Committee), including financial performance;
- Monitoring implementation progress and obtaining assurance of:
    - Delivery of financial benefits of merger integration and reconfiguration;
    - all components of post-merger benefits realisation; and
    - Mitigations to climate change;

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

## 2. RESPONSIBILITIES

**Strategies and delivery of the strategic agendas**

2.1 To receive confirmation from the Board, on an annual basis, of:

- the relevant breakthrough objectives and
- the relevant strategic initiatives

which are to be held to account by the Committee.

2.2 To obtain assurance that the relevant breakthrough objectives and strategic initiatives, for which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, appropriate challenge and escalating to the Board when required.

2.3 Statutory requirements

2.3.1 To review the Trust's draft Annual Report and Accounts, in conjunction with the Audit Committee, and following satisfactory external audit, making recommendations jointly to the Board for approval, signature, submission and filing.

2.4 Financial and operational performance

2.4.1 To review for recommendation to the Board the annual plan and medium-term financial plans, including, to the extent necessary and relevant considering the wider Dorset system's annual plan.

2.4.2 To review and make comment to the Board on the long term strategic financial plans of the Trust, and to the extent necessary the wider Dorset system, including consideration of the level of capital investment and financial risk.

2.4.3 To review and make comment to the Board on the substance of the annual revenue and capital budgets of the Trust, and to the extent necessary the wider Dorset system, and to consider and make recommendations to the Board of Directors on tenders, contracts and business cases for capital and revenue schemes which exceed the Committee's delegated limits set out in the Scheme of Delegation of the Board and/or Standing Financial Instructions.

2.4.4 To review the financial and operational performance and controls reporting of the Trust, and to the extent necessary the wider Dorset system, to include overall financial performance, operational performance against Constitutional and other NHS England standards, financial performance of each Care Group, cash flow, debtors and creditors, efficiency improvement programmes, capital spend against plan and resources available.

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

2.4.6 To keep under review the quality, quantity and timeliness of financial, operational and analytical information provided to the Board and recommend any required changes, particularly in response to changes required to regain budget trajectory or in national requirements on a monthly or annual basis as appropriate.

2.4.7 In respect of major capital projects of the Trust, and to the extent necessary the wider Dorset system, to consider business cases in detail and where necessary advise on strengthening prior to making recommendations to the Board for its approval or otherwise. To monitor these projects post-approval and scrutinise any cost or time variances.

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

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

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

2.4.11 To monitor banking arrangements, including approving tenders of banking services.

2.4.12 To support the Trust in fulfilling the requirements of its licence and commissioner contracts in relation to key performance indicators.

2.4.13 To keep the Board updated on any identified regulatory and statutory duties related to financial performance of the Trust and how this impacts delivery against the control total.

2.4.14 To consider the impact of accounting policies for external reporting, taking into account the requirements of NHS England and other appropriate bodies.

2.4.15 To review the estates strategy and Estates masterplan, providing input and recommendations to the Board, and to monitor progress against and risks associated with the strategy and monitoring other estates-related improvement plans.

2.4.16 To review the Private Patient Strategy, providing input and recommendations to the Board and to monitor progress against and risks associated with such strategy.

2.4.17 To review the development and delivery of commercial strategies of the Trust, including partnership arrangements with other organisations, providing input and recommendations to the Board.

2.4.18 To review the Trust's procurement strategy including having regard to the priorities at national and integrated care system (ICS) level and challenges to the delivery of change and providing input to the Board.

2.5 Digital

2.5.1 To review the Digital Strategy and provide input and recommendations to the Board for approval.

2.5.2 To monitor the implementation of the Trust's information management, technology and digital plans as enablers to efficiency and transformation, receiving regular progress reports to scrutinise delivery and the meeting of key milestones.

2.5.3 To receive reporting in relation to cyber security including regular maintenance of critical systems and equipment and minimising impact on clinical services during downtime.

2.6 Sustainability

2.6.1 To review the Sustainability Strategy (Green Plan) and provide input and recommendations to the Board for approval.

(For this purpose, sustainability means meeting the needs of the current generation without compromising future generations of the ability to meet their needs, in social, economic or environmental terms. The Trust and the wider NHS are also assessing the health and wellbeing of the population for environmental

changes, including the impacts of a warming planet, air quality and mitigations for these negative changes).

2.6.2 To monitor the implementation of the Trust's sustainability plans, receiving regular progress reports to scrutinise delivery and the meeting of key milestones.

2.6.3 To review the Trust's draft Annual Report prior to recommendation to the Board for matters of sustainability, climate adaptation and carbon reduction and related areas of corporate social responsibility.

2.7 ICS

2.7.1 To receive and review financial and other relevant reports of or relating to the Dorset ICS and provider collaborative.

**Risk Management**

2.8.1 To regularly review the Board Assurance Framework (including through in-depth review of specific risks) and to ensure that it reflects the assurances for which the Committee has oversight, with risks highlighted being appropriately reflected on the risk registers. This shall include, but not be limited to the Committee acting in accordance with Board approved risk appetite and risk tolerance levels when reviewing risks.

2.8.2 To be kept appraised of all new and current risks rated 12-25 applicable to the Committee's scope identified on the risk register across the organisation and progress of action plans identified to mitigate these risks.

## 3. MEMBERSHIP & ATTENDANCE

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

3.2 In addition, the following will attend the Committee to provide information and advice with prior agreement of the Committee Chair and/or to present a report to the Committee or a Chief Officer is unable to attend:

- Deputy Chief Finance Officer;
- Director of Operational Performance and Oversight;
- Group Directors of Operations.

Group Directors of Operations will attend as invited, and others including, but not limited to:

- the Chair of the Medical Advisory Committee for Private Health UHD;
- the Chair of the Medical Advisory Committee for Dorset Heart Clinic;
- the Trust Sustainability and Carbon Manager;
- a representative from Communications;
- a representative from Bournemouth, Christchurch and Poole Council;
- a representative from Bournemouth University
- the Director of Transformation;
- the Director of Integration;

- the Director of Organisational Development;

as invited by the Committee Chair. An Associate Non-Executive Director will be a standing invitee to the Committee.

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

3.4 Subject to paragraphs 3.2 above and 3.6 below, only members of the Committee have the right to attend Committee meetings. If an executive director 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. The Chief Executive Officer will attend on an ad-hoc basis or as required. The Committee Chair may ask any or all of those who attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

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

3.6 Any member of the Board of Directors may attend any meeting of the Committee with prior agreement of the Committee Chair.

3.7 Governor(s) may be invited by the Committee Chair to attend meetings of the Committee as observer(s). Observers are not members of the Committee.

## 4. AUTHORITY

4.1 The Committee is authorised by the Board to investigate/review any activity within the Terms of Reference and to make decisions within its delegated authority limits.

4.2 The Committee is authorised to approve its own governance cycle.

4.3 The Committee shall have delegated authority to approve or reject tenders, award contracts and approve business cases for capital and revenue schemes up to the value delegated to it by the Board.

4.4 The Committee is authorised to approve Treasury Management Policies and Investments.

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

4.6 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions and all employees are directed to co-operate with any request made by the Committee.

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

## 5. CONDUCT OF BUSINESS

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

5.2 The Committee will normally meet on a monthly basis (and not less than 10 times in each financial year) and at such other times as the Committee Chair shall require.

5.3 Meetings of the Committee shall be quorate if there are at least three members present which will include two Non-Executive Directors and one Executive Director. 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.

In the absence of the Chief Finance Officer, his/her deputy must be present.

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

5.5 Meetings of the Committee shall be called by the Company Secretary at the request of the Committee Chair or Chief Finance Officer.

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

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

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

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

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

5.11 Members will be expected to conduct business in line with the Trust's values and objectives.

5.12 Members of, and those attending, the Committee shall behave in accordance with the Trust's Constitution, Standing Orders and Codes of Conduct (including, but not limited to, observing confidentiality).

5.13 Members must demonstrably consider the equality and diversity implications of decisions they make.

## 6. RELATIONSHIPS & REPORTING

6.1 The Committee shall be accountable to the Board.

6.2 The Committee shall make recommendations to the Board in relation to issues that require decision or resolution by the Board.

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

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

6.5 For the avoidance of doubt:

- the Quality Committee will have oversight of quality and safety issues including private patient care as part of the quality governance process; and
- the People and Culture Committee will have oversight of the development by the Trust of an effective staff structure and workforce operating model across the organisation; and
- the Population Health and System Committee will have oversight of the implementation by the Trust of its responsibilities pursuant to the Our Dorset strategic plan for population health and health inequalities.

6.6 The governance of Private Health UHD is within the Surgical Care Group and Dorset Heart Clinic within the Medical Care Group. There are operational management groups for these, who report via the Care Group management governance.

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

## 7. MONITORING

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

7.2 The Trust's Annual Report will include attendance of members, frequency of meetings and whether meetings were quorate.

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

## 8. REVIEW

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

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

**APPENDIX A**

## ATTENDANCE AT FINANCE AND PERFORMANCE COMMITTEE MEETINGS

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

# TERMS OF REFERENCE

## for the

## University Hospitals Dorset NHS Foundation Trust

# People & Culture Committee

**May 2024**

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

## DOCUMENT DETAILS

| | |
|---|---|
| **Author:** | Yasmin Dossabhoy |
| **Job Title:** | Associate Director of Corporate Governance |
| **Signed:** | |
| **Date:** | ~~May 2024~~February 2025 |
| **Version No:** (Author Allocated) | ~~2.3~~3.1 |
| **Next Review Date:** | July ~~2024~~2026 |

| | |
|---|---|
| **Approving Body/Committee:** | Board of Directors |
| **Chair:** | Rob Whiteman |
| **Signed:** | |
| **Date Approved:** | ~~1 May 2024~~[July 2025] |
| **Target Audience:** | Board of Directors |

**Document History**

| Date of Issue | Version No: | Next Review Date: | Date Approved: | Director responsible for Change | Nature of Change |
|---|---|---|---|---|---|
| August 2020 | 1 | August 2021 | August 2020 | Company Secretary | New document |
| October 2021 | 1.1 | October 2022 | 24 November 2021 | Company Secretary | Addition of two Groups at 9.1 Addition of an Attendee at 2.2 |
| January 2023 | 2.0 | January 2024 | 25 January 2023 | Company Secretary | Full review and re-draft. |
| May 2023 | 2.1 | January 2024 | 24 May 2023 | Company Secretary | Membership of the Committee increased from three to four Non-Executive Directors |
| September 2023 | 2.2 | July 2024 | 27 September 2023 | Company Secretary | Updated strategic objectives in 1.2. |
| May 2024 | 2.3 | July 2024 | 1 May 2024 | Company Secretary | Updated Committee membership and quorum |
| January 2025 | 3.1 | July 2026 | [July 2025] | Company Secretary | Off-cycle review to align to other Committee Terms of Reference |

## TABLE OF CONTENTS

1. **PURPOSE** ..... 5
2. **RESPONSIBILITIES** ..... 5
3. **MEMBERSHIP & ATTENDANCE** ..... 6
4. **AUTHORITY** ..... 6
5. **CONDUCT OF BUSINESS** ..... 6
6. **RELATIONSHIPS & REPORTING** ..... 6
7. **MONITORING** ..... 9
8. **REVIEW** ..... 9

| **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 | ~~1 May 2024~~ |
| Print Name | Rob Whiteman | Signature of Chair | |

**UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST**

**PEOPLE & CULTURE COMMITTEE**

**TERMS OF REFERENCE**

## 1. PURPOSE

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

1.2 The purpose of the People & Culture Committee is to support the Trust in achieving its strategic objective~~s~~: **"Be a great place to work"** ~~and **"Start on our Patient First journey"**~~**.**

1.3 The People & Culture Committee will do this through:

- Providing input and recommendations to the Trust's Board of Directors (Board) for the development of the People Strategy and the Equality, Diversity & Inclusion Strategy;
- Assisting the Board in its oversight of achievement of breakthrough objectives and strategic initiatives relating to the People & Culture domains;
- Obtaining assurance on the implementation of the People Strategy and Equality, Diversity & Inclusion Strategy; and
- Receiving and reviewing information and data relating to workforce reporting to the Board.

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

## 2. RESPONSIBILITIES

**People Strategy and delivery of the People Agenda**

2.1 To receive confirmation from the Board, on an annual basis, of:

- the relevant breakthrough objectives; and
- the relevant strategic initiatives;

which are to be held to account by the Committee.

2.2 To obtain assurance that the relevant breakthrough objectives and strategic initiatives for which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, appropriate challenge and escalating to the Board when required.

**Risk Management**

2.3.1 To regularly review the Board Assurance Framework (including through in-depth review of specific risks) and to ensure that it reflects the assurances for which the Committee has oversight, with risks highlighted being appropriately reflected on the risk registers. This shall include, but not be limited to the Committee acting in

accordance with Board approved risk appetite and risk tolerance levels when reviewing risks.

2.3.2 To be kept appraised of all new and current risks rated 12-25 applicable to the Committee's scope identified on the risk register across the organisation and progress of action plans identified to mitigate these risks.~~To review the Trust's significant risks report and receive updates on directorate workforce risk issues, action plans or unresolved matters/concerns for escalation.~~

**Oversight and Assurance**

A great place to work

2.3.4 To review reports from the Guardian of Safe Working and Freedom to Speak Up Guardian as well as Safe Staffing reviews.

2.3.5 To consider reports on national and local surveys including the staff survey and GMC survey as they relate to workforce, monitoring the implementation of actions agreed to be taken to address areas of concern identified.

2.3.6 To obtain assurance that appropriate feedback mechanisms are in place for those raising incidents and that a culture of openness and transparency in respect of incident reporting is encouraged by supporting the Speaking Up agenda.

2.3.7 To oversee and monitor the implementation of the Equality, Diversity and Inclusion strategy.

2.3.8 To obtain assurance in relation to the Trust's security management - violence prevention and reduction strategy.

Compassionate inclusive leadership, focused on improvement of quality and efficiency of services for patients

2.3.9 To oversee the development by the Trust of an effective staff structure and workforce operating model across the organisation.

2.3.10 To monitor delivery of staff engagement plans to ensure there are clear communication channels across the organisation which provide staff with key information during the transformation of services.

2.3.11 To monitor organisational integration and cultural development and the implementation of action plans as necessary.

Building skills and capabilities

2.3.12 To receive reporting relating to changes in Professional Education and Essential Core Skills training to ensure compliance and continued provision of high quality care.

2.3.13 To monitor the provision of training and development and implementation of solutions which deliver a skilled, flexible modernised workforce improving productivity, performance and reducing health inequalities.

2.3.14 To obtain assurance that effective performance management systems are in place in support of delivery by the Trust of improving capability and capacity to provide high quality, safe patient care.

Strategic workforce planning

2.3.15 To monitor major workforce transformation programmes, including to obtain assurance that no such programme has an unforeseen adverse impact on workforce or on the performance of the Trust.

2.3.16 To receive and monitor workforce indicators including recruitment, retention/turnover, sickness, appraisals and training.

Mandated/Statutory requirements

2.3.17 To oversee and monitor progress against national NHS England workforce standards and reporting including the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).

2.3.18 To review the Trust's Equality and Diversity Monitoring Report.

2.3.19 To review the Gender Pay Gap Report.

2.3.20 To review the annual consultant revalidation report.

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

## 3. MEMBERSHIP/ATTENDANCE

3.1 Membership of the People & Culture Committee comprises of three Non-Executive Directors, the Chief People Officer and the Chief Operating Officer.

3.2 In addition, the following will attend the Committee to provide information and advice with the prior agreement of Committee Chair and/or to present a report to the Committee or a Chief Officer is unable to attend:

- Chief Nursing Officer;
- Chief Medical Officer;
- Deputy to Chief People Officer;
- Associate Director of Communications;
- Director of Organisational Development;
- Care Group Directors of Operations;
- Associate Director for Allied Health Professionals & Healthcare Scientists;

and others as invited by the Committee Chair.

3.3 The Committee will be chaired by a Non-Executive Director of the Trust (other than the Chair of the Audit Committee). A Non-Executive Deputy Chair may be nominated (other than the Chair of the Audit Committee). In the absence of the Chair and/or an appointed Deputy, the remaining members shall elect one of the Non-Executive Directors present to chair the meeting.

3.4 Subject to paragraphs 3.2 above and 3.6 below, only members of the Committee have the right to attend Committee meetings. 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. The Committee Chair may ask any or all of those who attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

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

3.6 Any member of the Board may attend any meeting of the Committee with prior agreement of the Committee Chair.

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

## 4. AUTHORITY

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

4.2 The Committee is authorised to approve its governance cycle.

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

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

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

## 5. CONDUCT OF BUSINESS

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

5.2 The Committee will normally meet on a quarterly basis and at such other times as the Chair of the Committee shall require.

5.3 Meetings of the Committee shall be quorate if there at least three members present, which will include at least one Non-Executive Director and one Executive Director. 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 Committee is inquorate, then the meeting can progress if those present determine. However, no business shall be transacted; items requiring approval may be submitted to the next meeting of the Board as an urgent item.

5.5 Meetings of the Committee shall be called by the Company Secretary at the request of the 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 People Officer, as considered appropriate. The Company Secretary (or their nominee) shall collate and circulate papers to Committee members. Unless otherwise agreed, papers should be provided not less than seven working days before the meeting and the agenda and papers should be circulated not less than five working days before the meeting.

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

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

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

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

5.11 Members will be expected to conduct business in line with the Trust's values and objectives.

5.12 Members of, and those attending, the Committee shall behave in accordance with the Trust's Constitution, Standing Orders and Codes of Conduct (including, but not limited to, observing confidentiality).

5.13 Members must demonstrably consider the equality and diversity implications of decisions they make.

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## 6. RELATIONSHIPS AND REPORTING

6.1 The Committee shall be accountable to the Board.

6.2 The Committee shall make recommendations to the Board in relation to issues that require decision or resolution by the Board.

6.3 The Committee Chair shall present a report summarising the proceedings of each Committee meeting at the next meeting in public 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 Committee shall refer to the Audit Committee, Finance & Performance Committee, Quality Committee and/or Population Health & System Committee any matters requiring review or decision in such forum(s).

6.5 For the avoidance of doubt:

- ~~the Finance and Performance Committee will have oversight of coordination and coherence of the entire transformation agenda;~~
- the Quality Committee will have oversight of quality and safety issues ~~including private patient care as part of the quality governance process~~; and
- the Population Health and System Committee will have oversight of health inequalities, work with system partners in establishing the Dorset ICS and the development of the Dorset provider collaborative.

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

## 7. MONITORING

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

7.2 The Trust's Annual Report will include attendance of members, frequency of meetings and whether meetings were quorate.

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

## 8. REVIEW

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

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

**APPENDIX A**

**ATTENDANCE AT PEOPLE & CULTURE COMMITTEE MEETINGS**

| **NAME OF COMMITTEE:** | People & Culture Committee | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **Meeting Dates** | | | | | | | | |
| **Present (*include names of members present at the meeting)*** | | | | | | | | | |
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| **In Attendance** | | | | | | | | | |
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| Was the meeting quorate? Y / N<br>(*Please refer to Terms of Reference*) | | | | | | | | | |

University Hospitals Dorset
NHS Foundation Trust

# TERMS OF REFERENCE

## for the

## University Hospitals Dorset NHS Foundation Trust

# Population Health and System Committee

**August 2024**

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

## DOCUMENT DETAILS

| | |
|---|---|
| **Author:** | Yasmin Dossabhoy |
| **Job Title:** | Associate Director of Corporate Governance |
| **Date:** | ~~August 2024~~[February 2025] |
| **Version No:** (Author Allocated) | 1.~~3~~4 |
| **Next Review Date:** | August 2025 |

| | |
|---|---|
| **Approving Body/Committee:** | Board of Directors |
| **Chair:** | Rob Whiteman |
| **Signed:** | |
| **Date Approved:** | ~~4 September 2024~~[March 2025] |
| **Target Audience:** | Board of Directors |

**Document History**

| Date of Issue | Version No: | Next Review Date: | Date Approved: | Director responsible for Change | Nature of Change |
|---|---|---|---|---|---|
| March 2023 | 1 | March 2024 | 27 March 2023 | Associate Director of Corporate Governance | New document |
| September 2023 | 1.1 | July 2024 | 27 September 2023 | Associate Director of Corporate Governance | Addition of Medical Director for Integrated Care in section 3.2 |
| May 2024 | 1.2 | July 2024 | 1 May 2024 | Associate Director of Corporate Governance | Update to membership |
| August 2024 | 1.3 | August 2024 | 4 September 2024 | Associate Director of Corporate Governance | Annual review |
| February 2025 | 1.4 | February 2025 | August 2025 | Associate Director of Corporate Governance | Off-cycle review to reflect attendees and consistency with other Terms of Reference |

## TABLE OF CONTENTS

1. PURPOSE ..... 4
2. RESPONSIBILITIES .....
3. MEMBERSHIP & ATTENDANCE ..... 5
4. AUTHORITY ..... 6
5. CONDUCT OF BUSINESS .....
6. RELATIONSHIPS & REPORTING ..... 6
7. MONITORING ..... 8
8. REVIEW ..... 8

| | | | |
|---|---|---|---|
| **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 | 4 September 2024 |
| Print Name | Rob Whiteman | Signature of Chair | |

**UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST**

**POPULATION HEALTH AND SYSTEM COMMITTEE**

**TERMS OF REFERENCE**

## 1. PURPOSE

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

1.2 The Population Health and System Committee will do this including through:

- Providing oversight of the implementation by the Trust of its responsibilities pursuant to the Our Dorset strategic plan for population health and health inequalities;
- Assisting the Trust's Board of Directors (Board) in its oversight of achievement of breakthrough objectives and strategic initiatives relating to population health and health inequalities;
- Receiving and reviewing information and data relating to population health and health inequalities reporting to the Board.

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

## 2. RESPONSIBILITIES

**Our Dorset Strategic Plan and Trust's objectives and initiatives for Population Health and Health Inequalities**

2.1 To receive confirmation from the Board, on an annual basis, of:

- the relevant breakthrough objectives; and
- the relevant strategic initiatives;

which are to be held to account by the Committee.

2.2 To obtain assurance that the relevant breakthrough objectives and strategic initiatives for which the Board has delegated responsibility for oversight to the Committee, are being delivered effectively through monitoring progress, appropriate challenge and escalating to the Board when required.

**Population Health and Health Inequalities**

2.3 **Strategic development, monitoring and review**

2.3.1 To develop the architecture to support outcomes-based population health improvement and measurement.

2.3.2 To consider key population health/pathway issues and commission work from clinical groups within the Trust as appropriate, reviewing re-engineered pathways and outcomes.

2.4 **Assurance**

2.4.1 To obtain assurance that the Trust's delivery plan aligns with the Dorset Integrated Care Board strategy and/or relevant aspects of the Core 20 plus 5 approach.

2.4.2 To obtain assurance that the Trust has efficient processes to identify variation in outcomes, incorporating those with protected characteristics and other vulnerable groups.

2.4.3 To obtain assurance that significant strategic change programmes deliver a positive impact, where possible, on reducing variation in outcomes between groups with protected characteristics and other vulnerable groups and services are adapted to meet the needs of those groups appropriately.

2.5 **ICS**

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

2.6 **Learning and innovation**

2.6.1 To consider and review, as appropriate, available good practices and learning from other organisations.

2.7 **Anchor Institutions**

2.7.1 To conduct deep dives in relation to the Trust's approach to being an anchor institution.

## 3. MEMBERSHIP/ ATTENDANCE

3.1 Membership of the Population Health and System Committee comprises of three Non-Executive Directors and the Chief Strategy & Transformation Officer.

3.2 In addition, the following will attend the Committee to provide information and advice with prior agreement of the Committee Chair and/or to present a report to the Committee or if a Chief Officer is unable to attend:

- Medical Director for Integrated Care
- Director of Operational Performance & Oversight
- Representatives of the Dorset Integrated Care Board

and others as invited by the Committee Chair. An Associate Non-Executive Director will be a standing invitee to the Committee.

3.3 The Committee will be chaired by a Non-Executive Director of the Trust. A Non-Executive Deputy Chair may be nominated. In the absence of the Chair and/or an appointed Deputy, the remaining members shall elect one of the Non-Executive Directors present to chair the meeting.

3.4 Subject to paragraphs 3.2 above and 3.6 below, only members of the Committee have the right to attend Committee meetings. 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. The Chief Executive Officer may attend on an ad-hoc basis or as required. The Committee Chair may ask any or all of those who attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

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

3.6 Any member of the Board may attend any meeting of the Committee with prior agreement of the Committee Chair.

3.7 Governor(s) may be invited by the Chair to attend meetings of the Committee as observer(s) Observers are not members of the Committee.

## 4. AUTHORITY

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

4.2 The Committee is authorised to approve its governance cycle.

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

4.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions and all employees are directed to co-operate with any request made by the Committee.

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

## 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 Committee and any of its meetings.

5.2 The Committee will normally meet on a quarterly basis and at such other times as the Committee Chair shall require.

5.3 Meetings of the Committee shall be quorate if there at least two members present, which will include the Chair (or a Non-Executive Director deputy). 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 Committee is inquorate, then the meeting can progress if those present determine. However, no business shall be transacted; items requiring approval may be submitted to the next meeting of the Board as an urgent item.

5.5 Meetings of the Committee shall be called by the Company Secretary at the request of the 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 Medical Officer, as considered appropriate. The Company Secretary (or their nominee) shall collate and circulate papers to Committee members. Unless otherwise agreed by the Committee Chair, papers should be provided not less than seven working days before the meeting and the agenda and papers should be circulated not less than five working days before the meeting.

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

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

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

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

5,11 Members will be expected to conduct business in line with the Trust's values and objectives.

5.12 Members of, and those attending, the Committee shall behave in accordance with the Trust' Constitution, Standing Orders and Codes of Conduct (including, but not limited to, observing confidentiality).

5.13 Members must demonstrably consider the equality and diversity implications of decisions they make.

5.14 Members of, and those attending, the Committee shall behave in accordance with the Trust's Constitution, Standing Orders, and Codes of Conduct (including, but not limited to, observing confidentiality).

5.15 Members must demonstrably consider the equality and diversity implications of decisions they make.

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## 6. RELATIONSHIPS AND REPORTING

6.1 The Committee shall be accountable to the Board.

6.2 The Committee 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 Committee meeting at the next meeting in public 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 Committee shall refer to the Audit Committee, Finance & Performance Committee, People & Culture Committee and/or Quality Committee any matters requiring review or decision in such forum(s).

6.5 For the avoidance of doubt:

- the People and Culture Committee will have oversight of the development by the Trust of an effective staff structure and workforce operating model across the organisation; and
- the Quality Committee will have oversight of quality and safety issues including private patient care as part of the quality governance process.

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

## 7. MONITORING

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

7.2 The Trust's Annual Report will include attendance of members, frequency of meetings and whether meetings were quorate.

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

## 8. REVIEW

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

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

**APPENDIX A**

**ATTENDANCE AT POPULATION HEALTH AND SYSTEM COMMITTEE MEETINGS**

| **NAME OF COMMITTEE:** | Population Health and System Committee | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **Meeting Dates** | | | | | | | | |
| **Present (*include names of members present at the meeting)*** | | | | | | | | | |
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| **In Attendance** | | | | | | | | | |
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| Was the meeting quorate? Y / N<br>(*Please refer to Terms of Reference*) | | | | | | | | | |

University Hospitals Dorset
NHS Foundation Trust

# TERMS OF REFERENCE

## for the

## University Hospitals Dorset NHS Foundation Trust

# Quality Committee

**August 2024**

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

## DOCUMENT DETAILS

| | |
|---|---|
| **Author:** | Yasmin Dossabhoy ~~and Ewan Gauvin~~ |
| **Job Title:** | Associate Director of Corporate Governance ~~and Corporate Governance Manager~~ |
| **Signed:** | |
| **Date:** | ~~August 2024~~ |
| **Version No:** (Author Allocated) | 2.52 |
| **Next Review Date:** | July 2025 |

| | |
|---|---|
| **Approving Body/Committee:** | Board of Directors |
| **Chair:** | Rob Whiteman |
| **Signed:** | |
| **Date Approved:** | ~~4 September 2024~~[March 2025] |
| **Target Audience:** | Board of Directors |

**Document History**

| Date of Issue | Version No: | Next Review Date: | Date Approved: | Director responsible for Change | Nature of Change |
|---|---|---|---|---|---|
| October 2020 | 1 | October 2021 | July 2020 | Company Secretary | New document |
| May 2021 | 1.1 | October 2021 | 26 May 2021 | Assistant Company Secretary | Removed CEO as member of the committee at section 2.1<br>Added the CEO's attendance at section 2.4<br>Added CEO's receipt of papers at section 5.4 |
| October 2021 | 1.2 | October 2022 | November 2021 | Company Secretary | Added the Care Group Quality & Risk Groups to the reporting groups in sections 1.4 and 9.1<br>Added Associate Director of AHP/HCS as an attendee in section 2.2 |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | Added that the Clinical Lead for Clinical Audit is to attend for the Annual Audit Plan and Annual Report in section 2.2. |
| January 2022 | 1.3 | January 2023 | | Corporate Governance Assistant | Changed "Quality Governance Group" to "Clinical Governance Group" in sections 1.4 and 9.1. |
| January 2023 | 2.0 | January 2024 | 25 January 2023 | Company Secretary | Full review and re-draft. |
| May 2023 | 2.1 | January 2024 | 24 May 2023 | Company Secretary | Membership of the Committee increased from three to four Non-Executive Directors |
| September 2023 | 2.2 | July 2024 | 27 September 2023 | Company Secretary | Updated strategic objectives in 1.2. |
| May 2024 | 2.3 | July 2024 | 1 May 2024 | Company Secretary | Update to members and quorum |
| August 2024 | 2.4 | July 2025 | 4 September 2024 | Company Secretary | Annual review |
| January 2025 | 2.5 | July 2025 | [5 March 2025] | Company Secretary | Off cycle review to update Committee membership |

## TABLE OF CONTENTS

1. **PURPOSE** ..... 4
2. **RESPONSIBILITIES** .....
3. **MEMBERSHIP & ATTENDANCE** ..... 5
4. **AUTHORITY** ..... 6
5. **CONDUCT OF BUSINESS** .....
6. **RELATIONSHIPS & REPORTING** ..... 6
7. **MONITORING** ..... 8
8. **REVIEW** ..... 8

| **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 | ~~4 September 2024~~ |
| Print Name | Rob Whiteman | Signature of Chair | |

**UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST**

**QUALITY COMMITTEE**

**TERMS OF REFERENCE**

## 1. PURPOSE

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

1.2 The purpose of the Quality Committee is to support the Trust in achieving its strategic objectives: "**Improve patient experience, listen and act"** and **"Save lives, improve patient safety".**

1.3 The Quality Committee will do this including through:

- Providing input and recommendations to the Board for the development of the Clinical Strategy, Quality Strategy, Risk Management Strategy, Clinical Audit Strategy and the End of Life Care Strategy;
- Assisting the Trust's Board of Directors (Board) in its oversight of achievement of breakthrough objectives and strategic initiatives relating to the Quality domain;
- Ensuring robust clinical governance structures, systems and processes are in place across all services;
- Promoting a culture of learning and continuous improvement;
- Obtaining assurance on the implementation of the quality strategy; and
- Receiving and reviewing information and data relating to quality performance reporting to the Board.

1.4 The Committee serves to provide assurance that the Trust has an effective framework within which it can provide an effective patient experience by working to improve and assure the quality and safety of services it provides in a timely and cost-effective manner across the following areas: quality, patient experience, patient safety, clinical outcomes, risk management, health and safety, safeguarding (children and adults), infection prevention and control, medicines management, learning from deaths and end of life care.

1.5 The Committee acts as a means of internal assurance for compliance against the Care Quality Commission regulating and inspection compliance framework.

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

## 2. RESPONSIBILITIES

**Quality Strategy and delivery of the Quality Agenda**

2.1 To receive confirmation from the Board, on an annual basis, of:

- the relevant breakthrough objectives; and
- the relevant strategic initiatives;

which are to be held to account by the Committee.

2.2 To obtain assurance that the relevant breakthrough objectives and strategic initiatives for which the Board has delegated responsibility for oversight to the

Committee, are being delivered effectively through monitoring progress, appropriate challenge and escalating to the Board when required.

**Risk Management**

2.3.1 To oversee that the Trust has robust management systems and processes in place for ensuring high standards for quality of care.

2.3.2 To oversee that the Trust has an effective framework to support assurance regarding Trust systems relating to patient safety, patient outcome and patient experience.

2.3.2 To regularly review the Board Assurance Framework (including through in-depth review of specific risks) and to ensure that it reflects the assurances for which the Committee has oversight, with risks highlighted being appropriately reflected on the risk registers. This shall include, but not be limited to the Committee acting in accordance with Board approved risk appetite and risk tolerance levels when reviewing risks.

2.3.3 To be kept appraised of new and current risks, in accordance with the Risk Management Strategy, identified on the risk register across the organisation and progress of action plans identified to mitigate these risks.

**Assurance**

2.4 Statutory requirements

2.4.1 To review the annual quality report.

2.4.2 To review the quarterly and annual mortality reports.

2.4.3 To review the annual adult and children safeguarding report and statement.

2.4.4 To review the annual reports on claims.

2.4.5 To review the annual infection prevention and control report and statement.

2.4.6 To review the annual health and safety report.

2.5 External reviews

2.5.1 To receive assurance from other significant assurance functions, both internal and external, on review of the findings of external reviews and consider the implications to the Trust. These will include, but not be limited to, regulators and inspectors.

2.5.2 To monitor the Trust's responses to relevant external assessment reports and the progress of their implementation, including the reports of the Care Quality Commission.

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

2.6 Safe

2.6.1 To review reports on serious incidents, mortality, learning from deaths, never events, claims and inquests to receive assurance that appropriate thematic review, investigation and learning to reduce risk has been undertaken.

2.6.2 To receive reports including:

- identification of areas of concern and escalations; and
- in the context of quality risks and assurances over the Trust's system of internal control as reflected in the Board Assurance Framework;

from defined sub-groups of the Trust Management Group and/or Board Committees (including, as considered required, Safeguarding, Infection Prevention & Control, Radiation Protection, Medicines Governance, Health and Safety, Mortality Surveillance, Clinical Governance Group).

2.6.3 To review and monitor Quality Impact Assessments relating to cost improvement programmes and transformation programmes to obtain assurance that there will be no unforeseen detrimental impact on the quality of care for patients.

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

2.6.5 To obtain assurance over the Trust's maternity services including receipt of reports from the Maternity Safety Champion and relevant maternity safety and performance dashboards.

2.6.6 To obtain assurance over the safe delivery of the Trust's palliative and end of life care services including receipt of the annual End of Life Care Report and Care of the Dying Audit.

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

2.6.8 To obtain assurance in relation to the safe delivery of the Trust's children's services.

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

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

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

2.7 Effective

2.7.1 To ensure a comprehensive clinical audit programme is in place to support and apply evidence-based practice, implement clinical standards and guidelines and drive quality improvement. This shall include through monitoring progress against the annual programme and the Clinical Audit Strategy.

2.7.2 When requested by the Board, or where determined by the Committee, to monitor the implementation of action or improvement plans in relation to quality of care, particularly in relation to incidents and similar issues.

2.8 Caring

2.8.1 To consider reports from the Patient Advice & Liaison Service and other sources of feedback (such as Healthwatch) on formal and informal patient feedback and to consider action in respect of matters of concern.

2.8.2 To consider the results of issues raised and the trends in patient surveys of in-patients and out-patients activities and estate surveys such as PLACE that may

impact on clinical quality, and to gain assurance of the development of suitable improvement and the completion of action to address the issues raised.

2.9 Well-Led

2.9.1 To receive and consider the Trust's clinical governance and risk management reports and review recommendations on actions for improvement.

2.9.2 To provide assurance reporting to the Board that the Care Quality Commission's fundamental standards for quality and safety are monitored and highlight any gaps in compliance, controls or assurance.

2.9.3 To review, make comment and provide assurance reporting to the Board on the care and safety issues which are subject to other regulatory scrutiny (for example, NICE).

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

2.10 Responsive

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

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

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

2.11 ICS

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

## 3. MEMBERSHIP/ ATTENDANCE

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

3.2 In addition, the following will attend the Committee to provide information and advice with prior agreement of the Committee Chair and/or to present a report to the Committee or a Chief Officer is unable to attend:

- Chief People Officer;
- Deputy Chief Nursing Officers;
- Deputy Chief Medical Officer;
- Director of Infection Prevention and Control;
- Care Group Medical Directors;
- Associate Director of Pharmacy;
- Associate Medical Director (Chair of CGG);
- Care Group Directors of Nursing;
- Associate Director of Quality Governance and Risk;
- Clinical Lead for Clinical Audit;
- IR(ME)R Lead/Chair of Radiation Group;
- Associate Director of Allied Health Professionals & Healthcare Scientists

and others as invited by the Committee Chair.

3.3 The Committee will be chaired by a Non-Executive Director of the Trust (other than the Chair of the Audit Committee or Finance and Performance Committee). A Non-Executive Deputy Chair (other than the Chair of the Audit Committee or Finance and Performance Committee) may be nominated. In the absence of the Chair and/or an appointed Deputy, the remaining members shall elect one of the Non-Executive Directors present to chair the meeting.

3.4 Subject to paragraphs 3.2 above and 3.6 below, only members of the Committee have the right to attend Committee meetings. 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. The Chief Executive Officer will attend on an ad-hoc basis or as required. The Committee Chair may ask any or all of those who attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

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

3.6 Any member of the Board may attend any meeting of the Committee with prior agreement of the Committee Chair.

3.7 Governor(s) may be invited by the Chair to attend meetings of the Committee as observer(s). Observers are not members of the Committee.

## 4. AUTHORITY

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

4.2 The Committee is authorised to approve its governance cycle.

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

4.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions and all employees are directed to co-operate with any request made by the Committee.

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

## 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 Committee and any of its meetings.

5.2 The Committee will normally meet on a monthly basis (and not less than 10 times in each financial year) and at such other times as the Committee Chair shall require.

5.3 Meetings of the Committee shall be quorate if there at least four members present, which will include the Committee Chair (or a Non-Executive Director deputy), and two Executive Directors, one of whom must be the Chief Medical Officer or Chief Nursing Officer. 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 Committee is inquorate, then the meeting can progress if those present determine. However, no business shall be transacted; items requiring approval may be submitted to the next meeting of the Board as an urgent item.

5.5 Meetings of the Committee shall be called by the Company Secretary at the request of the Committee Chair.

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

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

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

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

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

5.11 Members will be expected to conduct business in line with the Trust's values and objectives.

5.12 Members of, and those attending, the Committee shall behave in accordance with the Trust's Constitution, Standing Orders and Codes of Conduct (including, but not limited to, observing confidentiality).

5.13 Members must demonstrably consider the equality and diversity implications of decisions they make.

## 6. RELATIONSHIPS AND REPORTING

6.1 The Committee shall be accountable to the Board.

6.2 The Committee shall make recommendations to the Board in relation to issues that require decision or resolution by the Board.

6.3 The Committee Chair shall present a report summarising the proceedings of each Committee meeting at the next meeting in public 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 Committee shall refer to the Audit Committee, Finance & Performance Committee, People & Culture Committee and/or Population Health & System Committee any matters requiring review or decision in such forum(s).

6.5 For the avoidance of doubt:

- the People and Culture Committee will have oversight of the development by the Trust of an effective staff structure and workforce operating model across the organisation; and
- the Population Health and System Committee will have oversight of the implementation by the Trust of its responsibilities pursuant to the Our Dorset strategic plan for population health and health inequalities.

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

## 7. MONITORING

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

7.2 The Trust's Annual Report will include attendance of members, frequency of meetings and whether meetings were quorate.

7.3 On an annual basis, the Committee will provide a self-assessment report to the Board detailing how the Committee has discharged its obligations as set out within

its terms of reference, specifically incorporating an assessment of its effectiveness and making recommendations for improvement, where appropriate. This will form part of the assurances which support the Annual Governance Statement and the Trust's Annual Report disclosures.

## 8. REVIEW

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

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

**APPENDIX A**

**ATTENDANCE AT QUALITY COMMITTEE MEETINGS**

| **NAME OF COMMITTEE:** | Quality Committee | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **Meeting Dates** | | | | | | | | |
| **Present (*include names of members present at the meeting)*** | | | | | | | | | |
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| **In Attendance** | | | | | | | | | |
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| | | | | | | | | | |
| Was the meeting quorate? Y / N<br>(*Please refer to Terms of Reference*) | | | | | | | | | |

University Hospitals Dorset
NHS Foundation Trust

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# TERMS OF REFERENCE

## for the

## University Hospitals Dorset NHS Foundation Trust

# Transforming Care Together Group

**February ~~2024~~2025**

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:** | 13/05/2024 |
| **Version No:** (Author Allocated) | 0.42.3 |
| **Next Review Date:** | MayAugust 2025 |

| | |
|---|---|
| **Approving Body/Committee:** | Board of Directors |
| **Chair:** | Rob Whiteman |
| **Signed:** | |
| **Date Approved:** | 6 March 2024 |
| **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 | 2.0.2 | | | Director Integration | Adopted trust format, added in content from Liverpool, amended for Service Ready Group feedback |
| December 2023 | 0.32.1 | | | CSTO/COO | Feedback from NED discussion |
| 26/02/2024 | 0.42.2 | May 2025 | 6 March 2024 | CSTO/COO | Version following TCT Inaugural meeting for Board Approval |
| February 2025 | 2.3 | | | CSTO | Version following annual review |
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# TABLE OF CONTENTS

1. PURPOSE ..... 5
2. RESPONSIBILITIES ..... 6
3. MEMBERSHIP & ATTENDANCE ..... 8
4. AUTHORITY ..... 9
5. CONDUCT OF BUSINESS ..... 9
6. RELATIONSHIPS & REPORTING ..... 10
7. MONITORING ..... 10
8. REVIEW ..... 11

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|---|---|---|---|
| **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 | ~~Rob Whiteman~~ | Signature of Chair | |

**UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST**

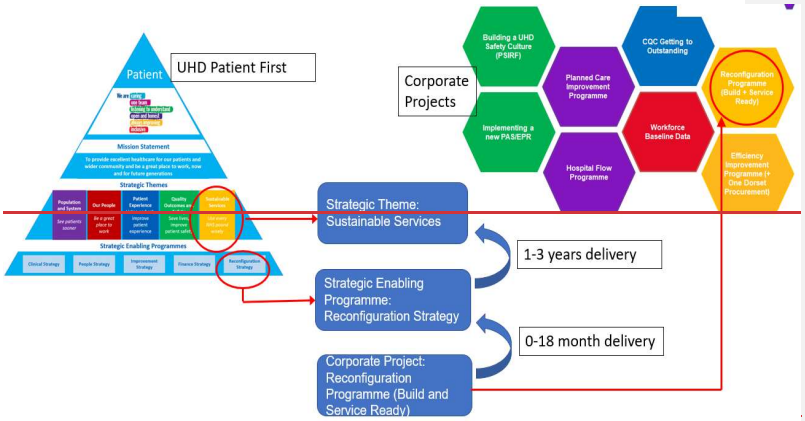
**TRANSFORMING CARE TOGETHER GROUP**

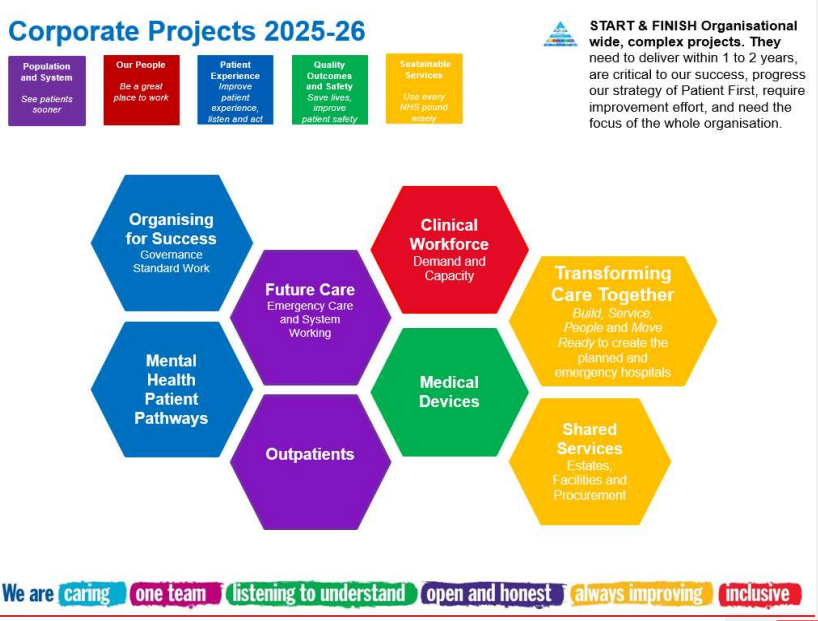
**TERMS OF REFERENCE**

## 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~~three workstreams to ensure the transformation is "Build Ready~~" and~~," "Service Ready~~."~~," and "People Ready." Explicit reference to the other ~~7~~ corporate projects will also be made, as they are also mutually supportive of the Trust objectives, and progress against all the strategic themes. This is pictorially set out below:



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1.3 The **objective** of the Transforming Care Together Programme is to deliver safe, 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 (to include Move Ready and Digital readiness), Build Ready, and People Ready programmes. ~~The latter~~Build Ready 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 (to include Move Ready and Digital readiness), Build Ready and People Ready and 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-.

i) Group to link to ICB CSR Service Change Steering Group.

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

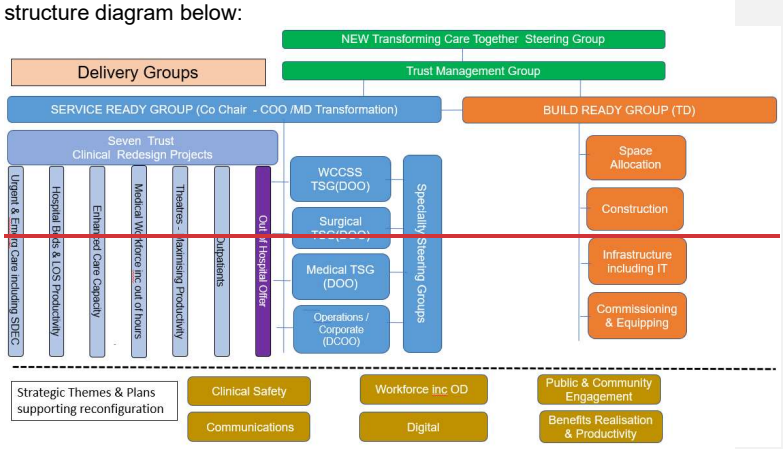
### Strategies and delivery of the strategic agenda

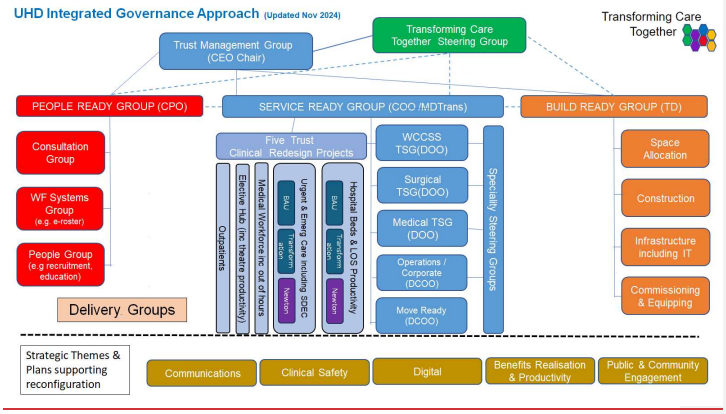
2.1 To receive confirmation from the Board, on an annual basis, of the relevant breakthr Formatted: Justified objectives, strategic initiatives, and corporate projects within the remit of the Group, for which it is to be held to account.

2.2 To obtain assurance that the programme is being delivered effectively thr Formatted: Justified 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 (to include Move Ready and Digital readiness), Build R Formatted: Justified and People 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~~Service Ready aspects:

- Assure the implementation of the future operating model, ensuring there ~~is over~~ 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~~committee to ~~receive assurance~~ensure 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.~~

- CSR Service Change Steering Group: ~~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~~ effectively.

- The TCT programme will oversee the work of the Service Ready Group, which includes Move Ready. This is to ensure operational teams are aware of onsite changes and impacts from estates work (Build Ready). The group will ensure that operational, clinical, and non-clinical services are fully prepared for safe moves into new locations, with focus on moving into the BEACH building (Move Planning). This includes pre-move planning, the move process itself, and post-move service delivery. Clinical services will be appropriately supported, and all relocations will be well-organised and controlled.

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- Digital elements of the TCT portfolio will be delivered to support the Service Ready, Build Ready and People Ready parts of the programme. This includes ensuring IT systems and other digital infrastructure are in place to support safe and effective service moves ensuring technical readiness for transitions into new locations such as the BEACH building. The Digital Governance Board will be the means by which this is managed and the TCT programme update will be delivered as part of Service Ready in line with the governance process, with any major risks or dependencies escalated through the appropriate governance routes.

- Any other duties as advised by the Board.
- Non-Execs/Execs.

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.

2.6 **Risk Management** For the People Ready aspects:

- Preparedness of the workforce for moves including organisational develop
- Staff engagement
- Workforce capacity and capability
- People processes and ways of working
- Statutory compliance with the management of change.

**Risk Management** 2.3.3 To regularly review the Board Assuran Framework (including through in-depth review of specific risks) and to ensure t 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.

2.3.47.1 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.

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.

2.7.2 To be kept appraised of all new and current risks rated 15-25, clinical and non-cli identified on the risk register across the organisation and progress of action plans identified to mitigate these risks.

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## 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
- Chief Finance Officer
- Chief People 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 Nursing Officer
- ~~Chief People Officer~~
- Chief Medical Officer
- ~~Member from NHS Dorset ICB~~ [Chief ~~Strategy and Transformation~~Digital Officer]
- Member from Executive Team DHC/DCH [Rep TBD]
- Senior BCP representative [Rep TBD]
- ~~Medical Director for Transformation~~
- Deputy CEO – NHS Dorset
- Director of Integration
- Director for Transformation
- Medical Director Strategy & Transformation.

3.3 The Group will be chaired by the Chair of the Board. A Non-Executive Deputy C should be nominated. In the absence of the Group Chair and/or any appointed Dep 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 hav 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.

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## 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 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 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 pr determine. However, no business shall be transacted; items requiring approval ma 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 o Chair.

5.6 The Company Secretary (or their nominee) is responsible for preparing the agend 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 B

5.8 Under exceptional circumstances, in the case of emergency or urgency, iten 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

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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 limit 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.

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5.10 Proceedings and decisions made will be formally recorded by the Company Secr team (or their nominee) in the form of minutes, which will be submitted to the next meeting of the Group for approval.

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## 6. RELATIONSHIPS AND REPORTING

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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 in public 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 For the avoidance of doubt:

- the People and Culture Committee will have oversight of the development by the Trust of an effective staff structure and workforce operating model across the organisation; and
- the Population Health and System Committee will have oversight of health inequalities.
- the Quality Committee will have oversight of quality and safety issues including private patient care as part of the quality governance process; and
- The Finance and Performance Committee will have oversight of the financial (capital and revenue) plans, and the operational performance.
-

6.~~5~~6 The Group shall receive reports from sub-groups of the Trust Management G (including the Build Ready ~~and~~, Service Ready and People 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.

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## 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. This will form part of the assurances which support the Annual Governance Statement and the Trust's Annual Report disclosures.

## 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.

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**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)*** | | | | | | | | | |
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| **In Attendance** | | | | | | | | | |
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| | | | | | | | | | |
| Was the meeting quorate? Y / N<br><br>(*Please refer to Terms of Reference*) | | | | | | | | | |

# Appendix - Attendance at Part 1 Board Meetings

| Part 1 | | 01 May 2024 | 03 July 2024 | 04 September 2024 | 6 November 2024 | 8 January 2025 |
|---|---|---|---|---|---|---|
| | Beverley Bryant | | | | | |
| | Pankaj Dave | | | | | |
| | Judy Gillow | | | A | | |
| | Siobhan Harrington | | | | | |
| | Sarah Herbert | | | | | |
| | Fiona Hoskins | | | | | |
| | John Lelliott | | | | | |
| | Femi Macaulay | | | | | |
| | Helena McKeown | A | | | | |
| | Mark Mould | | | | | |
| | Pete Papworth | | | | | |
| | Sharath Ranjan | | | | | |
| | Richard Renaut | | | | | |
| | Tina Ricketts | | | | A | |
| | Cliff Shearman | | | | | |
| | Claire Whitaker | | | | | |
| | Rob Whiteman | | | | | |
| | Peter Wilson | | | | | |
| In Attendance (excl Governors, members of public and non-Standing Invitees) | David Broadley | | | | | |
| | Carol Box | | | | | |
| | James Donald | | | | | |
| | Yasmin Dossabhoy | | | | | |
| | Tracie Langley | | | | | |
| | Ewan Gauvin | | | | | |
| | Alison Honour | | | | A | A |
| | Eiri Jones | | | | | |
| | Irene Mardon | | | | | |
| | Lorraine Tonge | | | | | |
| | John Vinney | A | A | A | | |
| | Klauda Zwolinska | | | | | |
| Was the meeting quorate? | | Y | Y | Y | Y | Y |

Key

| | |
|---|---|
| | Not in Attendance |
| A | Apologies |
| D | Delegate Sent |