University Hospitals Dorset
NHS Foundation Trust

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

BOARD OF DIRECTORS – PART 1 MEETING

Wednesday 8 January 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

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 8 January 2025 via Microsoft Teams.

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

Rob Whiteman
Trust Chair

AGENDA – PART 1 PUBLIC MEETING

9:30 on Wednesday 8 January 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**
9:50	**4**	Update from the Council of Governors	**Verbal**	**Review**	**Lead Governor**
10:00	**5**	**MINUTES**			
10:02	**5.1**	For Accuracy and to Agree: Minutes of the Board of Directors Meeting held on 6 November 2024	**Paper**	**Approval**	**Chair**
10:03	**5.2**	Matters Arising - Action List	**Paper**	**Review**	**Chair**
10:05	**6**	**TRUST CHAIR AND CHIEF EXECUTIVE UPDATES**			
10:05	**6.1**	Trust Chair's Update	**Verbal**	**Information**	**Chair**
10:15	**6.2**	Chief Executive Officer's Report • ICB minutes	**Paper**	**Information**	**CEO**
10:30	**7**	**STRATEGY, RISK AND PERFORMANCE**			
10:30	**7.1**	Integrated Quality, Performance, Workforce, Finance and Informatics Report *Questions to the Executive Team by exception*	**Paper**	**Assurance**	**Execs**
11:15	**7.2**	Quality Committee – Chair's Report – November and December 2024	**Paper**	**Assurance**	**Committee Chair**

		• Maternity Incentive Scheme *(to be presented by Director of Midwifery and Clinical Director*	**Paper**	**Decision**	
11:35	**7.3**	Finance and Performance Committee – Chair's Report – November and December 2024	**Verbal**	**Assurance**	**Committee Chair**
11:40	**7.4**	People and Culture Committee – Chair's Report – December 2024 • Guardian of Safe Working Hours • 2024/25 Annual In-Patient Establishment Review	**Paper** **Paper** **Paper**	**Assurance** **Assurance Review**	**Committee Chair**
11:45	**7.5**	Transforming Care Together – Chair's Report – December 2024	**Verbal**	**Assurance**	**Committee Chair**
11:50	**8**	**PEOPLE AND CULTURE**			
11:50	**8.1**	People & Culture Strategy	**Paper**	**Approval**	**CPO**
11:55	**8.2**	Annual Equality Diversity and Inclusion Report	**Paper**	**Assurance**	**CPO**
12:00	**9**	**ITEMS FOR APPROVAL/INFORMATION**			
12:00	**9.1**	Risk Register: review of significant risks; new risks rated 15 and above	**Paper**	**Information**	**CNO/ Execs**
12:05	**10**	Any Other Business	**Verbal**	**Discussion**	**Chair**
	11	Reflections on the Board Meeting	**Verbal**	**Discussion**	**Chair**
	12	Questions from the Council of Governors and Public arising from the agenda. Governors and Members of the public are requested to submit questions relating to the agenda by no later than noon on Sunday 5 January 2025 to company.secretary-team@uhd.nhs.uk			
	13	**Date and Time of Next Board of Directors Part 1 Meeting:** Board of Directors Part 1 Meeting on Wednesday 8 January 2025 at 9:30.			
	14	**Resolution Regarding Press, Public and Others:** To agree, as permitted by the National Health Service Act 2006 (as amended), the Trust's Constitution and the Standing Orders of the Board of Directors, that representatives of the press, members of the public and others not invited to attend to the next part of the meeting be excluded due to the confidential nature of the business to be transacted.			
12:15	**15**	**Close**	**Verbal**		**Chair**

* Late paper
[R] Associated item in Reading Room

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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

Quarterly Reports

- Guardian of Safe Working Hours Report
- Mortality Report
- Quality Impact Assessment Report
- Nursing Establishment Review
- Maternity Staffing Report

AGENDA – PART 2 PRIVATE MEETING

12:30 on Wednesday 8 January 2025

Time	Item		Method	Purpose	Lead
12:30	**16**	Welcome, Introductions, Apologies & Quorum	**Verbal**		**Chair**
	17	Declarations of Interest	**Verbal**		**Chair**
12:32	**18**	**MINUTES AND ACTIONS**			
12:32	**18.1**	For Accuracy and to Agree: Minutes of the Board of Directors Meeting held on 4 December 2024	**Paper**	**Approval**	**Chair**
12:33	**18.2**	Matters Arising – Action List	**Paper**	**Review**	**Chair**
12:35	**19**	**UPDATES**			
12:35	**19.1**	Chief Executive Officer's Update • One Dorset Provider Collaborative Highlight Report	**Paper**	**Information**	**CEO**
13:15	**19.2**	• Feedback/Escalations from Committee Chairs (not already covered in Part 1) • Feedback From Dorset County Hospital Board	**Verbal**	**Information**	**Committee Chairs**

13:30	**19.3**	Feedback from Service Visits	**Verbal**	**Information**	**All**
13:40	**20**	**STRATEGY AND FINANCE**			
13:40	**20.1**	Finance Update	**Paper**	**Review**	**CFO**
13:55	**21**	**QUALITY AND PEOPLE**			
13:55	**21.1**	Patient Safety Event Report	**Paper**	**Review**	**CMO**
14:05	**22**	**ITEMS FOR APPROVAL/INFORMATION**			
14:05	**22.1**	Hip and Knee Consumables	**Paper**	**Approval**	**CFO**
	22.2	Physical Bed Stock	**Paper**	**Approval**	**CFO**
	22.3	Poole Hospital Cancer Treatment Trust	**Paper**	**Approval**	**CFO**
	22.4	Endoscopy Electrical Infrastructure Upgrade	**Paper**	**Approval**	**CSTO**
	22.5	New Hospitals Programme – Full Business Case B	**Paper**	**Approval**	**CSTO**
	23	Any Other Business	**Verbal**		**Chair**
	24	Reflections on the Board Meeting	**Verbal**		**Chair**
	25	**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	**26**	**Close**	**Verbal**		**Chair**

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Items for Next Standing Board Part 2 Agenda

Standing Reports

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

Annual Report

- Operational Budget (subject to national timeline)

List of abbreviations:

Officer titles

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

Other abbreviations

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

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

BOARD OF DIRECTORS PART 1

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

Present:	Rob Whiteman	Trust Chair *(Chair)*
	Beverley Bryant	Chief Digital Officer
	Pankaj Davé	Non-Executive Director
	Judy Gillow	Non-Executive Director
	Siobhan Harrington	Chief Executive Officer
	Sarah Herbert	Chief Nursing Officer
	John Lelliott	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
	Cliff Shearman	Non-Executive Director
	Claire Whitaker	Non-Executive Director
	Peter Wilson	Chief Medical Officer
In attendance:	David Broadley	Medical Director, Integrated Care
	Colin Blebta	Public Governor
	Robert Bufton	Public Governor
	Sharon Collett	Public Governor
	Samantha Dean	Staff member
	Yasmin Dossabhoy	Associate Director of Corporate Governance *(minutes)*
	Rob Flux	Staff Governor
	Mel Hartley	Patient Experience and Engagement Lead
	Paul Hilliard	Appointed Governor
	Helen Martin	Freedom to Speak Up Guardian
	Irene Mardon	Deputy Chief People Officer
	Diane Smelt	Public Governor
	Lorraine Tonge	Director of Midwifery
	Kani Trehorn	Public Governor
	Karen Uphill	Carers Advisor, Lead
	Michele Whitehurst	Public Governor
	Klaudia Zwolinska	Corporate Governance Assistant
	2 members of the public in attendance	

BoD 255/24	**Welcome, Introductions, Apologies & Quorum** Rob Whiteman welcomed everyone to the meeting, in particular Beverley Bryant, Chief Digital Officer. Eiri Jones, Non-Executive Director from Dorset County Hospital (DCH) would be observing Part 1 meetings of the Board. There was a reciprocal arrangement in place where Judy Gillow would be observing Part 1 of the DCH Board meetings. Expressing his keenness for the two Boards to work together, Rob Whiteman referenced David Clayton-Smith, Matthew Bryant, Siobhan Harrington and himself having met the previous day.

	Pankaj Davé was thanked for his outstanding service to the Board. He had agreed to his term being extended to the end of November 2024 while two new Non-Executive Directors went through their process of due diligence and onboarding. Reflecting upon his final Board meeting at the Trust, Pankaj Davé commented that it had been an amazing journey, a privilege and an honour. There had been some challenging times, but he left feeling energised about the future developments at the Trust. Commenting upon the fantastic people and their care for patients, the merger having made a significant difference, the investments being made and the reconfiguration, he considered that an incredible hospital would be built. Apologies had been received from Tina Ricketts, Chief People Officer, who was represented by Irene Mardon. Apologies had also been received from Alison Honour, Associate Non-Executive Director from Bournemouth University. The meeting was declared quorate.
BoD 256/24	**Declarations of Interest** John Lelliott declared that he had ceased to be a member of the Board of Covent Garden Market Authority with effect from 20 September 2024. No existing interests in the matters to be considered were declared. In addition, no further interests were declared.
BoD 257/24	**Patient Story** Sarah Herbert introduced the Patient Story, thanking Theresa for attending the meeting to share her story about care at the Trust. She also thanked Mel Hartley and Karen Uphill for their support for Theresa. The story was a powerful one about the impact the Trust could have on its patients and their families. Sarah Herbert outlined that she and Peter Wilson were shortly to commence a Trust wide project on patient centred care. Theresa's story captured the importance and value of this. Theresa was the carer of a 21 year old, Ace, who was autistic. Ace had transitioned from female to non-binary and used the pronouns "they" and "them". Being Ace's advocate and carer was of primary importance to Theresa. The previous year, she had experienced intense pain and vomiting for ten days. She had phoned 111 and was ambulanced to hospital. She expressed that she felt it impossible to prioritise herself because of potential negative impact on Ace. Having stayed in hospital for seven days, in April 2024, it was agreed she needed an operation. At her pre-operative assessment, it had been agreed that her operation could take place in the morning to reduce the impact upon Ace, who often woke up late morning. The nurse spoke of adult safeguarding and Ace's capacity as her next of kin, which she had found upsetting. However, determined to reduce the impact on Ace, she contacted PALS who put her in touch with the carer's support service. She had not anticipated that her role as carer could be lightened through the support available. Her fear was not being able to protect Ace from harm while she was under general anaesthetic. She wanted someone to message Ace to communicate the positive outcome of the operation and it was important to her that those communicating with Ace used the correct pronouns and understood neurodiversity. Also, she wanted to avoid the possibility of her operation being postponed, particularly in light of the preparation leading up to it. She explained to the Board some of the aspects of what the preparation had involved. Highly commending the compassion and willingness to listen shown by Karen Uphill throughout, she highlighted the relief she had felt by being listened to and understood. Karen Uphill had shortly before then

	attended autism training and had experience of working with the neurodiversity nurse practitioner within the Trust, which had greatly increased her knowledge. The support given had included pre-prepared messages to be given by the hospital to Ace by way of reassurance. Theresa spoke very positively about the care provided for Ace while she herself was being looked after. There had been some learning as the message for Ace had been delayed due to a miscommunication, highlighting the importance of well-trained staff communicating with the right person at the right time. Thanking the Trust for the care she had received, Theresa explained that it was the communication, language and support she received that enabled her to address her health, after having spent many years prioritising Ace. Thanking Theresa for sharing her story and expressing pride at the personal approach taken by the service, Siobhan Harrington commented upon the incredible contribution made by carers across the country. She had also been struck by Theresa's description of Mel Hartley and Karen Uphill "knowing [her] heart". Theresa's story highlighted for the Board the importance of the service and it being developed and supported going forward. Echoing Siobhan Harrington's comments, Claire Whitaker felt proud and noted that the quality of the service was underpinned by specific training which informed and supported the approach and experience. Helena McKeown commented upon the compassionate care, also noting that strategically, looking after carers ensured the person they cared for helped to avoid further costs down the line. Appreciating the powerful learning shared and pleased at how the organisation had responded, Judy Gillow enquired how this would be spread across the Trust for others to be able to use the learning as well. Responding to this, Sarah Herbert referenced the focus upon person centred care within the organisation. Through the project being launched, a large body of work would be carried out with two component elements - shared decision making, particularly plans of care with medical teams; and person-centred care in relation to fundamentals, making individuals feel included, informed and collaborated with. This would be presented to Quality Committee in future. Rob Whiteman echoed the importance of training, citing the example of the use of appropriate pronouns. The Board NOTED the Patient Story.
BoD 258/24	**For Accuracy and to Agree: Minutes of the Board of Directors Meeting held on 4 September 2024** The minutes of the Part 1 meeting of the Board of Directors held on 4 September 2024 were APPROVED as an accurate record.
BoD 259/24	**Matters Arising – Action List** *BoD203/24 – Transition arrangements between paediatric and adult care* – Peter Wilson updated that a meeting had taken place between the paediatric team and others having an interest in transitional care between Children and Young People's and Adult Services. A group was being formed, with an A3 being prepared to support next steps being determined. He proposed that an update be presented to Quality Committee in 3-4 months' time, with a presentation to Board in 6 months' time. Action CLOSED.
BoD 260/24	**Trust Chair's Update** Rob Whiteman presented his Trust Chair's Update:

	• Reiterating the desire to work successfully to develop the provider collaborative for Dorset. • Highlighting that the new Government had presented its first budget. The largest tax increase in approximately 30 years had been seen, with the government raising an additional £41 billion through taxation. The Government would be spending £100bn more through borrowing and tax increases combined. He reflected that it had been more of a public services budget than a growth budget. The NHS had been treated favourably with £22bn of extra expenditure, as well as capital spending increasing by £3.1bn next year, rising to £13.6bn. This did, however, still mean challenges for the Trust's operations. While the NHS had fared better than some other public services and there was gratitude for the extra resources, the gap for the Dorset system as well as ensuring that the Trust's own operational plans were delivered remained tight. • Non-Executive Directors continued to carry out their visits to services within the Trust, triangulating what was seen in reporting. Since the last meeting of the Board, services visited had included infection prevention and control, pharmacy and oral and maxillofacial surgery. The Board NOTED the Trust Chair's Update.
BoD 261/24	**Chief Executive Officer's Report** Presenting her report, Siobhan Harrington added: • Thanking everyone and referencing the winter plan, there was an emphasis on patient safety and looking after staff going into winter. • She was keen that the Trust was actively engaged in the consultation on the 10 year health plan. An internal process was being worked through to respond to it. There had been a number of national, regional and local responses. An update would be provided on the process to actively engage through the winter on the plan. It was a unique opportunity to influence the future of the NHS over the next 10 years. • The money identified through the autumn budget was welcomed. There was not yet clarity on how the money would be devolved or spent. It showed a commitment to the NHS. The Trust's role would be to transform and deliver with the resource identified. • Generally, the Trust was keeping a grip of its financial position, which was shown from the reporting. This was attributable to everyone's efforts. At a Dorset system level, the financial position remained challenged, with a gap of circa £30m – the Trust needed to be part of the solution to this. • The provider collaborative was at a pivotal point to deliver a step-change in the delivery of elective care. Work remained on the operating model, with discussions ongoing. Focus was continuing upon integrated teams, procurement and workforce. She also referenced the Electronic Health Record (EHR). • Referencing the Insight visits, she invited Sarah Herbert to comment, who outlined the overwhelmingly positive feedback from the first visit, focused upon emergency pathways and trauma. It had been reassuring for the executive team that work had already been underway on a number of the areas identified where improvement could be made. The second had been the maternity visit, with the LMNS and regional colleagues from the wider system. Thanking Lorraine Tonge and the maternity team, Sarah Herbert commented that she and Siobhan Harrington had been incredibly proud to see the

team represent themselves in the manner they had, with professionalism, a united approach and strong leadership. One comment received had been that the service was almost unrecognisable from what it had been a couple of years prior. In addition, from the review meeting with the maternity support incentive programme, the service had now been moved from improvement to sustainability with a view to exiting following the move to the BEACH building. The team had been complimentary about the improvement work and the pace at which it had taken place.

Siobhan Harrington echoed thanks to Lorraine Tonge and the team. The improvements could be seen in the strength of the reporting now being presented to the Board.

- In relation to the Patient First improvement methodology, this was at a point of being embedded and for the clinical teams shifting from formal classroom training to the clinical spaces. This would include having improvement boards up and those already trained training colleagues.
- Staff survey responses were currently at 49.8% with her aspiration being to exceed the previous year's response rate of 59%. She encouraged all colleagues to complete the survey.
- She also welcomed Beverley Bryant, who was getting to grips with the Trust's EHR journey and the risk with current processes.
- Referencing the integrated performance report (IPR), she drew attention to some of the tensions and challenges with no criteria to reside (NCtR). Mark Mould had worked extensively to drive forward and support the work with Newton, the strategic partner, in Dorset. She expressed confidence that this would have impact in the next two years. For the current winter, the Trust was trying to take the learning from Newton's diagnosis and build it into the winter planning.
- Significant progress had been made on 65 week waits.
- Later in the Board meeting would be the naming of the new building at the Royal Bournemouth Hospital site, with a ground breaking ceremony to take place that day. The plan was to have a six storey building at the Royal Bournemouth Hospital before Christmas.

Referencing the integrated care partnership Board meeting that he had attended on behalf of Rob Whiteman on 22 October 2024, Pankaj Davé enquired whether there was clarity in the budget to manage some of the system-level financial interfaces in an improved manner. Responding to this, Siobhan Harrington commented that this was not the case; however, the approach in Dorset was to build upon the very good diagnostic work from Newton, which could be seen in the Trust's winter plan. The issue with the financial position and local authorities was challenging, with strong relationships being important as well as transparency about what the Trust could do and how much it needed system partners to do. The Trust's relationships with BCP Council were good: the transfer of care hubs were working and building. Adding to this, Mark Mould commented upon the importance of partners holding themselves to account in terms of use of capacity. He had suggested to the integrated care board (ICB) earlier that day – and was awaiting feedback on this - that collectively, as took place in relation to 65 week waits, a weekly conversation occurred at a senior level to track through the progress that needed to be made.

Judy Gillow asked whether there was opportunity to look across the system at how risk was managed. She had observed differences in risk tolerance and alignment would be a potential key to success. Agreeing with this, Siobhan Harrington commented upon this being critical. She referenced the discussions that had taken place the previous winter in relation to system risk,

	risk assessment and risk appetite; however, there was opportunity for further maturity. Adding to this, Mark Mould referenced discussions that he and Sarah Herbert had about collective mitigation of risk across the system where there were complex higher risk patients. They were working on an escalation process with the ICB. David Broadley referred to a presentation at the integrated neighbourhood teams board he had attended the previous day which had resonated and which had included shifting from a risk averse approach to holding risk collectively. Referring back to Pankaj Davé's comment about interaction of finances, John Lelliott enquired whether there was a methodology being considered of areas of overlap and duplication. Siobhan Harrington confirmed that for the urgent and emergency care pathways, this was part of the Newton work. She considered that there was also opportunity for the elective pathway, working with DCH. Helena McKeown stated that she would appreciate a briefing upon how the Better Care Fund was being used system wide. Rob Whiteman suggested that he and Siobhan Harrington consider this for a Board development session. Reflecting upon the discussions and a meeting that had taken place between chairs of the Quality Committees within the system, Cliff Shearman commented upon the importance of having a common vision. Siobhan Harrington referenced a meeting that had taken place the previous day, with discussions about having a five year integrated plan for Dorset which had clarity about the vision. This would be progressed within the next couple of months, with the Trust actively involved in creating and supporting that work. Rob Whiteman summarised the discussions that had taken place. The Board NOTED the Chief Executive Officer's Report.
BoD 262/24	**Board Assurance Framework** Richard Renaut presented the Board Assurance Framework adding that: • In addition to the development of the strategy deployment reviews, the accountability framework had been greater aligned to those. • Work would be commenced in November 2024 on the following year's objectives taking into account, where possible, the long term NHS plan and also local in-year priorities including reconfiguration. A workshop had been planned, with Board discussion to take place prior to the objectives being presented for approval in February 2025. • As part of the horizon scanning recommended for a Board development session, he suggested that aspects may include, for example, the US elections and the Trust's Clinical Strategy. • There would be further discussion in relation to the EHR in Part 2 of the meeting of the Board. In relation to BAF Risk 1, Helena McKeown commented upon the reference in the current challenges section to therapy staffing, enquiring whether additional investment in therapy was required to enable people to leave hospital and be more independent. Sarah Herbert outlined that as reflected in the staffing reports, in relation to the AHP workforce, there were currently challenges related to the capability within the existing footprint outside of NCtR. While re-enablement and deconditioning work would be a priority, the acuteness of many patients gave rise to challenges with delivery, but this was an area that required further consideration. Siobhan Harrington also explained that through the Care Group and strategy deployment review process, the Care Groups discussed the objective, their level of risk and - where there were gaps in workforce - the associated plans. This facilitated

	the appropriate conversations occurring with teams running frontline operational services. She also added that she had attended the launch of the Health Services University the previous week and had been fortunate to meet Princess Anne. Relationships related to the training of AHPs were very strong and gave an opportunity for the future when considering new roles and different ways of working. Peter Wilson also commented upon the opportunity through the work with Newton particularly related to different working with community colleagues. Rob Whiteman highlighted the areas which were amber in the report, with finances to be discussed later in the meeting and EHR in Part 2 of the meeting. He invited Richard Renaut to comment on BAF Risk 9 related to reconfiguration, which would also be discussed as part of the Transforming Care Together report later in the meeting. Richard Renaut reported that while it was over 15 and therefore red, there were good controls in place; it was a large, complex programme. The Board NOTED the Board Assurance Framework Report.
BoD 263/24	**Integrated Quality, Performance, Workforce, Finance and Informatics Report** Rob Whiteman introduced the IPR, inviting Mark Mould, Peter Wilson and Sarah Herbert to present first. Mark Mould reminded the Board that the IPR related to the September 2024 period, with as usual, a flavour of performance in October 2024 being provided. It had been presented to the Trust Management Group and relevant Board Committees. Adding to the report, he reported that: • On 6 November 2023, there had been 55 escalation beds open. As at 6 November 2024, there were 3 open. • Referencing the performance on the 4 hour organisational standard, with the Trust having ended the month at 72.5% against a target of 75%, 12 months prior, the Trust had been at 61%. The Trust was on a trajectory of improvement and had been ambitious. Looking at the challenges in both September and October 2024, there had been an escalation in the numbers coming through the front door. On 13 days in September 2024, there had been over 600 attendances, with the Trust's average being 470. However, during the month, the number of admitted patients within four hours had improved as well as ambulance handovers. It was expected that, working with SWAST, further improvements would be seen with ambulance handovers. • For planned care, 8% more work had been carried out in comparison to the baseline year with the length of waits reducing. He gave the example of a cohort of 5726 patients waiting over 65 weeks in April, with this having reduced to 65 at the end of September 2024. • There was a trajectory of improvement on cancer access, with the services that did not have sustainable capacity being known. This had been seen with 65% for the 28 day standard moving to 69% in September and it was currently expected that reporting for October 2024 would be 75%. Particular improvement had been seen in gynaecology and some improvement in dermatology. • With the winter plan, one of the themes related to NCtR, with the others relating to the Trust. It was important to focus upon what the Trust needed to do, alongside that of partners. Sarah Herbert presented highlights from the Quality, Safety and Patient Experience reporting that: • There had been an increase in falls, with thematic work being undertaken which would be reported in full to the December 2024

meeting of the Quality Committee, giving a deep dive and further understanding on the areas requiring specific focus.

- In relation to pressure ulcers, it had previously been considered that a further time lag would be given to review the data. This was intended to enhance data accuracy once presented. One of the consequences of this had been the slight increase.
  Purpose-T, a NICE recommended assessment tool, had been implemented which would help staff and enable them to deliver better pressure relief to patients in a timely manner; the impact of this would be regularly reviewed, with an update given in due course.
- Significant inroads were being made in relation to complaints, with the ambition having been to change the trajectory from 55 to 35 days. As at the current week, the latest data was that a trajectory of 37 days average per complaint response time was now being achieved. Work remained on some of the longer outlier complaints. However, there was very good support within the Care Groups who were working closely with the team. There were better processes in place with matters being dealt with in a more timely manner. On the next complaints report, more conversions to early resolution as opposed to formal complaints would be seen.

Peter Wilson reported that:

- He would come back to mortality as part of the mortality review; the monthly Hospital Standardised Mortality Ration was a volatile number.
- There had been an increase in medication incidents in the number of patient safety events. While not statistically significant, this was being considered through the Medicines Governance Group and would be reported through the Clinical Governance Group to Quality Committee. The initial findings were that it was nothing specific; however the pharmacy teams being under significant pressure was known.
- The Trust had moved from Learning From Patient Safety Events to the Patient Safety Incident Response Framework. There had been a period of adjustment since April 2024, with a full team now in place and the first of the thematic reviews being seen. The decrease in the number of incidents was because of this change. He explained that going forward, it was not that a decrease in the number of reports was the desired outcome; rather a decrease in the number of moderate and severe reports.

Cliff Shearman commented favourably upon what appeared to be a step-change in the IPR. The organisation had been struggling with fractured neck of femur; however, there was a dramatic change in the reporting that he considered was a very positive reflection on the team. It showed that when teams were allowed and enabled to get on and deliver, they did. Adding to this, Rob Whiteman asked that thanks be passed on to the orthopaedics team for the fractured neck of femur performance, with there having been a consistent change over a period of time.

Echoing Cliff Shearman's comments, Sharath Ranjan noted the sustained improvement. While there could be forthcoming changes that would have an impact, having considered the winter plan, the build ready, service ready and people ready work, there was assurance that there were considerable mitigants in place for the challenges that may arise. He enquired how the message would be reinforced to the teams to keep the momentum going. Siobhan Harrington commented that morale across the organisation was mixed; it was a fine balance between being optimistic and positive and acknowledging the challenges and progress. At the staff briefing the following

	week, the messages would be cascaded and also shared with the Care Group leadership. It was important that recognition of the improvement was given. She encouraged the Non-Executive Directors to share this when they visited services, particularly through what was likely to be a long winter for staff. Adding to this, Peter Wilson relayed the positive change in communication style at the Clinical Directors' meeting, which occurred weekly; difficult conversations occurred but people were now listening more, reflecting and working together. Helena McKeown commented upon the 36 hour performance measures for fractured neck of femur, noting that for other trauma presentations achieving surgery the timeframes were 24 hours and 48 hours. She considered it would be helpful if the measures were the same. Mark Mould explained that the national reporting referenced the 36 hours from admission; however the Trust also measured 36 hours of being fit for surgery. The team were endeavouring to give comparison of times where those other traumas may take priority. However, he agreed that it may be beneficial to see alignment on the whole and he would review the use of 24 hours and 48 hours with the team. Commenting upon seemingly static progress from the data on theatre utilisation since the previous year, Rob Whiteman asked what may be expected to be seen in the coming quarters. Mark Mould responded that the aspiration was for 85%. There had been a number of cancellations in month for various reasons. Consequent upon this, the escalation process had been considered and strengthened. There may also be situations where it may be appropriate to open a bay, with this mechanism having been incorporated as part of the escalation. However, he also highlighted that the amount of cases during the month had been more than previously; and the number of lists operating were more than previously. Adding to this, Pete Papworth agreed that theatre utilisation was an important metric including in light of the cost of the assets; it was also important to continue the improvement and productivity work to remove aspects from theatre that did not need to be there. He considered that there was an opportunity to perform more in procedure rooms, releasing theatre time for those procedures that could only be performed there. Mark Mould confirmed that a piece of work had been undertaken to scope the procedural facilities working with estates across the Trust to be clear on the specification; this should provide additional capacity in different settings. Thanking Mark Mould, Rob Whiteman confirmed that this would be useful for the Board Development session in 2025 on theatres. In relation to workforce, Irene Mardon highlighted: • The Trust remained on track to deliver its workforce plan in the current year. Where the staffing status against operational plan and monitoring showed an increase in substantive staff, this was expected at the time of year because of the number of newly qualified nurses that joined in September. Agency was under plan; bank was above but Sarah Herbert was heavily involved to support that. • Past Board discussions had noted the value aligned to all staff receiving an appraisal, both medical and non-medical. The Trust was not where it wanted to be on this. Work was ongoing with the Care Groups. • Pay uplifts for resident doctors were due to paid in November for 2024/25. The agenda for change staff pay uplifts were paid in October 2024. With the intermediate pay scales for Band 8 and above, these would be paid in November 2024. Helena McKeown enquired whether all staff had been informed of the need for e-visas and for assurance that staff would not be inadvertently lost through

	the change in the application system. Responding to this, Irene Mardon confirmed that there had recently been an audit to demonstrate the Trust's processes were fit for the national requirement. There had also been communications out to staff. Rob Whiteman referenced recent media reports about consultants being paid over four times their pay, with the Secretary of State indicating that it should be more in the region of one and a half times. He enquired whether this was relevant for the Trust to consider. Peter Wilson responded that while this was of importance, he did not consider it had the same relevance for the Trust as had been reported. Within the Trust the rate card had been aligned and it was similar across the southwest. It had not been signed off through the JLNC, with communication and negotiation ongoing about the actual number. The Trust had sought to achieve equity and fairness. Through Locums Nest, it was known that fill rate for resident doctors and consultants had increased since aligning the rate card and using Locums Nest. The pay bill had reduced by circa £80-£100k per month in comparison to the previous year. Considerable work was ongoing through job planning, with the current phase being looking at group job plans. A process was in place to look at how waiting list initiative payments (WLIs) could be ceased and recruitment occur internally. In summary, it was an ongoing issue, but he did not consider the Trust to currently be in the same position as some of the other organisations. Sharath Ranjan enquired whether there was a likelihood of a national cap. Responding to this, Peter Wilson explained that as part of the pay deal that the British Medical Association (BMA) had negotiated with DHSC was that there was not a single negotiating body that considered the matter. The agreement in the Trust with the BMA was that it was negotiating individually. However, for certain areas such as medical agency, the Trust had been part of a southwest group where a single rate card was created. It was now being considered how this could be rolled out nationally. He suggested that this was where some confusion had arisen as this was permissible for people not employed by the organisation; he drew the distinction where individuals were employed by the Trust. Pete Papworth presented the Finance aspects, highlighting the areas set out in the cover sheet to the report, adding that: • Confirmation of the national industrial action funding into Dorset had now been received, which was just short of £1m. Based on the cost incurred and allocation received, the Trust would be recompensed £700k. Although this would be £300k short of the full financial impact, this should be favourable against the budget in month 7. • In September 2024, agency expenditure had been 2.7% of the total pay bill, with it being year to date 3.1%. This was below the national cap of 3.2% of total pay bill. • The efficiency improvement programme target of £42m of savings had been fully identified, although there were a number of schemes within that which were deemed high risk. • The Trust continued to forecast delivery of its full year financial plan, with a detailed monthly forecast supporting this. The three key risks continuing to be worked through were: the £3.8m high risk efficiency schemes; the national pay award funding; and increased spend requirements over the winter period. • The programme was expected to be delivered in full from a capital perspective. Two exceptions were: ○ The new hospitals programme, which was forecasting an underspend of circa £10m in the current year. Work with the regional capital team and the national team to consider

	reprofiling the capital funding to match the revised spend profile was taking place. ○ Due to environmental issues that had affected the timing of planning permission, the community diagnostic centre was forecasting some slippage of approx. £8m. Options to mitigate were being explored. The Finance and Performance Committee would be kept informed about these. • Echoing Siobhan Harrington's earlier comments about the Dorset system's financial position being very challenging, he referenced the conversations taking place with the NHS England regional team related to a formal revision to the forecast outturn. A more detailed paper would be presented in Part 2 of the Board meeting. • A briefing had been scheduled for Chief Finance Officers and Chief Operating Officers earlier that week in relation to the budget but this had been cancelled with the national NHS England team continuing to work through some of the detail. • It was expected that next year would be a challenging financial year. Plans were ongoing across Dorset. In relation to EHR, Pete Papworth reported that the regional and national outline business case approval process was continuing to be navigated. Further scenarios were being modelled to support this in view of some affordability issues and questions that had been received. While drawing attention to the current delayed implementation of EHR of February 2028, he also highlighted opportunities from the EHR in addition to the clinical safety and quality benefits. He referred to efficiencies and financial opportunities such as with scanning of medical records. Cliff Shearman asked about the decrease in private patients income referenced in the Finance section of the IPR, noting the private patients plan and outsourcing. Answering this, Pete Papworth explained that the partnership arrangement through Dorset Heart Clinic was performing well and had exceeded its budget expectations in the current year. The University Hospitals Dorset Private Patient Unit had been challenged from an activity perspective driven by some of the operational pressures, such as with bed capacity and theatre capacity. This had been a recurrent theme for the past two years and formed part of the rationale for considering options and seeking to develop a further partnership to improve the position. Richard Renaut added that there had been an increase in comparison to the previous year, but not as much as planned. Discussions were taking place with a provider in connection with the Trust's strategy. This would be discussed further at an upcoming Board Development Session. The Board NOTED the Integrated Quality, Performance, Workforce, Finance and Informatics Report.
BoD 264/24	**Quality Committee – Chair's Report – September and October 2024** Cliff Shearman presented the Quality Committee – Chair's Report from 24 September 2024, with a meeting also having been held on 29 October 2024. Adding to the report, he referenced that: • There had been considerable discussion, explanation and questioning about Mortality Governance. The direction being taken was understood, with an understanding of the processes. There was comfort in relation to the status of this within the Trust. • A deep dive had taken place in relation to future planning for Infection Prevention and Control.

	Introducing Lorraine Tonge's presentation of the Maternity Safety Champions Report, he referenced the extensive scrutiny that the maternity service had received and the very positive progress, including with the Maternity Incentive Scheme. <u>Maternity Safety Champions Report</u> Lorraine Tonge presented the Maternity and Neonatal Quality and Safety Report also echoing the positive progress on the MIS standards, with key assessments taking place in the coming week. The Trust was currently on trajectory to achieve compliance with the MIS standards; a current area of focus was ATAIN (avoiding term admissions into neonatal units) where the Trust was currently an outlier. An updated position would be presented to the Maternity Safety Champions meeting and to the Quality Committee. Actions in this area were being reviewed and how those may not be delivering the desired quality improvement. Referencing the three stillbirths noted in the report and specifically the higher number than previously, Siobhan Harrington enquired whether there were particular concerns. Responding to this, Lorraine Tonge agreed with it being a challenging month and expressed concern for those who had sadly lost their babies. The Trust's position was 2.41 per 1000, while nationally it was 3.3; the Trust was therefore below the national target level. It was known that unfortunately these fluctuations did occur and while there was not a specific concern for the Trust to report, she again expressed sadness for all those concerned. Adding to this, Peter Wilson explained that approximately 9 months prior there had been a similar cluster with an external review of stillbirths conducted at the Trust's request. This had not identified any issues with the care of mothers or their babies. The way in which the Trust investigated deaths of any patient meant that the Trust was continually learning from deaths. The likelihood was that if there were thematic reviews showing linkages, these would be seen. Echoing this, Sarah Herbert also referenced the extensive work undertaken by the team, including on social media platforms, to promote awareness related to reduced foetal movement. The team had looked at the specific cases to ascertain if there was any additional learning. <u>7 Day Services Board Assurance Framework</u> As a member of the Quality Committee, Helena McKeown strongly supported the key recommendations of the 7 Day Services Board Assurance Framework. The Board NOTED: • the Quality Committee – Chair's Report – September and October 2024; • Maternity Safety Champions Report (which report included confirmation of the neonatal nursing establishment meeting the British Association of Perinatal Medicine (BAPM) neonatal nurse standards; and the medical workforce having support of the board safety champions in recruiting the additional neonatal consultant required to meet the BAPM standards); • 7 Days Services Board Assurance Framework; • Mortality Report; • Annual Infection Prevention and Control Report; and • Annual End of Life Report. The Board APPROVED the Annual Infection Prevention and Control Statement.

BoD 265/24	**Finance and Performance Committee – Chair's Report – September and October 2024** John Lelliott introduced the Finance and Performance Committee – Chair's Report for September 2024, with a number of the items having been carried forward to the October 2024 meeting. Most of the areas had been covered earlier in the Board meeting. At the October 2024 meeting: • There had been substantive time spent with Rob Morgan from NHS Dorset, given the interrelationship with the Trust's finances. There had been particular focus in relation to personal healthcare commissioning – which was overbudget – the steps being taken by the ICB and the impact this would have upon the Trust. • Although pharmacy had made some savings overall, there was a significant overspend in relation to drugs. This would be considered in further depth at the next meeting of the Committee. • The Committee had considered the New Hospitals Programme Full Business Case B. • Fire safety had been an area that the Committee wanted to consider further and to bring to the Board's attention, particularly acceptance of the risk being taken by the Board. He invited Mark Mould to present the Annual Winter Plan and Richard Renaut, the BU Partnership Strategy. <u>Annual Winter Plan</u> Mark Mould presented the Annual Winter Plan, which had been considered by the Executive team, twice by the Trust Management Group and by the Finance and Performance Committee adding: • There would be points in time during the winter that would be extremely challenging. • A set of actions in the winter plan had been agreed aligning to the Trust's strategic themes. Some were dependent upon external partners, with conversations having taken place about NCtR. • He and Sarah Herbert would present back to the nursing forum; engagement had taken place with clinical directors and general managers. Referencing the earlier discussion related to therapists, Helena McKeown enquired about them being prioritised third if funding were to become available. Mark Mould explained that it was unlikely that additional funding would be received. However, at a point in time, it had been considered that the most significant impact would be based upon the priorities set out in the paper. If the money were to be received, the priorities would be reviewed. He explained that in relation to the first priority, Newton had indicated that extending same day emergency care would improve seven day services and also potentially improve the number of people going into in-patient beds. With priority two, going through winter, there would be some escalation beds open at some point, which would require management. Priority three remained important. In relation to flu and Covid vaccines, Helena McKeown asked about timelines of when and how many staff could expect to be vaccinated. Responding to this, Sarah Herbert reported that the Trust had been actively encouraging flu and Covid vaccines. The current rates were 26% of staff having received a flu vaccine, just under 20% had Covid vaccine and approximately 20% had both. She had approached another large organisation in close proximity whose total rate for the year were 52%. There appeared to be a national picture of low uptake. The Trust was providing information on its intranet,

	making drop in sessions available and delivering vaccines in the workplace through peer vaccinators. Adding to this, Peter Wilson commented upon the data capture issue across the country of staff having vaccinations with their GPs or elsewhere. There was a challenge in these circumstances with staff needing to come forward and self-report if they had been vaccinated elsewhere. This also highlighted the importance of benchmarking against other organisations. Pete Papworth commented that although there had been no specific increase in budgets for winter, funding had been received and £6.8m deployed into budgets to manage the urgent and emergency care pressures. The Trust was funded for 40 escalation beds over the winter period and decided to deploy them evenly through the year. Additional money had been put into extra urgent treatment centre capacity, increased same day emergency care provision on both sites and expanded workforce to deliver extended hours in discharge lounges. The particular risk currently was that as a system, the NCtR challenge had not been reduced. Consequently, a pressure was being seen that was not in the Trust's operational plan. If there were money available, it was known where this would be prioritised and deployed. John Lelliott summarised that the Finance and Performance Committee had endorsed the Annual Winter Plan. However, as Pete Papworth had outlined, an increased funding risk existed. Rob Whiteman raised that the NHS was often provided with additional money for winter but trusts did not necessarily budget for what the full pressure may be. He queried whether a budget ought to be set that included an anticipation of what the winter pressures may be at the beginning of the year. Responding to this, Pete Papworth explained that there had been a demand and capacity plan that provided that if the NCtR were addressed, there would be sufficient resource and financial provision for winter. Consequently, there had been planning to deliver the aspirations and capacity and demand requirements. <u>Bournemouth University (BU) Partnership Strategy</u> Richard Renaut updated the Board that the BU Partnership Strategy presented was an interim version. With Alison Honour having joined as Vice Chancellor, the University would be reviewing its strategies. The Trust was seeking to engage in that process as well as its own clinical strategy work. Judy Gillow expressed disappointment at the BU Partnership Strategy document; indicating that there was nothing unique to the system and respective organisations. She considered that the partnership with BU would be crucial going forward and how research opportunities were maximised. She had been particularly struck when she observed the DCH Board, at research initiatives being carried out by BU to support BU in achieving its objectives. She welcomed a further review of the strategy, including having tangible outcomes which were relatable to the Trust's strategic direction. Siobhan Harrington added that she had met with Alison Honour the previous week, who had described how BU would be more outward focused and the importance of the partnership. She had attended the Trust's leadership event and annual members meeting. There was an opportunity to align the work being carried out into key themes, maximising the partnership and having clear key performance indicators showing progress. Siobhan Harrington expressed positivity about the way forward. Echoing Siobhan Harrington's comments, Claire Whitaker commented positively upon Alison Honour's outward focused approach. She proposed that it would be helpful for the Board to have a conversation about what was wanted from the partnership, particularly from a research perspective and potentially engagement work. Richard Renaut outlined there having been a

	detailed strategy in the previous year, with specific measurable actions against thematic work, not only health related. He welcomed the opportunity for a Board Development session, with Claire Whitaker requesting that the Trust's broader relationship with universities be considered. The health sciences universities were also active in the area, with a set of relationships to be managed appropriately. The Trust continued to lobby for a medical school in Dorset. Peter Wilson had attended a meeting the previous week about that. BU needed to make a decision upon it. The Board NOTED the Finance and Performance Committee – Chair's Report – September and October 2024 and BU Partnership Strategy. The Board APPROVED the Annual Winter Plan.
BoD 266/24	**People and Culture Committee – Chair's Report – September 2024** Sharath Ranjan presented the People and Culture Committee Chair's Report – September 2024, thanking Pankaj Davé for his work as Chair of the Committee. The People Strategy would be presented at the December 2024 meeting of the Committee and to the Board in January 2025. The Committee had met before the budget and the winter plan. There were potential aspects that may therefore change such as apprenticeships. While the agency reduction plan had been considered, he was also conscious of the potential demands of winter. <u>Maternity Staffing Review</u> Referencing the maternity safe staffing report, Sharath Ranjan commended the work undertaken to close the risk related to staffing. Thanking Lorraine Tonge for the report and the progress made, Siobhan Harrington noted the 12 month turnover rate and enquired about the extent of concern related to people choosing to retire and mitigation of the risk. Answering this, Lorraine Tonge confirmed that the turnover rate had slightly increased in September 2024. Staff were expecting the move to the BEACH building in April 2025. Consultation was occurring, which had commenced on 4 November 2024. Staff who had gone to other organisations had mostly now moved; however, some fluctuation was expected in the coming months. There was currently 0% vacancy. New qualified midwives had been employed and had commenced in post. It was anticipated that the majority of staff would move to the new build. Adding to this, Sarah Herbert explained that there had been a meeting with BU earlier that week. The Trust was in a position where it could not offer as many positions to qualifiers as there were newly qualifieds coming through. There was a potential pipeline available if people did therefore leave. The new environment and change would appeal to many midwives with the improvements being made. The staffing numbers had been reviewed in depth; taking account of the position of the safety of the service going into the move, it had been agreed with Pete Papworth that the staffing numbers within the new setting would be re-reviewed once the service had stabilised. This review would also consider the impact of the potential growth in catchment with the new location. The Board NOTED the People and Culture Committee – Chair's Report – September 2024 and Maternity Staffing Review.
BoD 267/24	**Population Health and System Committee – Chair's Report – October 2024** Helena McKeown commended the excellent presentation on carbon reduction provided by Stuart Lane. She considered that this may be beneficial for a Council of Governors' Development Session. The Board NOTED the Population Health and System Committee – Chair's Report – October 2024.

BoD 268/24	**Audit Committee – Chair's Report – October 2024** Judy Gillow presented the Audit Committee – Chair's Report – October 2024 adding – for awareness - that: • It had been a comprehensive meeting covering a number of areas. • A counter-fraud report on private patients had been reviewed, with this being broadened out to wider issues relating to invoicing, up to date policies and induction. The discussion within the Committee had raised considerable concern about the control environment, recognising though that work was being carried out. It had been agreed by the Committee that a deep dive into Private Patients would take place at the next meeting in January 2025, picking up the recommendations from the counter fraud report and the wider issues of concern. • The connections between the Board, its sub-committees, the Trust Management Group and the strategy deployment reviews had been raised. While not wanting to becoming embroiled in the operational issues, there were concerns relating to assurance about the strength of the connections through the organisation of how risks were discussed. It had been helpful to see in the Chief Executive Officer's report more detail about the discussions at Trust Management Group but further consideration may be beneficial in relation to assurance at every level on key risks. Richard Renaut added that the first meeting of the task and finish group in relation to private patients had taken place the previous day, with good clinical engagement. In relation to the strategy deployment reviews, Siobhan Harrington reported that Dame Marianne Griffiths was continuing to work with the Trust. It had previously been discussed that at a certain point there would be a Board level discussion about the next steps in the Trust's development. She would discuss with Rob Whiteman having a development session in February-March 2025 to consider the approach and any changes to it. Currently, certain aspects were being double-run. The Board NOTED the Audit Committee – Chair's Report – October 2024 and Emergency Preparedness, Resilience and Response. The Board APPROVED the Standing Financial Instructions and the Policy on the use of External Auditors for Non-Audit Services.
BoD 269/24	**Charitable Funds Committee – Chair's Report – November 2024** Claire Whitaker presented the Charitable Funds Committee – Chair's Report – November 2024, highlighting that: • It had been a good meeting. • A plan would be worked upon by Debbie Anderson and Pete Papworth in relation to the level of reserves. • The annual reports and accounts and maintenance on the second CT scanner would be presented in Part 2 of the Board meeting. • There had been: o Discussions about not implementing a lottery; o Discussions about the charity's status and it not becoming independent; o Information about the proposed staff hub; o An update on Wifi, with the Committee being keen to know more about timings. Pete Papworth added that there were many initiatives where people's donations would be very welcomed and appreciated. Currently the fund

	balance was higher than desired, partly due to Covid and operational pressures with industrial action where people had not been able to focus on going above and beyond the core services and spending some of the charitable donations. The spend plans were coming through from the Care Groups. The Board NOTED the Charitable Funds Committee – Chair's Report – November 2024.
BoD 270/24	**Transforming Care Together – Chair's Report – October 2024** Introducing his report, Rob Whiteman outlined that the Group had an overarching view on Build Ready, Service Ready and People Ready but was not a decision making Group. Given the timing of the meeting, a written report had not been prepared. However, he reported that: • There had been good discussion about seven day working. • There had also been good discussions about the work commissioned from Newton. • There had been some discussion in relation to the funding of endoscopy. • A fairly lengthy discussion had taken place in relation to engagement. Judy Gillow and Claire Whitaker, in particular, had been keen to encourage Executive Directors to consider capacity to carry out good engagement to complement communications, these being very different. • It had been positive to hear from Irene Mardon in relation to the five subgroups taking place to ensure people had the appropriate tools to go through the processes they were managing locally. The Group was currently assured on all three stages, including having controls and mitigations in place. There had also been positive discussion about the current status in relation to Wessex Fields. The Board NOTED the Transforming Care Together – Chair's Report – October 2024.
BoD 271/24	**Freedom to Speak Up Guardian Report** Helen Martin presented the Freedom to Speak Up Guardian Report adding: • Speaking Up month had been full of activities, presentations and walkabouts, commencing with the Board Development Session with the National Guardian, Jayne Chidgey-Clark. • The paper reflected quarter one, with her presenting data reflecting both quarter one and quarter two. More people were using the Freedom to Speak Up Guardian (FTSUG) route to raise concerns, have conversations and for signposting opportunities. The key theme remained behaviours with people saying that they were choosing FTSUG in more than 1/3 of cases rather than approaching their line manager. Learning showed that 40% of the issues seen by the FTSUG related to leadership and management skills; 22% related to civility, with other issues related to health and wellbeing and awareness of where to get help if needed. Integration and merger issues were increasing. All of such issues were being monitored by the People and Culture Committee. Thanking Helen Martin and her team for their work, Judy Gillow expressed her support for the work being taken forward by Tina Ricketts on leadership and management development. There appeared, however, to remain a middle block of managers where their staff did not appear to have confidence to go to them. Recognising confidentiality, she enquired about opportunities for those managers to receive feedback to raise their awareness. Responding to

	this, Helen Martin explained that she had empathy for middle managers having to deal with many of the issues. Sometimes, however, they may not see some of the issues concerning others. On a case by case basis, the conversation with the line manager was explored in a supportive manner. Referencing previous discussions, Cliff Shearman expressed that he was very interested in the cultural change that FTSU brought, how this was captured and evidenced that it was occurring. Helen Martin proposed discussing this separately with Cliff Shearman and working on it together. Also thanking the FTSUG team, Siobhan Harrington noted the challenge with triangulation of cultural temperature across the organisation. At the Trust Management Group, the culture champions provided feedback about their work across the Trust, some of which was difficult to listen to, as well as there being some good reflections. Through the Patient First work, Dame Marianne Griffiths had conducted a culture audit at the start of the process. This would be repeated in the new year and would help to provide an objective view of the change. Adding to this, Helen Martin referenced the change in governance being made by Tina Ricketts which would support a broader cultural picture being received. Sarah Herbert agreed that there were opportunities in relation to triangulation and knowing hot spots to co-ordinate the response, including safety and HR data along with freedom to speak up. She also referenced the praise given by the National Guardian at the recent Board Development Session about the Board's openness, curiosity and genuine engagement. The Board NOTED the Freedom to Speak Up Guardian Report, supporting the Annual Declaration.
BoD 272/24	**Board Committee membership** Rob Whiteman presented the report, noting also that John Lelliott was the sponsor for environmental sustainability. Commenting upon the significance of the digital agenda, Pete Papworth raised Beverley Bryant's membership of Board Committees, which would be discussed separately. The balance of Executive and Non-Executive Director membership of the Committees was noted. The Board APPROVED the Board Committee Membership.
BoD 273/24	**Terms of Reference** The Board APPROVED the Appointments and Remuneration Terms of Reference and Charitable Funds Committee Terms of Reference.
BoD 274/24	**Risk Register: review of significant risks; new risks rated 15 and above** Recognising that the risk register was developing, Judy Gillow noted that there were several risks where the risk tolerance or appetite had been exceeded and queried the process being followed for these. Rob Whiteman proposed that the Audit Committee consider the approach with it then being discussed at a Board Development Session. He also commented upon the importance of the Audit Committee advising on the operation of the processes. This was supported by Judy Gillow and Sarah Herbert. The Board NOTED the Risk Register.
BoD 276/24	**Any Other Business** There was no further business.

BoD 277/24	**Questions from the Council of Governors and Public arising from the agenda** No questions had been received from the Council of Governors or members of the public arising from the agenda.
BoD 278/24	**Reflections on the Board Meeting** Rob Whiteman commented that it had been a good meeting with it being positive to see the dynamic of the Committees' assurance to the Board. It was also beneficial for the Board to have time to question the assurance and receive other important items. On behalf of the Non-Executive Directors, he thanked the Executive team for the progress being made.
BoD 279/24	**Resolution Regarding Press, Public and Others** The Board APPROVED, as permitted by the National Health Service Act 2006 (as amended), the Trust's Constitution and the Standing Orders of the Board, that representatives of the press, members of the public and others not invited to attend to the next part of the meeting be excluded due to the nature of the business to be transacted. There being no further business, the meeting was closed.
	The date and time of the next Standing Board of Directors Part 1 Meeting was announced as Wednesday 8 January 2025 at 9:30 via Microsoft Teams.

Board Part 1 Action List - January 2025						
Meeting Date	**Minute No.**	**Matter Arising / Action**	**Lead**	**Due Date**	**Progress**	**Status**
04/09/2024	BoD203/24	To advise when a Board report detailing the steps to enhance the transition arrangements between paediatric and adult care will be provided	Peter Wilson	Nov-24	**Nov 24**: verbal update to be provided. **Nov 24:** Peter Wilson updated the Board that a group was being formed with an A3 being prepared to support next steps being determined. An update would be presented to the Quality Committee in 3-4 months' time, with a presentation to the Board in 6 months' time.	Complete

JANUARY 2025 TRUST BOARD
CHIEF EXECUTIVE UPDATE

1 INTRODUCTION

A huge thank you to all our staff who have worked over the last Christmas and New Year period. It has been incredibly busy with pressure on our urgent and emergency pathways. Our staff have been incredible. Thank you to all our teams for their ongoing focus on patient safety and looking after one another. We maintain work with system partners to support patient flow and to reduce the pressure on our emergency departments.

Sadly, at the time of writing this update, the number of flu cases in hospitals across England have already exceeded last year's peak, with one in 18 hospital beds taken up or closed by a festive bug. We have been continuing to promote to all of our staff the opportunities for them to take up the offer of flu and covid vaccinations. To help reduce the spread of germs, we encourage all our staff, patients and visitors to practice effective hand washing.

As we start 2025, I wish all of our patients, staff, community members and colleagues across the Dorset system a happy new year. Here at UHD we have an important year ahead that will ensure our continued progress and improvement for patients and our staff.

2 NATIONAL NEWS

2.1 Evolution of NHS operating model

Since our last Board meeting held in public, on 13 November 2024, NHS England wrote to all trusts about proposed changes to the NHS operating model. The aim of these changes includes:

- every part of the NHS having increased clarity on its accountabilities;

and

- ensuring that the way the NHS works supports delivery of current priorities and is set up to deliver the neighbourhood health model.

Integrated care boards will be tasked with leading on strategic commissioning in their systems. They will have the primary responsibility for "ensuring neighbourhood health is delivered, identifying population health needs and acting on reversible risk factors to improve healthy life expectancy and reduce utilisation of secondary care".

2.2 Change NHS – Help build a health service fit for the future

As referenced in my last Chief Executive Officer's Update to the Board, "Change NHS", the national engagement exercise to develop the 10-year health plan was launched in October 2024. The 10-year plan will focus upon three shifts:

- Moving care from hospitals to communities;
- Making better use of technology;

and

- Focussing on preventing sickness, not only treating it.

Members of the public, staff and experts across the health and care landscape have an opportunity to help reimagine the NHS – by sharing views, experiences and ideas. This will be part of co-designing and building an NHS fit for the future.

Early in December 2024, three of our Executive Directors - Peter Wilson, Chief Medical Officer, Beverley Bryant, Chief Digital Officer and Richard Renaut, Chief Strategy and Transformation Officer – participated in the south west's 10-year plan system leadership engagement workshop.

I would encourage our patients, staff and wider community to take part and have their say: Change NHS. On 6 February 2025, we will be hosting a virtual "Understanding Hospital at Home" talk, which will be followed by an interactive workshop where members of the public can help shape the plan.

2.2 Launch of Learning and Improvement Networks

NHS England has selected fourteen trust Chief Executive Officers to lead a nationwide improvement drive on emergency and elective care. They will head up learning and improvement networks (LINs) as part of NHS England's IMPACT programme. Each NHS England region has been given two improvement leads.

I was delighted to be appointed as one of the two leads for the southwest, alongside Peter Lewis, Somerset NHS Foundation Trust. Each LIN is to work up a limited number of proposals to deliver best practice ideas in elective and emergency with a view to these being tested at scale.

2.3 Insightful Provider Board

NHS England's recent publication, "The Insightful Provider Board", was an area of focus at our recent Board development session. Published in November 2024, it provides good practice guidance for boards to consider relating to reporting they receive and seeking of assurance.

The document is intended to support boards to make effective use of data. It contains suggested approaches to consider for planning, monitoring and seeking assurance about progress. We will continue to draw upon this guidance.

2.4 National Quality Board risk guidance for integrated care systems

On 4 December 2024, the National Quality Board (NQB) published "Principles for assessing and managing risks across integrated care systems", this being part of a wider suite of guidance developed by the NQB for integrated care systems.

The document sets out key principles to use when assessing risks in situations which are rapidly changing or based on multiple factors and where collaborative approaches and whole system solutions may be required. As risk management within a system context continues to mature, this guidance is welcome.

3 DORSET UPDATES

3.1 Chair stepping down at NHS Dorset

Jenni Douglas-Todd will be stepping down from her role as Chair of Dorset's integrated care board from 31 March 2025. She will be leaving to focus on her new role as Chair of Isle of Wight NHS Trust and Portsmouth Hospitals University Trust, alongside her role as Chair of University Hospital Southampton NHS Foundation Trust.

We would like to thank her for the experience she has brought, commitment she has given and wish her well in her new role.

3.2 Provider Collaborative

Congratulations to Sarah Macklin, our Group Director of Operations for Women's, Children's, Cancer Care and Support Services, who has taken up a two-year secondment as the Delivery Director for the One Dorset Provider Collaborative.

Work is underway on the development of an ambition statement for the provider collaborative. Priorities for the ODPC will be reviewed as we go through the planning round for 2025/2026 with all system partners.

3.3 Financial position within Dorset

The financial position within the Dorset system continues to be challenging.

At a national level, the final planning guidance for the 2025/26 financial year has not yet been published.

4 UHD

4.1 Maternity Update

The Maternity Incentive Scheme - a national program designed to support safer maternity and perinatal care by driving ten safety actions - is now in its sixth year. Ahead of the submission deadline of 3 March 2025, our team has been collating evidence to demonstrate our achievement of the ten maternity safety actions.

The April 2025 opening of our new state of the art maternity and neonatal unit in the BEACH building at the Royal Bournemouth Hospital site will, at the date of this meeting be, only 12 weeks away.

4.2 Joint Advisory Group on Gastrointestinal Endoscopy accreditation

Congratulations to our endoscopy services at Royal Bournemouth Hospital who were awarded JAG accreditation. This is given to endoscopy services which have demonstrated they meet best practice quality standards.

5 OUR PEOPLE

5.1 Annual NHS Staff survey

We again had a positive 58% response rate to the NHS Staff Survey. It is a time of great change in the organisation and we will continue to listen to staff feedback and analyse the results as we receive them.

6 FINANCIAL POSITION

At the end of November 2024, the Trust had reported a deficit of £7.588 million against a planned deficit of £6.214 million, resulting in an adverse variance of £1.374 million. The variance is due to the phasing of recovery actions compared to the original plan.

Agency spend in month was £0.973 million and was under the cap value equating to 3.2% of total pay expenditure. This is a reduction when set against the expenditure in March.

Efficiency savings of £27.763 million have been achieved against a target of £25.128 million. As of 31 November 2024, efficiency improvement plans are reporting a forecast risk adjusted saving of £41.2 million, non-risk adjusted is in line with the target of £42 million including the trust-wide cross cutting schemes.

7 POPULATION AND SYSTEM

7.1 Performance Headlines

During November 2024, additional operating pressures were more evident, with both acuity and activity increasing. However, the Trust has maintained a good level of delivery for our patients.

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 108.6% elective activity year to date in November 2024, exceeding the Trust's operational planning trajectory of 108.2%.

Significant progress was made in November on eliminating waits for elective treatment above 65 weeks, with only 16 patients remaining with a wait greater than 65 weeks. Waits above 52 weeks are also reducing at a faster rate than forecasted in the Trust's operational plan and cancer and diagnostic performance is improving.

Performance against the 4-hour organisational safety standard in November 2024, delivered 70.0% (7 out of 10 of our patients) being seen, admitted and discharged within 4 hours, against an internal trajectory of 76%.

Ambulance handover volumes remained static in November compared to October 2024, while the percentage of the total who waited longer than 60 minutes dropped significantly to only 4%, down from 7.5%.

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). There was some improvement – with a decrease to 192 (circa 20% of the Trust's beds) - from October's average number of patients with NCtR. However, this remains a significant risk to the winter plan.

8 STRATEGY AND TRANSFORMATION

8.1 In the short time since our ground breaking event for our new COAST building, visitors to Royal Bournemouth Hospital will have seen the incredible progress that has been made.

8.2 We recognise the recent challenges, in particular, there have been with traffic congestion at Royal Bournemouth Hospital. The second road into the site should be open by the end of January 2025.

9 ELECTRONIC HEALTH RECORD

9.1 The outline business case (OBC) for our Electronic Health Record has been submitted to regional colleagues in December as the first stage in the external approval of the funding.

10 TRUST MANAGEMENT GROUP

Our Trust Management Group continues to meet bi-monthly. Key issues discussed at its November and December 2024 meetings included:

- Updates from the Care Groups;
- Patient First progress;
- Integrated Performance Report;
- Safety focus with review of clinical governance group report;
- Risk Register;
- Medical Device Review;
- NHS Estates Technical bulletin in relation to water safety;
- People and Culture including the People and Culture Strategy 2024-27, Workforce Race Equality Standard and Workforce Disability Equality Standard reports;
- Bed mitigation plans;
- Recruitment function operating model;
- Business cases in relation to head and neck same day emergency care, neonatal consultant, physical bed stock, national uniform rollout, bank healthcare support worker pay progression and maternity failsafe officer.

11 UHD EXCELLENCE AWARDS

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

November: Kristy Larcombe, Emergency Department, Poole Hospital

December: Kathy Worth, Outpatients, Royal Bournemouth Hospital

12 INTEGRATED CARE BOARD NOVEMBER 2024

I attended the NHS Dorset ICB Board Meeting on 7 November 2024 where the minutes of the meeting held in September 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 5 September 2024 at 10am
In the Phoebe Room at the BCP Council offices, Civic Centre, Bourne Avenue, Bournemouth, BH2 6DY
and via MS Team

Members Present:		
	Jenni Douglas-Todd (JDT)	ICB Chair
	Rhiannon Beaumont-Wood (RBW)	ICB Non-Executive Member
	John Beswick (JB)	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) (part) (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)	Leader Dorset Council and ICB Local Authority Partner Member
	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
	Alyson O'Donnell (AOD)	ICB Deputy Chief Medical Officer (nominated deputy)
	Debbie Simmons (DSi)	ICB Chief Nursing Officer
	Forbes Watson (FW) (virtual)	GP Alliance Chair, Primary Care Partner Member
Invited Participants Present:		
	Louise Bate (LBa)	Manager, Dorset Healthwatch
	Zoe Bradley (ZB)	Interim Chair, Dorset VCSE Board
	Cecilia Bufton (CB)	Integrated Care Partnership Chair
	David Freeman (DF)	ICB Chief Commissioning Officer
	Dawn Harvey (DH)	ICB Chief People Officer
	Keith Phalp (KP) (virtual)	Pro Vice Chancellor for Education and Quality, Bournemouth University
	Ben Sharland (BS) (virtual)	GP Alliance Deputy Chair
	Jon Sloper (JS)	Chief Executive – Help and Kindness
	Dean Spencer (DSp)	ICB Chief Operating Officer
In attendance:		
	Liz Beardsall (LBe)	ICB Head of Corporate Governance
	Betty Butlin (BB) (for ICBB24/126)	Director of Adult Social Care, BCP Council
	Anita Counsell (AC) (for ICBB24/119 and 120)	ICB Deputy Director for Health Inequalities and Population Health Management
	Jane Ellis (JE)	ICB Chief of Staff
	Steph Lower (SL) (minutes)	ICB Deputy Head of Corporate Governance
	Mark Mould (MM) (for ICBB24/126) (virtual)	Chief Operating Officer, University Hospitals Dorset NHS Foundation Trust
	Lianne Oldham (LO) (for ICBB24/121 and 124) (virtual)	ICB Deputy Director, Strategy and Transformation

	Rachel Pearce (RP) (virtual)	Managing Director (System Commissioning Development), NHS England South West
	Fran Pingarelli (FP) (for ICBB24/127) (virtual)	ICB Head of People and Organisational Development
Public:		
	Two members of the public were present in the room. The meeting was also available via livestream.	
Apologies:		
	Neil Bacon (NB)	ICB Chief Strategy and Transformation Officer
	Paul Johnson (PJ)	ICB Chief Medical Officer
	Matt Prosser (MP)	Chief Executive, Dorset Council
	Andrew Rosser (AR)	Chief Finance Officer, SWASFT
	Stephen Slough (SS)	ICB Chief Digital Information Officer
	Kay Taylor (KT)	ICB Non-Executive Member
	Dan Worsley (DW)	ICB Non-Executive Member

ICBB24/115 Welcome, apologies and quorum

The Chair declared the meeting open and quorate and welcomed Professor Keith Phalp to his first meeting as the Bournemouth University participant. There were apologies from Neil Bacon, Paul Johnson, Matt Prosser, Andrew Rosser, Stephen Slough, Kay Taylor and Dan Worsley.

ICBB24/116 Conflicts of Interest

In relation to agenda item 7 – Inward Investment Strategy, Leesa Harwood declared she worked with two of the organisations named in the recommendations (Social Finance UK and Crowd Funding UK). It was agreed that she would participate in the discussion but would not take part in the decision.

ICBB24/117 Minutes of the Part One meeting held on 11 July 2024

The minutes of the Part One meeting held on 11 July 2024 were agreed as a true and accurate record.

Resolved: the minutes of the meeting held on 11 July 2024 were approved.

ICBB24/118 Action Log from the Part 1 meeting held on 11 July 2024

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

Regarding Item ICBB24/112 in relation to the further work needed to Board reports, an update would be provided to the next meeting.

Action: DF/LB

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

<u>Standing Items</u>

ICBB24/119 Board Story: Tackling Inequalities

The Deputy Chief Medical Officer introduced the Tackling Inequalities Board Story.

The Board Story film gave an overview of the definition of health inequalities and how these inequalities were manifested in the Dorset system. The story focused on the work being undertaken with communities on Portland, as part of the Portland Project. Interviews with X and Y gave insights into the experience of an elderly Portland resident's difficulties with

accessing optometry services in Poundbury and a project in Boscombe to increase equity of access to health checks.

The ICB Deputy Director for Health Inequalities and Population Health Management confirmed that the Dorset Health Inequalities Dashboard provided rich data and insights into deprivation to help understand where specific attention was needed.

There was a clear link between tackling health inequalities and the integrated neighbourhood work with generic themes as well as street/area specific issues.

The Board Story showed some good examples of improving access, but it was recognised that improvement and equity in outcomes was key.

There was a need to be clear on what was health or community development with transport issues given as an example. These were being tackled through the local authorities Local Transport Plans.

The Board welcomed the Tackling Inequalities Board Story.

Resolved: the Board noted the Tackling Inequalities Board Story.

ICBB24/120 Tackling Inequalities in Outcomes, Experience and Access – deep dive

The ICB Deputy Chief Medical Officer introduced the Tackling Inequalities in Outcomes, Experience and Access deep dive.

Through the use of the NHS Confederation Toolkit, the focus was around creating the right culture, engaging and demonstrating strong leadership and building a robust governance framework, all of which were critical to reducing inequalities in health. The Toolkit identified a number of key questions for the Board to reflect on in assessing culture, leadership and governance as set out in the paper and an insight from the Board was welcomed as to what needed to be strengthened in these areas.

Dorset was 'average' in terms of the national/regional position however there was a need to get better at seeing what was hidden underneath 'average'.

There was a need to ensure health inequalities were addressed internally to provide the right foundations for staff to focus on health equity. Population Health Management training was being undertaken across the system to provide individuals with the skills to understand why and how it was relevant to their role and to start to embed health inequalities as a golden thread running through everything.

The Board noted a Health Inequality conference was being planned for November.

There was a need to ensure issues were understood in detail to enable a solution rather than creating a bigger issue.

It was agreed the Board receive a future presentation of the Dorset Intelligence and Insight Service (DiiS) to gain better understanding of its use of the data.

Action: PJ

L Oldham joined the meeting.

Resolved: The Board noted the Tackling Inequalities in Outcomes, Experience and Access deep dive.

A Counsell left the meeting.

ICBB24/121 Board Assurance Framework

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

There were eight strategic risks with the inclusion of the new social mobility risk. Three risks had mitigations in place to bring back into the tolerance level and future high-level exception reporting was planned to provide assurance of the position.

The regulatory domain was not consistent with the other domains and following review, it was recommended an 'open' risk appetite be adopted to foster innovation and improve patient care.

Resolved: the Board approved the addition of risk 8 social mobility and an open risk appetite for the regulatory risk domain.

L Oldham left the meeting.

ICBB24/122 Chief Executive Officer's Report

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

Key messages included:

- the extended vaccination programme which would include the Respiratory Syncytial Virus.
- the potential impact of the GP collective action. The GP Alliance was concerned regarding the sustainability of primary care and the need for strategic changes to address the challenges faced. Proposals regarding potential collective action were being finalised and would be shared during September. NHS Dorset recognised the significant pressures general practice has and continued to experience in Dorset and continued to work with the GP Alliance in terms of their response.

  At the appropriate time, it was suggested that a communication be sent out to ward councillors to enable them to understand any potential impacts for their specific areas.

  Action: DF

- The Dorset Integrated Care System continued to face significant financial pressures and unidentified risk in delivering the agreed 2024/25 financial plan deficit. The financial recovery plans were significant and would require increased delivery in the second half of the year.

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

ICBB24/123 Integrated Performance - Committee Escalation Reports

The new Integrated Performance Report would now be taken as a supplementary paper to the Board with future Committee Escalation reports drawing out the key performance issues.

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

S Harrington joined the meeting.

Key issues included:

Integrated Care Partnership

- a well-received housing discussion which resulted in a further housing roundtable focused on the strands of work set out in the escalation report.
- a discussion around social mobility recognising the importance of underpinning factors and the connectivity with the ICP's other three priority areas.
- received an introduction to the Employment and Local Skills Improvement Plan and considered how local organisations could shape further and reduce/remove barriers to employment.
- received an update on Integrated Neighbourhood Teams, recognising the issues around the scale of cultural change required.

People, Engagement and Culture Committee

- the agenda format had been amended from the definitions of governance to people, culture and engagement to enable the right balance of discussions.
- approved the four new risks following disaggregation of the previous overarching workforce risk.
- noted the new Integrated Performance Report which was a step in the right direction.
- noted the progress and approach to delivering the ambitions of the NHS Long Term Workforce Plan and Adult Social Care Strategy noting how the risks played out in the workforce plans.
- received an engaging presentation from Bournemouth University showcasing an approach to a better listening approach in Dorset.
- discussed the ICS Equality Diversity and Inclusion report within the current socio/political context, including people's experiences.

Prevention, Equity and Outcomes Committee

- discussed the committee effectiveness review noting the low response rate.
- discussed potential Better Care Fund opportunities and how they could be used in a better/more preventative way.
- received a presentation on the Green Plan/Environmental Sustainability green plan with some takeaway questions in terms of system working and more accountability drawn to individuals in terms of their carbon footprint.
- noted the new social mobility risk and associated committee oversight.

Productivity and Performance Committee

- approved the three risks to be added to the corporate risk register noting both finance risks and risk NQ027 would be reviewed prior to the Board.
- noted the committee effectiveness review.
- noted the operational performance including the operational challenges regarding 65-week waits.
- Discussed the month 3 financial report and trajectory to return to plan. There was concern regarding where the efficiencies would be realised within the system and the committee was not assured at this time.

Quality, Experience and Safety Committee

- approved the recommended option for continuing delivery of the Learning Disabilities Mortality Review process by adopting a more collaborative utilisation of patient safety framework and took assurance there would be no negative impact on the regulatory requirements in doing so.

- approved the annual safeguarding report with a focus this year on more service user feedback.
- discussed the committee effectiveness review noting the low response rate with an action to consider a different approach to the process for future years.
- received the safeguarding policy which was essentially a rewrite to enable better readability.
- received the Children in Care and Care Experienced by Young People annual report noting the areas for development for 2024-25 and a request to see information regarding children placed out of county in future reporting.
- the committee was pleased to see progress being made on the implementation plan for the clinical networks.

The Board noted the successful appointment of a designated doctor for safeguarding children.

L Oldham joined the meeting.

Strategic Objectives Committee

- discussed the committee effectiveness review including how the committee gained assurance on progress towards the long-term targets, particularly in relation to prevention.
- received the Wessex Health Partners Annual Review 2023-24 noting the good progress made and assurance the plan was on track.
- received the Health Innovation Wessex quarter 1 report noting the innovation examples having a real impact on the ground.
- noted the Respiratory Pathfinder Deep Dive recognising the positive progress being made.

Risk and Audit Committee

- the committee approved the Emergency Preparedness, Resilience and Response updated business continuity plan.
- discussed the committee effectiveness review noting the areas of good practice and areas for development and the low feedback responses for other committees.
- the update on the consequences of the current financial environment would be covered under Part 2 of the meeting but the importance of staff communication and support was recognised.
- received the findings of two internal audits - HR processes and system operating model governance. The latter had been received by all provider trust Audit Committees however further work was needed internally before this was brought back to the Board for wider discussion.

Resolved: the Board noted the Committee Escalation Reports.

Items for Decision

In relation to the declaration made under item ICBB24/116, L Harwood would participate in the discussion but would not take part in the decision.

ICBB24/124 Inward Investment Strategy

The ICB Chief Commissioning Officer introduced the Inward Investment Strategy report.

The Inward Investment Proposal outlined the alternative investment opportunities available to the Dorset ICS to support the delivery of Dorset's priorities, 5-year forward plan and transformational delivery.

The Strategy was split into three key areas of development to be delivered over a three-year period – investment opportunities, making better investment decisions and funding distribution.

C Bufton left the meeting and B Butlin joined the meeting.

The Board noted that paragraph 2.8 regarding the Business Case development and support to the Gateway Process was no longer a recommendation as funding was available.

The Board noted this was a complex area with clear legal frameworks in place regarding NHS acceptance of external funding for business-as-usual work.

M Mould joined the meeting.

The Board welcomed the energy and intent underpinning the Inward Investment Strategy 2024-27 but there was concern regarding an opportunist approach including without understanding the strategic fit. A robust governance framework would be needed to ensure there were not unintended consequences in this kind of collaborative space.

More work was therefore required on matters relating to routes for attracting social funding, prioritisation, strategic alignment, reputational impact and the governance framework.

A policy would be needed to protect the organisation in terms of the legal position on working with partners on social funding.

There was also a need to think more broadly across partners rather than just the ICB and to engage with sectors in terms of their support needs.

The ICB was looking to position itself as the system facilitator and to work with the third sector in terms of skilling up to make appropriate bids.

Resolved: the Board welcomed the energy and intent underpinning the Inward Investment Strategy 2024-27 but did not approve the adoption of the strategy and requested further work on matters relating to routes for attracting social funding, prioritisation, strategic alignment, reputational impact and the governance framework.

L Oldham left the meeting.

Items for Noting/Assurance/Discussion

ICBB24/125 Clinical Plan implementation plan

The ICB Deputy Chief Medical Officer introduced the previously circulated Clinical Plan implementation plan report.

The Board noted the progress with the cardiovascular, respiratory and frailty and falls clinical networks.

Financial and workforce input would be key in terms of the networks delivering what was required.

Concern was raised regarding the pace of agreeing the 2024-25 priorities and subsequent delivery when already over part-way through the year.

There was a need to ensure engagement/representation from all providers to ensure decisions taken had full sign up and it was noted significant soft work was being undertaken in this regard.

The Board requested that SMART objectives be brought back to the Board from the clinical networks to build into 2025-26.

Action: AO'D

Z Bradley left the meeting

Resolved: the Board noted the Clinical Plan implementation plan.

B Sharland left the meeting.

ICBB24/126 No Criteria to Reside/Care Packages – Bournemouth, Christchurch and Poole (BCP) Council approach

The Director for Wellbeing, BCP Council introduced the presentation on the No Criteria to Reside/Care Packages – Bournemouth, Christchurch and Poole (BCP) Council approach.

The efforts and challenges in reducing the number of patients who were no criteria to reside in hospitals were discussed, with particular focus on the BCP area.

The progress made in reducing delays for discharge and the specific actions being taken to address the remaining challenges were highlighted, including protected resources being moved into hospital discharge and a dedicated role.

There was a need for better engagement with families and improving housing options for vulnerable individuals.

A deep dive in the BCP area was undertaken in mid-July with the review findings as set out on slide 7 of the presentation.

The system-wide Newton Project was already working closely with partners to map current data sets and further work was needed in terms of consistency/accuracy to understand one version of the truth.

The Healthwatch Dorset Manager encouraged reading Healthwatch Dorset's recently published blog regarding supporting patients to discharge safely.

It was requested there be regular future reporting into the Board via the Integrated Performance Report.

Action: DSp

Resolved: the Board noted the No Criteria to Reside/Care Packages – Bournemouth, Christchurch and Poole (BCP) Council approach

B Butlin and M Mould left the meeting.

ICBB24/127 ICS Equality, Diversity and Inclusion report

The Chief People Officer introduced the ICS Equality, Diversity and Inclusion (EDI) report.

A core purpose of integrated care boards was to address health inequalities but there was a deep cultural and systemic challenge in relation to equality, diversity and inclusion, heightened by the recent protests and behaviours.

The moral and business imperatives of addressing EDI within the system were emphasised highlighting the need for cultural and systemic change. The Board discussed the importance of leadership in driving the EDI agenda, acknowledging the discomfort in addressing these issues but stressing the necessity of remaining engaged with the uncomfortable aspects to foster true transformation and inclusivity.

Addressing this included ensuring staff had an inclusive positive working environment, feeling welcomed and valued.

For the NHS centrally there had been a long-standing focus on transactional activity and whilst this had helped, it hadn't moved the position consistently in terms of improvements in experience. This was built into the South West regional approach and Leading for Inclusion Strategy and it was recognised next steps and recommendations would take time to deliver.

The Board noted Matthew Bryant would be the regional level Chief Executive Officer sponsor for EDI for Dorset.

It was recognised that addressing these issues would need commitment to an ongoing series of development days.

The Board noted the December ICB Board Development facilitated session would be dedicated to leading on creating and developing cultures of equity and inclusion to drive an improvement in health inequalities.

A discussion would take place outside the meeting to consider the focus of a further discussion at the October Board Development session.

Resolved: the Board noted the ICS Equality, Diversity and Inclusion report.

CBB24/128 ICB Annual Assessment 2023-24

The Chief Operating Officer introduced the ICB Annual Assessment for 2023-24 which provided a summary of the Annual Assessment outcome for NHS Dorset.

The outcome confirmed NHS Dorset was considered to have been working in compliance with its statutory duties and its contribution to the four purposes of an ICS.

Several areas of good or outstanding practice were highlighted along with three areas requiring progress.

Resolved: the Board noted the ICB Annual Assessment for 2023-24.

Items for Consent

ICBB24/129 Data Security and Protection Toolkit Annual Report

Resolved: the Board noted the Data Security and Protection Toolkit Annual Report.

ICBB24/130 Safeguarding Children and Adults Annual Report

Resolved: the Board noted the Safeguarding Children and Adults Annual Report.

ICBB24/131 Children in Care and Care Leavers Annual Report

Resolved: the Board noted the Children in Care and Care Leavers Annual Report.

ICBB24/132 Questions from the Public

There were no questions received from members of the public.

ICBB24/133 Any Other Business

This was both John Beswick and Debbie Simmons' last Board meeting and on behalf of the Board the Chair thanked both for their valued contributions.

ICBB24/134 Key Messages and review of the Part 1 meeting

Due to time, this item was not taken.

ICBB24/135 Date and Time of Next Meeting

The next meeting of the ICB Board would be held on Thursday 7 November 2024 at 10am in the Boardroom at the offices of NHS Dorset ICB, Vespasian House, Barrack Road, Dorchester, Dorset, DT1 1TS.

ICBB24/136 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:

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 08 January 2025

Agenda item: 7.1

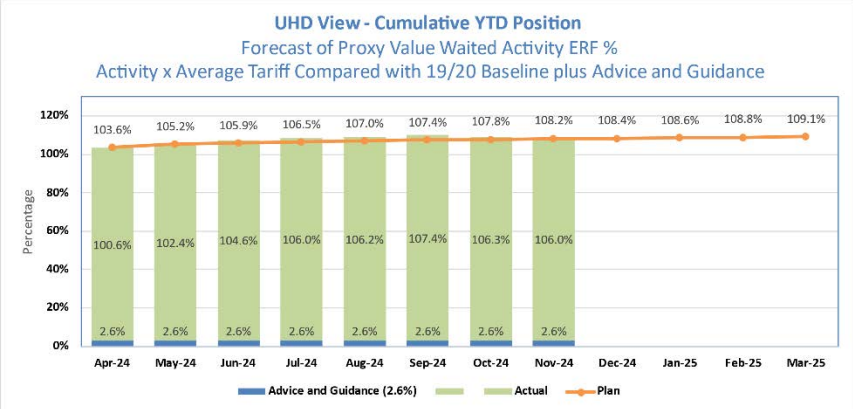
Subject:	Integrated Performance Report (Safety, quality, experience, workforce and operational performance)
Prepared by:	Executive Directors, Leanna Rathbone, Mark Major, Jonathan Wright, David Mills, Dr. Matthew Hodson, Irene Mardon, Jo Sims, Andrew Goodwin and Tracy Moran
Presented by:	UHD Chief Officers

Strategic themes that this item supports/impacts:	Population & System ☒ Our People ☒ Patient Experience ☒ Quality Outcomes & Safety ☒ Sustainable Services ☒
BAF/Corporate Risk Register: (if applicable)	BAF Risks 1-7 Trust Integrated Performance report for November 2024 - Appendix A
Purpose of paper:	Assurance
Executive Summary:	At the end of November 2024, the Trust has reported a deficit of £7.588 million against a planned deficit of £6.214 million, resulting in an adverse variance of £1.374 million. The variance is due to the phasing of the recovery actions compared to the original plan. Additional operational pressure became more evident in November with both acuity and activity increasing, impacting on elective and emergency care pathways, however the trust has maintained a good level of delivery for patients: • Elective value weighted activity at 108.6% compared to 19/20 enabled additional patients to be treated • Fewer patients this month have waits for elective care greater than 65 weeks and waits above 52 weeks are also reducing at a faster rate than the trust operational plan. • Diagnostic test turnaround times are maintaining strong performance with 89% of patients waiting less than 6 weeks and further planned improvement for December forecast. • Cancer 28 Day Faster Diagnosis Standard (FDS) in October 2024 increased by 6.6% to 75.6% compared to 69.0% in September 2024 with November outturn looking to have been maintained • Performance against the Organisational 4-hour Safety Standard delivered 70.0% (7 out of 10 of our patients) seen admitted and discharged within 4 hours

	• Ambulance handover performance better than the regional average with Poole Hospital remaining in the top three for the region. • Patients with a No Criteria to reside (NCtR) reduced in November to an average of 192 (circa 20% of Trust Beds) as compared to October's average of 200 with further work needed to reduce patients waiting. In line with our operating plan submission we are on track 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. The government has announced the 2024/25 pay award for staff under the remits of the NHS Pay Review Body and Doctors' and Dentists' Review Body which will come into effect from 1 April 2024. The pay award represents a 5.5% consolidated uplift for all permanent Agenda for Change staff. For doctors and dentists this will mean up-lifting salaries by 6% and Doctors and Dentists in training will also receive an uplift of £1,000. All pay uplifts will be made in the October payroll and backdated to 1 April 2024. 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). 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. As part of our commitment against the CQC Well-Led Framework we continue to develop the format and content of the IPR by: • Extending best practice use of Statistical Process Control (SPC) Charts. • Greater focus on key indicators as part of our Patient First roll-out programme linked to the Trust Strategic priorities and the Trust refreshed SDR process. • Providing SPC training to operational leads who compile the narrative against the data included within the report. ***We recognise as a Trust Board that behind every single metric discussed in this paper there is a patient.***
Urgent & Emergency Care	**Strategic goal: To meet the patient national constitutional standards for Planned and Emergency care supporting**

(1 Alert)	**reducing inequalities in outcome and access and improving productivity and value.**
	
	Advise (1): The 4-hour standard performance for November 2024 is 70.0% against an internal trajectory of 76%. The next target for December is 75%, which factors in the increased impact of seasonality.
	
	• **Type 1 Patients**
	  ○ Non – admitted performance for November was 71% vs target trajectory of 75%, 1% less as compared to October 24.
	  ○ Admitted performance for November was 33% vs trajectory of 42%, but did increase by 3% as compared to Oct 24.
	  ○ Breaches decreased in November by 156, this is approximately 5 patients per day despite static attendances.
	  ○ Fewer patients waited more than 12 hours as compared to Oct 24.
	  ○ Outflow from both departments was particularly challenged during the 4th week of the month, impacting several UEC metrics, with the Trust declaring internal capacity incident in response to occupancy and surge in demand across the region.
	
	• **Type 3 Patients (UTC)**
	  ○ All patients were seen within 4 hours.
	
	• **Ambulance Performance**:
	  ○ Ambulance handover volumes remained static vs October, whilst the percentage (of the total) who waited longer than 60 minutes, dropped significantly to only 4% down from 7.5%.
	  ○ The total hours lost to handover for UHD also saw a reduction of 311 hours across both sites.
	  ○ However, a total of 6% of patients spent time receiving care in a non-clinical area.
	
	The IPR provides detailed performance against the national Urgent & Emergency Care standards.
	 
	
	Improvement Areas:
	• The Trust continues to update/monitor the 4 Hour organisational counter measure summaries the project charters and the team plans.
	  ○ **Non-Admitted Performance:** Continuous improvement shows 8% improvement in pre-ceding 12 months. Focus on ambulatory pathways underperforming and driving an increased average wait to be seen.

	○ **Admitted Performance**: ED focus on reducing decision to admit time, some improvement made but need to reduce this earlier in the pathway- plan to focus in December on 'seen in 60.' Care Groups focusing on delivering winter plans and reducing variation in admitted performance. ○ **Season Planning**: winter plan in place with actuals vs plan monitored and reported to the Operational Deliver Group. Virtual ward overperforming vs plan. ○ **SDEC:** Specialty SDEC Meetings conducted with: Cardiology, Child Health, AMU, OPS, Surgery, Rheumatology. Discussion re current provision, future pathways, hours, access points and opportunities. Expansion plan to increase medical SDEC service at BH site in place, providing additional resilience at weekends. ○ **HISU:** 'Stay Well' campaign launched with the system, with a focus on tackling health inequalities for high volume activity such as vulnerable pensioners and unpaid carers. ○ **LOS:** 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 noted across Older Peoples Services and Orthopaedic wards. ○ **Mobilisation:** Dorset/ Newton team establishing programme and to ensure focus supports UEC delivery Enhanced support through the trusts Accountability Framework being established .
Occupancy, Flow & Discharge **(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) 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.** The number of patients with no criteria to reside (NCtR) despite some improvement, remains a significant risk to the winter plan. A reduction of 52 is needed for December 24 to deliver against the system trajectory and balance the Trust's bed forecast. **Improvement Areas:** ○ Use of the EDR (Estimated Date Ready) as a proactive planning tool by the Transfer of Care Hub to anticipate and bring forward discharge dates. ○ My Care Needs tool going live Dec 4th 2024, which will prompt earlier discharge conversations ○ Ongoing dialogue with partners using improvement trajectory to measure progress against the system plan. ○ Increase focus on patients waiting over 21 days with a criteria to reside to make sure that we have optimised the patient pathway for these group of patients. ○ Engagement through the UEC diagnostic report (Newton) and the mobilisation plan.

	○ ECIST supporting the Trust in improving LLOS position.
Referral to Treatment (RTT) **(3 Assure, 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.** **Assure (1): The Trust delivered 108.6% (value weight activity year to date) in November compared to the 2019/20 baseline period; this is above the threshold (103.7%), which allows access to elective recovery funding. The Trust is also achieving its operational plan year to date trajectory.** Activity levels year to date exceed the Trust's operational planning trajectory (108.2%).  **Assure (2) The Referral to Treatment (RTT) waiting list decreased in November 2024.** **Advise (1) RTT Waits >65 weeks fell further in November with the Trust reporting 16 breaches at the end of the month.** • The Referral to Treatment (RTT) waiting list size shows a decrease in November 2024 (-580) to 67,413 and the variation to the operational planning trajectory (67,095) has also reduced to 0.5% above trajectory. The target waiting list is within current process control limits; indicating it is achievable. • Of the 16 >65-week waits at the end of November, 7 patient are waiting corneal graft material to become available, and 6 patients had their colorectal surgery delayed due to a supplier shortage of surgical collagen. The Trust is working to book these two groups of patients for surgery as soon as possible. **Planning requirement** | **Oct 24** | **November 24** Referral to treatment 18-week performance | 60.8% | 61.1% ▲ | National Target 92% Eliminate >78 week waits | 0 | 0 | Plan Trajectory 0 Eliminate >65 week waits | 48 | 16 ▼ | Plan trajectory 0 September 2024 Reduce >52+ weeks | 2,177 | 2,172 ▼ | Plan Trajectory 2,629 by November 2024 Stabilise Waiting List size | 67,993 | 67,413 ▼ | Plan Trajectory 67,095 November 2024

	The Planned Care Improvement Group is using the Patient First methodology to deliver improvement and reports to Trust Management Group. **Key areas of focus** • Maintaining elective activity rates above the 2019/20 baseline, increasing to above 109% by March 2025. • Utilise UHD & ICB contract capacity with independent sector providers for treatment of long waiters. • Prioritised booking for all patients in the longwaiter cohort into outpatient and theatre capacity. • Increasing productivity within core capacity, including reducing missed appointments (DNAs) and improving theatre and outpatient session utilisation rates. **Theatre productivity** • Capped theatre utilisation in November was 82%. This marks an improvement above the process mean and is above the revised operational trajectory (Nov 79.1%). • Cancellations on the day, equipment/SSD, and available bed capacity remain the constraining factors that are being worked through **Outpatient productivity** • The Trust is maintaining an overall reduction in missed appointments rates (Did not attends) in 2024/25. The DNA rate in October was 5.6% and the target of 5% remains deliverable. • All clinics which are suitable (not excluded), now have text reminders switched on and text reminder notifications are now scheduled at 4 and 14 days prior to appointment (from 3 and 10) to improve clinic slot fill rates/reduce DNAs. • 55.4% of patient communication in November was by digital letter. • A clinic slot utilisation improvement project is now a key trust-wide Patient First project under the umbrella of the planned care improvement programme. **Assure (3): Time to theatre for fractured neck of femur (# NoF) patients - 72% operated on within 36 hours from admission** • November 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 72% operated on within 36 hours from admission. • Performance remains above the process mean for the third consecutive month and the target is within the upper and lower process control limits. • Overall trauma admissions in November were low, but complexity of cases remains a factor in achieving the target.
Cancer Standards **(1 Advise)**	**Strategic goal: To meet the patient national constitutional standards for Planned and Emergency care supporting reducing inequalities in outcome and access and improving productivity and value.** **Advise (1)** **Performance against the Cancer 28 Day Faster Diagnosis Standard (FDS) was recovered in October 2024 achieving at 75.6%**

- FDS performance showed a 6.6% improvement compared to 69.0% performance in September 2024. Improved performance in Quarter 3 continues to be demonstrated in November (currently 75.2%).
- Performance against the 31 Day Standard also recovered in October 2024 achieving the 96.2% standard.
- However, performance against the 62 Day Standard in October 2024 decreased to 67.0% compared with 68.0% in September

Improvement actions are detailed within the IPR and in the four key specialties contributing to the performance position, these include:

Breast:

- Recovery of 28D FDS performance by January 2025.
- Securing additional radiology capacity to enable delivery of one stop fast track clinics to address the increasing number of patients awaiting a first OPA.

Skin:

- Sustaining recovery of performance in 28D FDS over Christmas period.
- Additional insourcing activity continues to accommodate the year-on-year increase in referrals.
- Aligning site specific waiting lists for treatment to ensure patients are treated in chronological order.

Colorectal:

- Development of a business case to support the future workforce requirements and sustainable delivery.
- Agreement and implementation of a staffing resource plan with Wessex Cancer Alliance (WCA) following the completion of the initial Pathway Analyser. Further Pathway Analyser work in being undertaken in December 2024 to identify opportunities to increase 62 Day performance in line with Wessex-wide service provision.

Iron Deficiency Anaemia (IDA):

- Maintaining prioritisation of clinical reviews to move patients to 'straight to test' where appropriate.

DM01 (Diagnostics report) (2 Advise)

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

Advise (1) The DM01 standard has not been achieved in November with 10.6% of patients waiting more than 6 weeks for a diagnostic test. However, there was a significant reduction in the number of patients waiting over 13 weeks.

Standard: No more than 1% of patients should wait more than 6 weeks for a diagnostic test.

November 2024	Total Waiting List	< 6weeks	> 6 weeks	Performance
UHD	12,736	11,384	1,352	**10.6%**

- UHD remains one of the top performing trusts for diagnostics in the Southwest region.
- Overall, the percentage of patients waiting over 6 weeks for a diagnostic test increased from 9.8% to 10.6% in November 2024. The total diagnostic waiting list also increased in month.

	• In November there were 260 patients (2%) waiting more than 13 weeks for a diagnostic test (304 in October); the majority of these (229) are patients awaiting neurophysiology. A new outsourcing contract for Neurophysiology commenced in November to address this backlog. Interviews for a new Consultant are also taking place in January and a new Physiologist commenced in December 2024. • Improvement actions are being delivered as detailed within the IPR, including the delivery of the Community Diagnostic Centre programme.
Health Inequalities (1 Advise)	**Waiting list by Index of Multiple Deprivation (IMD)** Analysing elective waits for Quarter 3 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 continues to show a slight increase in variation by one week compared to people from IMD 3-10. Analysing the same data by age band identifies 5 weeks variation for children (<18 yrs). This will remain under review. **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 one week's variation between patients within community minority groups and white British populations in Quarter 3. <18-year-olds from community minority groups are waiting on average the same number of weeks as white British patients. This is a significant improvement compared to Quarter 1 (variation 8.5 weeks longer).
Maternity (1 Advise)	**Advise (1) There are 4 areas currently flagging as red RAG rated:** • PPH >1.5 litres- ongoing action plan • Apgar <7 at 5 minutes-normal variation • Term admissions to NICU-showing a special cause variation. • Quarterly stillbirth number >2.6 Improvement actions are detailed within the IPR.
Infection Prevention and Control: (1 Alert, 6 Advise)	**Quality, Safety, & Patient Experience Key Points** **Strategic goals: To achieve top 20% of Trusts in the country for mortality (HSMR)** **To reduce moderate/severe harm patient safety events by 30% through the development of an outstanding learning culture** • **Alert (1):** Disparity noted between reported Saving Lives Audits for Hand Hygiene compliance versus IPC observational assurance audits. Summary of IPC audit results presented to Group Directors of Nursing with action plans to be commenced to drive improvement with compliance. • **Advise (1) MRSA bacteraemia:** No cases of MRSA bacteraemia in November 2024. • **Advise (2) *Clostridioides difficile* cases**: Case numbers identified remain static compared to October with no periods of increased incidence recorded. • **Advise (3) *E.coli* bacteraemia:** Cases of *Escherichia coli* have decreased in November 2024 and remain within special cause variation. Work is continuing to identify themes, alongside work to improve hand hygiene compliance.

- **Advise (4) MSSA bacteraemia:** The number of Methicillin-sensitive *Staphylococcus aureus (*MSSA*)* fell in November 2024, below the median level.
- **Advise (5)** Increase in *Klebsiella Species* cases reviewed for Q2 no specific themes or trends identified, further work and sight with ICS to explore any causative factors for the spike in cases continues.
- **Advise (6) Hospital Associated cases trend**

Organism	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
MRSA	0	1	1	0	1	1	2	0	2	2	0	0	0
MSSA	4	3	3	6	6	4	1	4	8	8	5	5	3
C Diff	4	8	6	9	13	4	10	8	7	11	11	11	10
E Coli	11	17	17	8	8	14	14	9	14	13	7	9	12
Kleb	2	6	4	6	6	4	3	1	3	12	8	8	3
Pseudo	2	2	2	3	2	2	1	1	3	1	0	5	2
Outbreaks						2	0	4	1	2	1	0	3

A focus on the fundamentals of IPC practice including hand hygiene remains a core of the IPC winter plan, , working alongside care group colleagues.

Clinical Practice Team

(4 Advise)

Clinical Practice Team:

Advise (1) Moving and Handling - Essential Core Skills
The challenge to meet the face-to-face level two training requirements for clinical staff continues but we have seen a marginal improvement and continue with an external provider to provide support while there is a vacancy in the team. The risk register entry remains at 10 (moderate). The development of an eLearning Level 2 package is progressed and being reviewed in relation to the appropriate use within staff groups across UHD.

Falls prevention & management:
Advise (2) The number of moderate and above falls incidents in month has remained static in November with seven reported in month. These incidents will be following the appropriate scoping and investigation process through the patient safety investigation framework. Highest number of falls across elderly care wards, and OPAU. OPAU have launched Falls Prevention and Think Therapy Collaboration – staff training in place, and daily Think Therapy Ambassador identified. Less falls overall in November 2024 compared to October 2024, and less compared to November 2023. We saw a higher number of falls incidents during the third week of November 2024.

Tissue Viability:
Advise (3) The ability of the service to meet the increased demand remains on the risk register entry 1821 and rated as 9 (moderate), the action plan has been updated. There remains a considerable number of complex patients being referred to the service. The Tissue Viability Nurse Team (TVN) continue with the education and training following the roll out of the new Purpose-T a pressure ulcer risk assessment framework (October 2024)

Advise (4) Pressure Ulcers: *Note* as previously agreed with the CNO Pressure Ulcer Data reported within this IPR is 8-weeks in arrears, therefore October 2024 data is presented in this IPR report. There has been one Category 4 and 11 Category 3 pressure ulcers acquired during October 2024, (data reported 4-8 weeks in arrears). The category 4 and one Category 3 were due to a medical device. Appropriate patient safety investigation follow up has been

	completed and remains ongoing with regard to the Category 4 incident Data remains within usual variation control limits.
Patient Experience ***(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.** **Patient Experience and Engagement Team Overview:** **PALS and Complaints numbers for November 2024** **Advise (1) The number of open complaints over 55 days** is currently at 17 and continue to be prioritised within the complaints team and care groups and has continued to decrease with further measures to reduce the number of outstanding complaints continued. **Advise (2) Average complaint response timescale** reduction continues, November 2024 it was 53.7 working day average for a final response. Corporate complaints team are working on reducing this further. **Advise (3) Friends and Family Test (FFT)** The volume of FFT being received has maintained prior to the Patient Experience Team and Business Intelligence managing the SMS FFT Service. UHD has seen a sustained high satisfaction score. The Trust's overall positive score remains above the upper control limit. **Advise (4) Mixed Sex Accommodation Breaches** There were 11 incidents in November 2024 in critical care – continued monitoring of areas is in place with care group matrons.
Nurse Staffing: (2 Advise, 2 Assure)	**Care Hours per Patient Day (CHPPD):** **Advise (1)** November 2024 CHPPD remained stable at 4.7 for Registered Nurses/Midwives combined. **Red Flag Reporting:** **Assure (1)** The Red Flag data for November was 30 raised in month. 47% (14) were raised due to challenges in the provision of enhanced care for patients, 20% (6) were attributed to delays in delivering fundamental care and 10% (3) reported a Registered Nurse shortfall of more than 8 hours on a shift. There were no critical staffing incidents reported indicating that safe staffing was maintained overall. **Workforce Controls:** **Advise (2)** Red flag data is being triangulated with other quality and safety information in preparation for unannounced assurance visits to in patient wards. **Assure (2) Ongoing review shows no impact on care delivery or safety due to the current workforce controls.**
Workforce Performance:	**Strategic goal: To significantly improve staff experience, engagement, and retention.**
CPO Headlines	Our workforce plan will be challenging to achieve this year. Enhanced controls will be in place for the remainder of this year. Our agency usage continues to be ahead of plan and remains below the 3.2% national cap.

	Our staff turnover rate remains stable, and we are making progress with hard to fill vacancies. Our vacancy rate now stands at 6.5%. Appraisal compliance has improved to 82%.
HR Operations ***(2 Advise)***	**Advise – Local Clinical Excellence Awards (2023-24) –** Local Clinical Excellence Awards for the 2023-24 financial year will be distributed to all eligible Medical and Dental Consultants in December 2024 pay. Following National Consultant pay negotiations which concluded earlier this year, the contractual entitlement to access an annual award round ceases from this 2024 financial year. **Advise – Policies -** 4 policies were ratified by the Staff Partnership Forum in November (Freedom to Speak Up, Managing Disciplinary Issues, Staff Code of Conduct Expected Standards of Behaviour and Supporting Performance) these will be presented to the People and Culture Committee in December for final approval and subsequent publication during December and January.
Blended Education and Training	**Assure 1** Work Experience lead has moved to the Education and Training team from the Patient Experience team. **Advise 1** Skills England have stated their intention to review and potentially not fund Level 7 Apprenticeships. In the NHS these have been used to great success to widen participation and support our workforce needs. **Advise 2** T-Level students are starting at UHD in January (aged 16 – 18) a draft SOP is currently being socialised.
Workforce Systems ***(2 Assure, 2 Advise,)***	**Assure People Ready Group –** Meetings with Care Group teams moving to the BEACH are moving to the 4-meeting structure ensuring the required information is provided. **Advise Medical and Dental Rostering Project –** Review of the reports for Job Planning and Medical Rostering status is underway with a plan to support the metrics required for the Patient First score card. **Assure Corporate Project** – Fixed Term Contract review, the fixed term contracts continue to be reviewed with a new live tracker showing progress stages of each contract. **Advise AFC Pay Award** – Issues with the Pension re-banding for the Agenda for Change XR pay grades is now resolved.
Resourcing ***(1 Advise)***	**Advise** A programme of work has commenced to ensure that the Recruitment service is structured and operating to standards required for delivery of resources in the trust to support Transformation and Annual Workforce plans, whilst also meeting our Corporate objectives for Time to Hire and Vacancy rates. A paper is being present at Trust Management Group in December
Temporary Staffing (2 Advise)	**Advise –** In line with the draft People and Culture Strategy, project work has commenced for the business case review of the Temporary Staffing Service model.

Occupational Health (2 Advise)	**Advise 1** Winter wellbeing guides are being distributed and promoted across the trust. **Assure 1** In February 2025 Occupational Health will be moving their computer system from Eopas to G2. The G2 system will improve the digital ability of OH on a number of levels. In Pre-placement, applicants can complete a health declaration form on any device speeding up the recruitment process. HR teams have their own specific dashboards and can track real-time progress. These changes will aid in decreasing the recruitment time. Management referrals will be easier to complete and can be tracked my managers and HR throughout the process. Occupational Health will be able to record and process a greater depth of data analysis, giving better insight into health trends and referral rates across the trust. Vaccinations Vaccinations by Frontline Status Frontline Status / Headcount / Covid / Covid % / Flu / Flu % / Both / Both % Frontline: 8930 / 2426 / 27.17% / 3050 / 34.15% / 2278 / 25.51% Non-Frontline: 1057 / 370 / 35.00% / 406 / 38.41% / 348 / 32.92% **Total: 9987 / 2796 / 28.00% / 3456 / 34.60% / 2626 / 26.29%** Vaccinations by Care Group Care Group / Headcount / Covid / Covid % / Flu / Flu % / Both / Both % 153 Corporate: 1166 / 420 / 36.02% / 457 / 39.19% / 394 / 33.79% 153 Medical Care Group: 2917 / 666 / 22.83% / 868 / 29.76% / 626 / 21.46% 153 Non Directorate Care Group: 93 / 27 / 29.03% / 41 / 44.09% / 25 / 26.88% 153 Operations: 630 / 137 / 21.75% / 152 / 24.13% / 127 / 20.16% 153 Surgical Care Group: 2146 / 523 / 24.37% / 694 / 32.34% / 484 / 22.55% 153 WCCSS Care Group: 3035 / 1023 / 33.71% / 1244 / 40.99% / 970 / 31.96% **Total: 9987 / 2796 / 28.00% / 3456 / 34.60% / 2626 / 26.29%**
Organisational Development ***(4 Advise, 1 Assure)***	**Advise Team Development** – The Standard Financial Instruction Waiver for the TED Toolkit has been accepted so we are now moving onto the procurement phase. This will see a set of tools and resources to be shared on the People Ready Sharepoint to support leaders when leading their team through change and transition. **Assure Equality, Diversity and Inclusion** 3 pilot sessions of the Conscious Inclusion workshop have successfully been delivered and attended by 74 colleagues. **Advise Inclusive Recruitment-** Meetings have been held with Dorset ICS colleagues and UHD's Recruitment Team to establish a consistent recruitment approach across Dorset. **Advise Culture and Engagement -** The Staff Survey closed on the 29th November, where the indicative final response rate is 58.7% (5691 staff responses). The first initial management report outlining results is expected in mid-December and will be shared in line with the National Embargo guidelines. The revised launch date of the Thank You app is the 16th of December 2024. A number of volunteers across the Trust are

	currently testing the App to ensure a positive user experience for colleagues across the Trust once launched. **Advise FTSU** - 391 staff have raised a concern with the FTSU team (April – end Nov 2024). This is an increase of 58% from the same period the year before. The greatest theme that staff raised to the FTSU team was relating to behaviours (137 staff 35% for each theme) followed by policy and procedure (121staff; 31%). Forty-three per cent of behaviours are relating to incivility and 26% relating to toxic working environments. 49 referrals (12%) were made anonymously and 68 referrals (17%) by staff from our global majorities. Learning includes leadership and management (158 staff; 40%), developing a civil and respective culture (91 staff; 23%), wellbeing support (57 staff; 15%), merger and team integration (33 staff; 8%).
Trust Finance Position ***(1 Alert, 3 Advise, 1 Assure)***	**Strategic goal: To return to recurrent financial surplus from 2026/27** The Trust now produces a monthly forecast as detailed in the report. At the end of November, the revised forecast financial trajectory for the year end position is still forecast as break-even, noting the risk in relation to winter pressures. **Alert (1): Efficiency Improvement Programme** Efficiency savings of £27.673 million have been achieved against a target of £25.128 million. As of 31 November 2024, EIP (Efficiency Improvement Plans) are reporting a forecast risk adjusted saving of £41.2 million, non-risk adjusted is in line with the target of £42 million including the trust-wide cross cutting schemes. **Advise (1): Revenue Position** At the end of November 2024 the Trust has reported a deficit of £7.588 million against a planned deficit of £6.214 million, resulting in an adverse variance of £1.374 million. The variance is due to the phasing of the recovery actions compared to the original plan. Income is £2.3 million favourable to plan year to date. Included within this is a favourable position against Dorset ICB, a £435,000 favourable variance against NHSE and a £187,000 adverse variance against Hampshire and Isle of Wight ICBs. Other patient care income is £90,000 favourable due to low volume activity income (£137,000 favourable), RTA income (£79,000 favourable) and overseas patient income (£59,000 favourable), partially offset by a shortfall in private patient income of £181,000. Operating expenditure is £5.483 million adverse to plan year to date. Pay is £3,898 million adverse to plan year to date, primarily due to premium nursing agency expenditure. Clinical supplies expenditure is £1.895m adverse to plan year to date mainly due to CDC costs (offset by income). Drugs expenditure is £3.673million adverse to plan year to date mainly due to Dorset ICS block contract drugs. Purchase of healthcare is £2.537 million adverse to plan year to date mainly due to CDC costs (offset by income). Premises and fixed plant expenditure is £2.839 million favourable to plan year to date due to energy costs. Agency spend in month is £0.973 million and is under the cap value equating to 3.2% of total pay expenditure. This is a reduction when set against the expenditure in March.

	Advise (2): Public Sector Payment Policy In relation to the Public Sector Payment Performance the Trust is currently delivering performance of 94.4% against the national standard of 95%. **Advise (3): Capital Programme** The Trust has reported capital expenditure of £82.7 million against a plan of £104.6 million. The underspend is due to slippage on committed schemes due to phasing delays, primarily NHP (New Hospital Programme) and CDC (Community Diagnostics Centre). The forecast shows an unmitigated underspend of £18.4 million which is currently being reviewed with work ongoing in conjunction with NHSE to mitigate this risk. **Assure (1): Cash** As at 30 November 2024 the Trust is holding a consolidated cash balance of £109.3 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 ☐ 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
Finance & Performance Committee (Operational / Finance Performance)	16/12/2024	Pending
Trust Management Group Committee (Quality)	17/12/2024	Pending

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

University Hospitals Dorset
NHS Foundation Trust



Integrated Performance Report

Reporting month: November 2024
Meeting Month: January 2025

Contents

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 (month on month) of pathways exceeding 52+ weeks (consistently within trajectory).
- UHD achieved the 28d day faster diagnosos cancer standard in October (and provisionally November too)
- The Trust is delivering over 108% elective activity compared to the 2019/20 baseline year, resulting in more patients being seen and treated.
- UHD is the third highest performing Trust in the South West for diagnostic waiting times performance and celebrated the opening of an additional diagnostic imaging centre based at the Health Sciences University in October 2024.

Performance at a Glance Indicators (1)

			standard	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
SAFE																		
Quality	Presure Ulcers (Hospital Acquired Cat 3 & 4)			16	17	15	10	11	12	11	9	15	10	13	12	13
	Inpatient Falls (Moderate +)			3	4	2	13	7	4	8	2	6	8	7	10	7
	Medication Incidents (All)			192	164	140	156	163	166	193	177	168	156	176	161	126
	Patient Safety Incidents (All)			1367	1278	1260	1187	1230	1176	1254	1092	1211	1174	1183	1384	1191
	Hospital Acquired Infections	MRSA		0	1	1	0	1	1	2	0	2	2	0	0	0
		MSSA		4	1	3	6	6	4	1	4	8	8	5	5	3
		C Diff		4	8	6	9	13	4	10	8	7	11	11	11	10
		E. coli		11	8	17	8	8	14	14	9	14	13	7	9	12
		Kleb		2	6	4	6	6	4	3	1	3	12	8	8	3
		Pseudo		2	2	2	3	2	2	1	1	3	1	0	5	2
	Hand Hygiene Compliance			97.6%	95.3%	96.0%	95.7%	95.9%	95.1%	96.2%	95.9%	96.0%	94.7%	95.6%	96.6%	96.2%
	Infection Control Mandatory Training Compliance			87.4%	87.2%	87.6%	88.4%	88.3%	89.4%	89.2%	89.0%	89.4%	90.1%	90.0%	89.9%	89.6%
EFFECTIVE																		
Mortality	HSMR In Month (UHD)	Latest Aug 24	(source HED)	103.8	117.6	104	118.9	95.6	101.5	103	112.8	99.6	91.94			
	Deaths within 36hrs of Admission			40	45	23	38	32	30	24	39	32	18	28	22	32
	Deaths within 5 day readmission spell			16	20	14	19	21	18	19	20	15	16	23	21	18
CARING																		
	Complaints Received			89	81	62	60	66	78	90	68	64	58	76	75	63
	Complaint Response Rate (Grade based target)			42.3%	58.2%	56.2%	38.8%	38.8%	40.5%	58.6%	54.9%	59.3%	48.6%	56.6%	64.7%	42.2%
	Friends & Family Test			94.8%	94.4%	94.1%	94.2%	94.0%	94.7%	94.6%	95.0%	94.5%	94.9%	99.5%	94.3%	94.2%
WELL LEAD																		
Safety	Risks 12 and above on Register			47	47	48	43	40	36	38	45	45	44	59	67	68
	Risks 15 and above on Register			24	22	20	18	19	18	18	21	22	20	19	20	19
	Red Flags Raised			13	15	28	13	14	13	11	9	20	13	26	31	30
People	Turnover			11.2%	11.0%	11.1%	11.1%	11.1%	10.9%	10.7%	10.6%	10.5%	10.6%	10.7%	10.6%	10.6%
	Vacancy Rate	Reported 1 month in arrears		6.3%	6.3%	7.1%	9.4%	7.7%	9.6%	8.9%	8.3%	8.8%	8.6%	8.1%	6.5%	
	Sickness Rate (rolling 12 month)			4.6%	4.4%	4.5%	4.4%	4.4%	4.4%	4.4%	4.5%	4.6%	4.6%	4.6%	4.6%	4.6%
	Statutory and Mandatory Training			88.92%	88.93%	88.91%	89.43%	89.0%	89.5%	90.1%	90.2%	90.5%	90.9%	89.8%	90.1%	89.9%
	Appraisal Compliance - Values Based			61.18%	61.48%	62.18%	62.00%	62.3%	61.8%	59.4%	55.1%	55.8%	63.2%	71.5%	78.2%	81.2%
	Appraisal Compliance - Medical & Dental			72.59%	72.08%	75.96%	76.10%	75.7%	79.0%	78.6%	78.1%	79.7%	80.8%	77.9%	81.0%	82.8%
	Temporary Hours Filled by Bank			53.1%	52.4%	53.5%	55.6%	57.6%	57.8%	57.7%	61.3%	61.4%	62.1%	62.4%	60.7%	61.8%
	Temporary Hours Filled by Agency			27.8%	27.0%	24.6%	22.9%	23.2%	22.8%	22.0%	19.2%	18.5%	19.0%	19.4%	18.7%	18.2%
	Agency Pay as Proportion of Total Pay			4.5%	4.9%	5.3%	5.2%	4.4%	3.7%	3.5%	3.0%	3.0%	2.6%	2.7%	1.9%	2.0%

Performance at a Glance Indicators (2)

			standard	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	
RESPONSIVE																		
RTT	18 week performance %		92%	60.8%	59.8%	60.3%	62.2%	62.0%	63.0%	62.4%	61.1%	61.2%	61.1%	61.4%	60.8%	61.1%	
RTT	Waiting list size	67,095 November 24)		69,158	68,967	67,983	66,909	68,398	70,012	68,343	67,977	68,825	68,760	68,039	67,993	67,413	RAG rated based on trajectory
RTT	No. patients waiting 52+ weeks	2,629 (November 24)		4,196	3,879	3,722	2,967	2,767	2,813	2,960	2,999	2,841	2,532	2,226	2,177	2,172	RAG rated based on trajectory
RTT	No. patients waiting 65+ weeks			1,271	1,313	1,220	840	328	335	393	471	459	351	65	48	16	
RTT	No. patients waiting 78+ weeks		0	59	57	86	45	29	22	11	0	0	0	0	0	0	RAG rated based on trajectory
Theat	Theatre utilisation (capped) - main		85%	80%	79%	78%	80%	80%	82%	81%	80%	79%	83%	78%	79%	81%	
Theat	NOFs (Within 36hrs of admission - NHFD)		85%	56%	60%	73%	62%	64%	63%	51%	50%	47%	32%	80%	73%	72%	
Outpatients	**Outpatient metrics**																	
Outpatients	Overdue Follow up Appts			26,506	26,733	26,506	25,844	26,075	26,161	26,046	25,642	25,492	25,407	25,706	25,658	25,982	
Outpatients	% DNA Rate		5%	5.9%	6.2%	5.9%	5.6%	5.3%	5.3%	5.3%	5.1%	5.1%	5.7%	5.5%	5.3%	5.6%	
Outpatients	Patient cancellation rate			11.2%	12.3%	11.3%	11.1%	10.6%	11.0%	11.4%	11.6%	11.3%	11.2%	11.5%	11.2%	9.9%	
Outpatients	% non face to face (telemedicine) attendances		25%	17.3%	17.4%	17.5%	17.1%	17.2%	17.0%	17.3%	17.1%	17.2%	16.6%	17.7%	17.3%	17.4%	
DM 01	**Diagnostic Performance (DM01)**																	
DM 01	% of >6 week performance		1%	9.3%	10.8%	11.8%	8.7%	10.7%	11.8%	12.9%	11.6%	12.5%	14.7%	13.2%	9.8%	10.6%	
Cancel	28 day faster diagnosis standard		75%	64.3%	66.6%	72.5%	77.8%	75.2%	66.3%	73.5%	73.1%	73.4%	65.5%	69.0%	75.6%	*76.1%*	*November cancer position provisional*
Cancel	62 day standard		85%	65.8%	64.4%	62.7%	65.0%	68.9%	68.4%	66.8%	69.0%	67.7%	69.4%	68.7%	67.0%	*64.9%*	
Emergency Dept	4 hour care standard			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%	RAG rated based on trajectory
Emergency Dept	Arrival time to initial assessment		15	19.0	19.0	20.0	20.0	20.0	19.0	19.0	20.0	20.0	17.0	18.0	17.0	18.0	
Emergency Dept	Clinician seen <60 mins %			32.2%	31.9%	31.3%	33.0%	32.0%	29.0%	30.0%	29.0%	28.7%	34.0%	30.6%	30.0%	31.6%	
Emergency Dept	Patients >12hrs from DTA to admission		0	70	294	483	202	207	145	214	171	140	39	139	227	136	
Emergency Dept	Patients >12hrs in dept			851	1271	1681	927	979	745	801	785	702	400	705	924	652	
SWAST SCAST	Ambulance handovers			4281	4454	4385	3993	4332	4060	4336	4082	4052	4165	4087	4250	4151	
SWAST SCAST	Ambulance handovers - average hours lost UHD			40	49	45	30	32	28	30	31	28	24	30	32	27	
SWAST SCAST	Ambulance handovers - average hours lost RBH			42	48	48	33	35	32	33	36	33	26	31	36	28	
SWAST SCAST	Ambulance handovers - average hours lost Poole			39	49	43	27	29	24	26	27	24	23	28	27	25	
SWAST SCAST	Ambulance handover >60mins breaches			576	760	779	299	365	263	312	357	269	156	287	368	188	
Patient Flow	Bed Occupancy (capcity incl escalation)		85%	96.7%	95.3%	96.4%	92.4%	93.0%	94.0%	93.7%	92.7%	93.6%	89.0%	91.6%	92.3%	92.0%	
Patient Flow	Stranded patients:																	
Patient Flow		Length of stay 7 days		526	534	566	551	528	527	512	510	545	507	529	518	505	
Patient Flow		Length of stay 14 days		331	339	370	363	336	339	324	327	343	329	337	324	320	
Patient Flow		Length of stay 21 days	108	220	231	266	255	235	241	230	229	237	234	236	222	225	
Patient Flow	Non-elective admissions			6519	6214	6538	6135	6718	6494	7030	6365	6668	6458	6161	6737	6823	
Patient Flow	> 1 day non-elective admissions			3934	3909	3981	3673	4175	3973	4193	3957	4086	4011	3926	4179	4238	
Patient Flow	Same Day Emergency Care (SDEC)			2458	2157	2391	2295	2395	2365	2629	2384	2581	2446	2234	2558	2584	
Patient Flow	Conversion rate (admitted from ED)		30%	32.90%	30.50%	28.47%	29.30%	30.70%	31.10%	30.30%	29.90%	31.20%	31.80%	30.00%	30.70%	32.50%	

Statistical Process Control (SPC) – Explanation of Rankings

Variation/Performance \ Assurance	P	?	F	
H	**Excellent** — **Celebrate and Learn** • This metric is improving. • Your aim is high numbers and you have some. • You are consistently achieving the target because the current range of performance is above the target.	**Good** — **Celebrate and Understand** • This metric is improving. • Your aim is high numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** — **Celebrate but Take Action** • This metric is improving. • Your aim is high numbers and you have some. • HOWEVER your target lies above the current process limits so we know that the target will not be achieved without change.	**Excellent** — **Celebrate** • This metric is improving. • Your aim is high numbers and you have some. • There is currently no target set for this metric.
L	**Excellent** — **Celebrate and Learn** • This metric is improving. • Your aim is low numbers and you have some. • You are consistently achieving the target because the current range of performance is below the target.	**Good** — **Celebrate and Understand** • This metric is improving. • Your aim is low numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** — **Celebrate but Take Action** • This metric is improving. • Your aim is low numbers and you have some. • HOWEVER your target lies below the current process limits so we know that the target will not be achieved without change.	**Excellent** — **Celebrate** • This metric is improving. • Your aim is low numbers and you have some. • There is currently no target set for this metric.
—	**Good** — **Celebrate and Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER you are consistently achieving the target because the current range of performance exceeds the target.	**Average** — **Investigate and Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** — **Investigate and Take Action** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER your target lies outside the current process limits and the target will not be achieved without change.	**Average** — **Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • There is currently no target set for this metric.
H	**Concerning** — **Investigate and Understand** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • HOWEVER you are consistently achieving the target because the current range of performance is below the target.	**Concerning** — **Investigate and Take Action** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning** — **Investigate and Take Action** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies below the current process limits so we know that the target will not be achieved without change	**Concerning** — **Investigate** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • There is currently no target set for this metric.
L	**Concerning** — **Investigate and Understand** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • HOWEVER you are consistently achieving the target because the current range of performance is above the target.	**Concerning** — **Investigate and Take Action** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning** — **Investigate and Take Action** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies above the current process limits so we know that the target will not be achieved without change	**Concerning** — **Investigate** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • There is currently no target set for this metric.
—				**Unknown** — **Watch and Learn** • There is insufficient data to create a SPC chart. • At the moment we cannot determine either special or common cause. • There is currently no target set for this metric

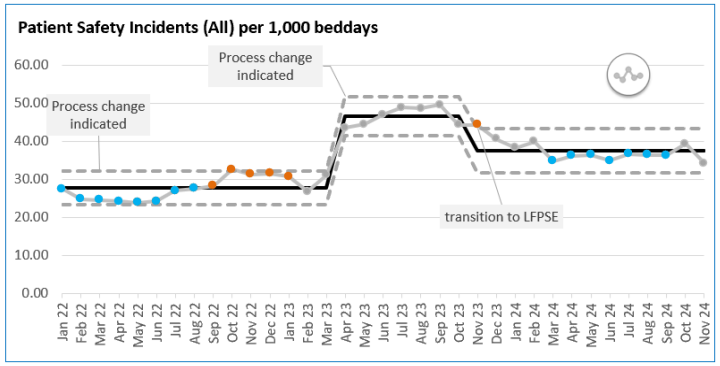
Quality Outcomes & Safety Patient Experience

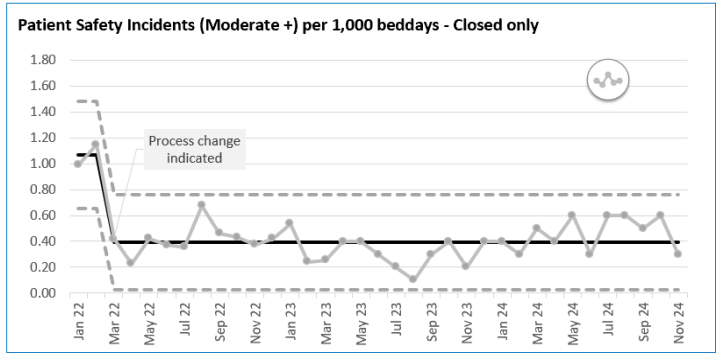
Sarah Herbert
Chief Nursing Officer
Dr Peter Wilson
Chief Medical Officer

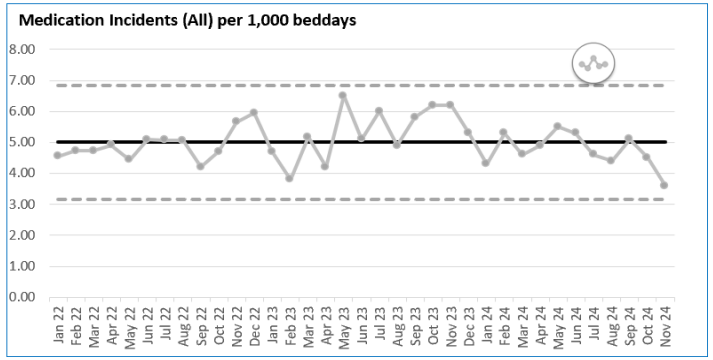
Operational Leads:
Matthew Hodson – Deputy Chief Nursing Officer (IPC, Workforce, Education and Research)
Madeleine Seeley – Interim Deputy Chief Nursing Officer (Clinical Practice, Patient Experience, Safeguarding)
Sean Weaver– Medical Director for Quality & Safety
Jo Sims – Associate Director Quality, 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

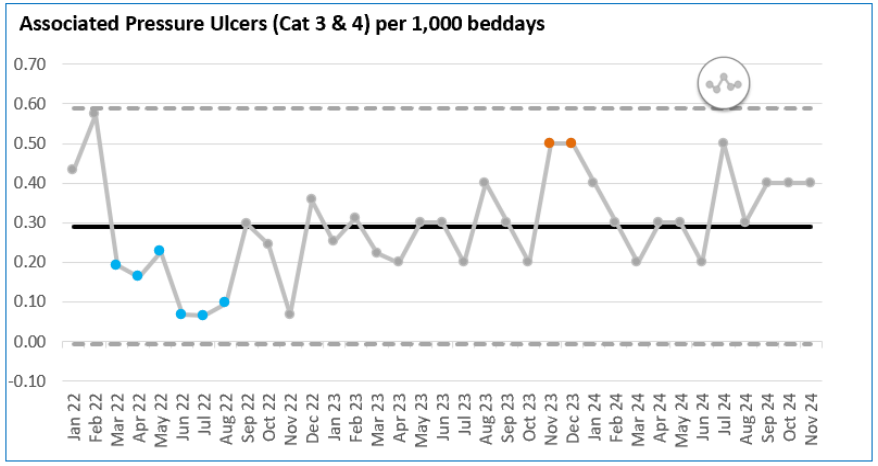
Performance

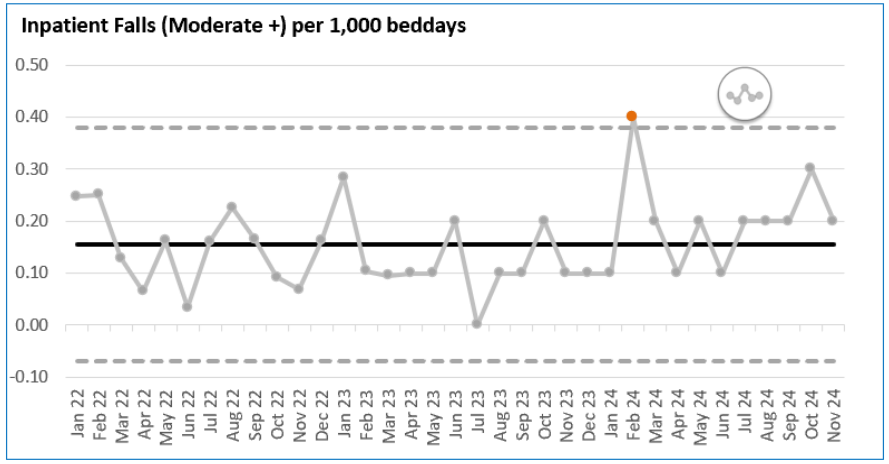
- The Trust transitioned to LFPSE in November 2023 meaning the adoption of a completely different taxonomy for reporting a patient safety event was introduced. The definition change significantly reduced the number of incidents reportable to LFPSE as a Patient Safety Incident.
- From 1 April 2024 the Trust has adopted the Patient Safety Incident Response Framework (PSIRF) and in October 24 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.
- An audit of PSIRF Responses for Q1 and Q2 is currently in progress.

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

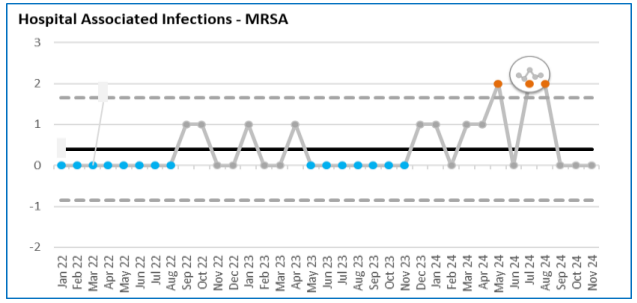
Clinical practice:

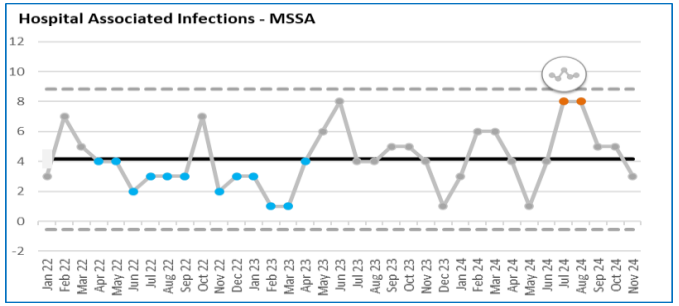
- There has been one Category 4 and 11 Category 3 pressure ulcers acquired during October 2024, (data reported 4-8 weeks in arrears). The category 4 and one Category 3 were due to a medical device. Appropriate patient safety investigation follow up has been completed and remains ongoing with regard to the Category 4 incident Data remains within usual variation control limits.
- Themes identified include medical devices, extended seating time, documentation gaps and skin frailty in keeping with end of life.
- November data evidences 7 moderate and above falls. Average number per month of moderate and above is 5, with an expected range between 0 and 12, so November is within expected variation.
- Our current UHD Falls (all harm) per 1,000 Bed Days is 5.0 in November 2024, a slight reduction on previous month and slightly below compared to last year November 2023 (5.2).

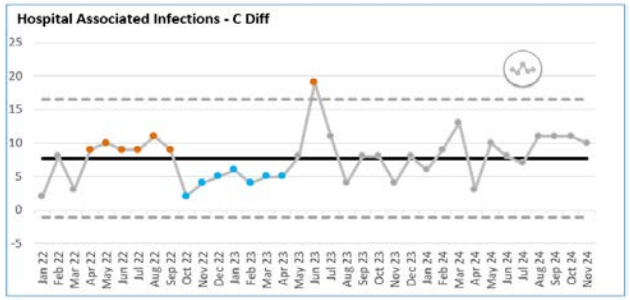
Key Areas of Focus

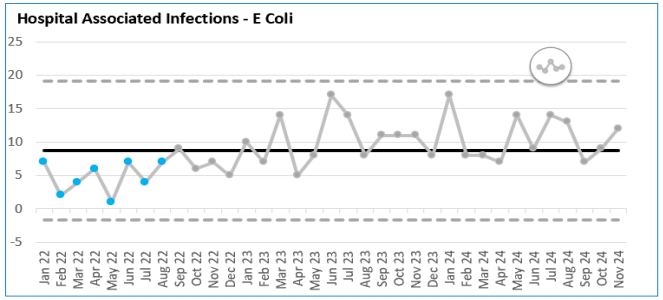
- Work continues with ward teams on Falls and Tissue viability improvement plans
- The Tissue Viability Nurse Team (TVN) continue with the education and training following the roll out of the new Purpose-T a pressure ulcer risk assessment framework (October 2024)
- Patient Safety team are conducting a thematic review/deep dive into pressure ulceration at UHD
- Tissue Viability team under review – case load/skill mix.
- The falls team continue to work with the Patient Safety team to adopt a PSIRF approach to develop a PSIRF training plan, with Falls PSIRF learning tools
- Highest number of falls across elderly care wards, and OPAU. OPAU have launched Falls Prevention and Think Therapy Collaboration – staff training in place, and daily Think Therapy Ambassador identified.

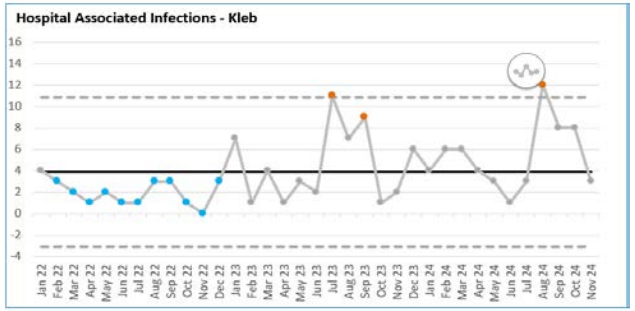
Quality (3) – Safe

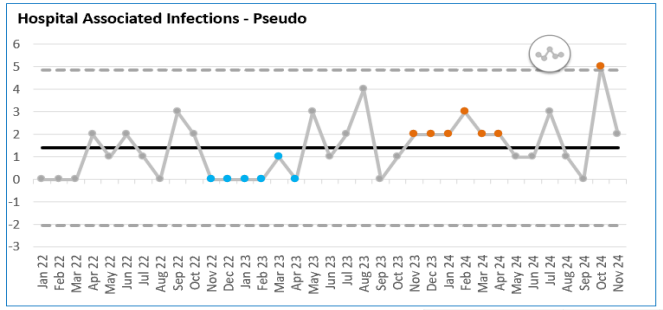












Background/target description

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

Performance

Infection Prevention and Control (IPC):

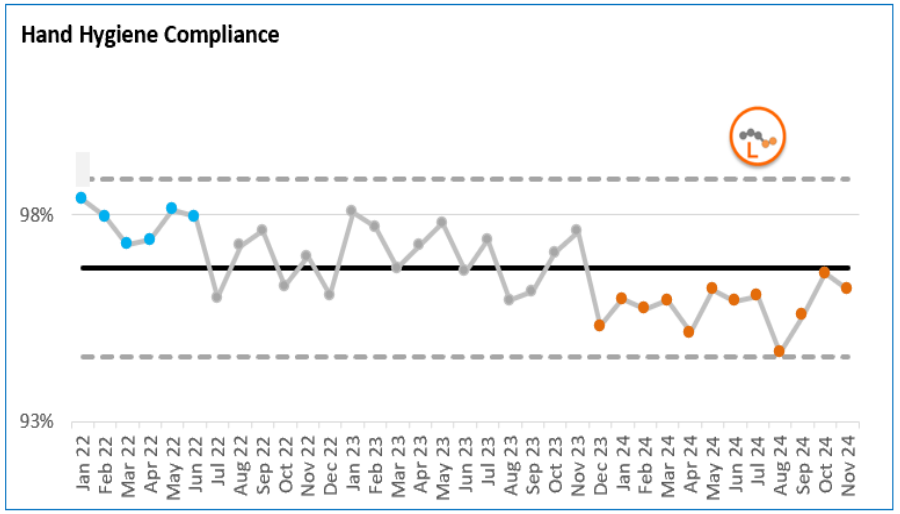
- There were no MRSA cases reported in November 24.
- Cases of MSSA decreased compared to October 24, falling below median level
- Cases of *Escherichia coli* bacteraemia increased in November in comparison to October, remain within special cause variation.
- *Clostridioides difficile* cases remain at a constant level in November.
- Total number of cases of *Klebsiella* fell in November below median level.
- Cases of *Pseudomonas* fell in November following a peak in October
- There were three outbreaks of Covid-19 reported during the month of November 2024.

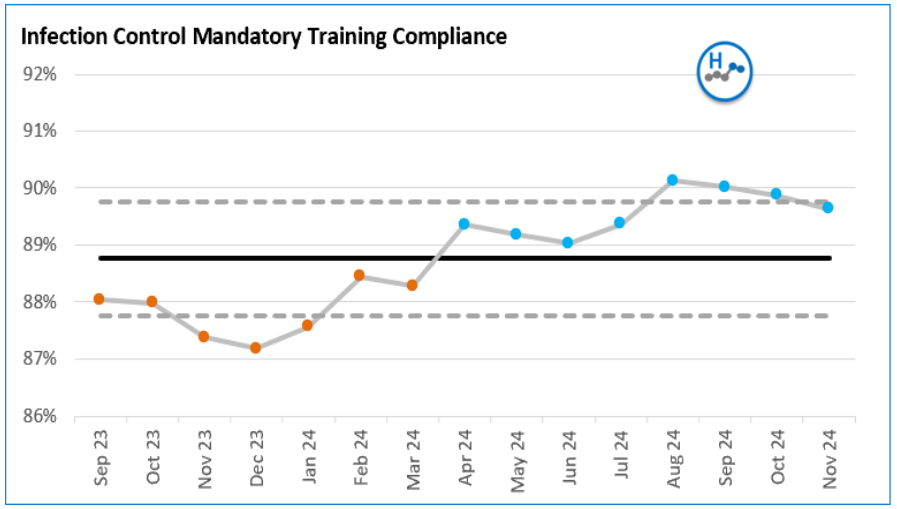
Key Areas of Focus

- Hand hygiene assurance audits
- Focus on Winter Plan and associated education

Organism	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
MRSA	0	1	1	0	1	1	2	0	2	2	0	0	0
MSSA	4	3	3	6	6	4	1	4	8	8	5	5	3
C Diff	4	8	6	9	13	4	10	8	7	11	11	11	10
E Coli	11	17	17	8	8	14	14	9	14	13	7	9	12
Kleb	2	6	4	6	6	4	3	1	3	12	8	8	3
Pseudo	2	2	2	3	2	2	1	1	3	1	0	5	2
Outbreaks						2	0	4	1	2	1	0	3

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 of hand hygiene compliance

November

- Medical care group: 95.3% compliance
- Surgical care group: 97.6% compliance
- WCSS care group: 95.8% compliance

- Disparity noted between reported Saving Lives Audits for Hand Hygiene compliance versus IPC observational assurance audits. Summary of IPC audit results presented to Group Directors of Nursing with action plans to be commenced to drive improvement with compliance

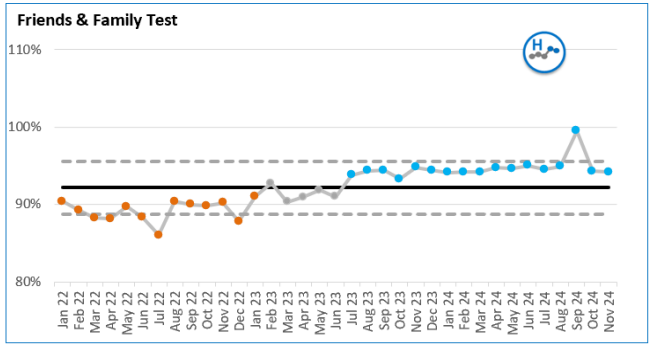
Infection Control Mandatory Training Compliance summary

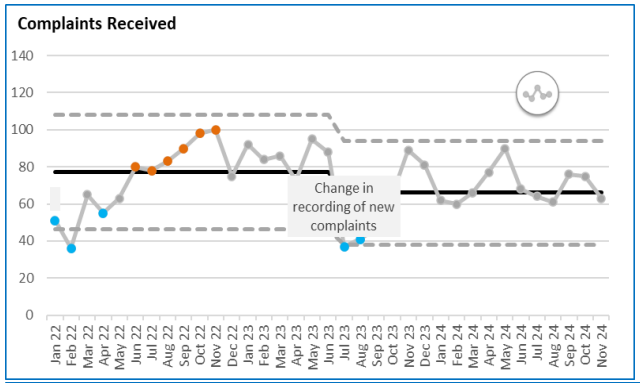
- Overall Trust compliance with Level 1 IPC training (all staff): 95.42%
- Overall Trust compliance with Level 2 IPC training (staff with patient contact): 86.81%

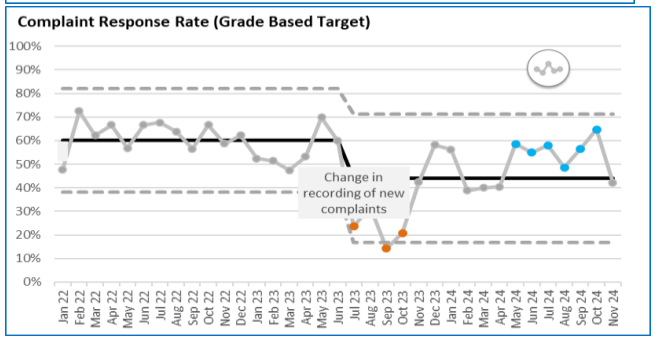
Key Areas of Focus

- The focus maintains Bare Below the Elbow and the fundamentals of IPC including hand hygiene and the correct use of PPE
- Roll out of IPC policy and procedures and the winter resources

Quality (5) – Caring







Performance and Areas of Focus

PALS and Complaints Data for November 2024:

Overview:

- 493 PALS concerns raised
- 40 new formal complaints
- 23 Early Resolution complaints (ERC) processed.
- The number of complaints that were responded to and closed was 65

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 and has continued to decrease. The average complaint turnaround time was 53.7 days in November 2024.

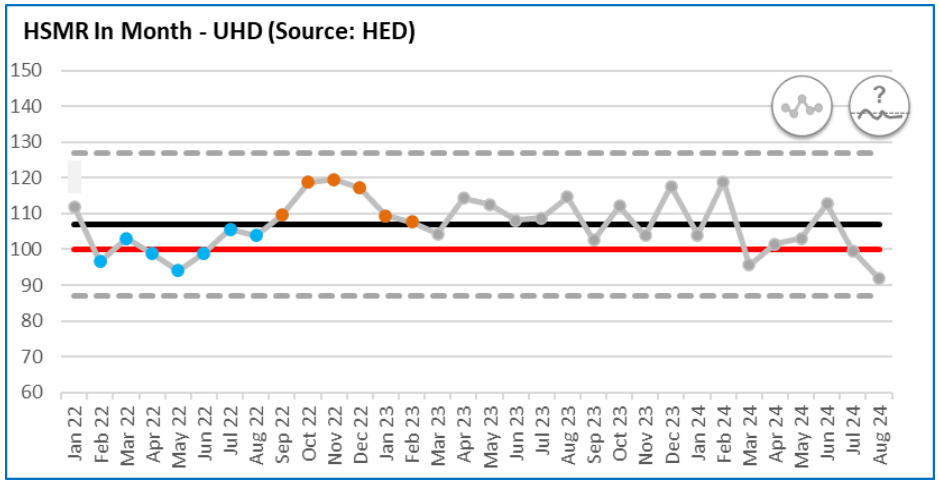
Friends and Family Test (FFT)

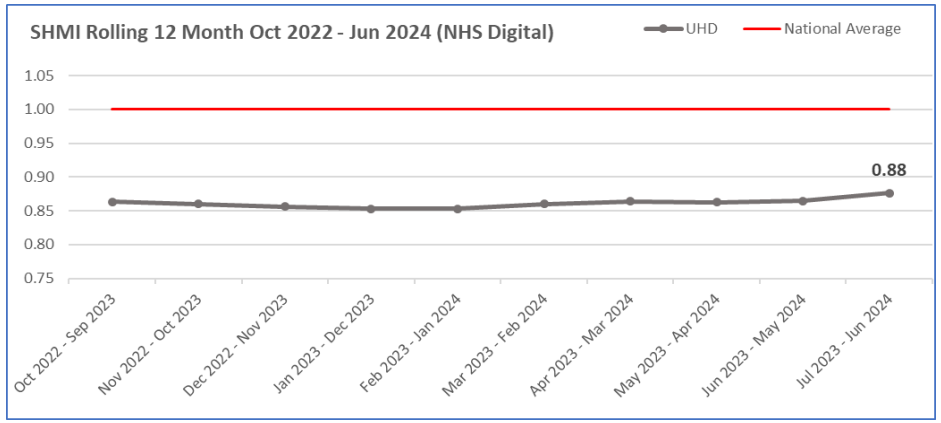
FFT results: FFT responses being received remain steady with a stable overall positive score Seen in the SPC chart as special cause improved variation. Note : As of, 05 September BI team advised that consent to contact, and mobile number data items from Agyle have been gained and we can now start to send FFT / HYS to these patients.

Mixed Sex Accommodation Breaches

There were 11 occurrences of MSA in November 2024 in critical care – monitoring of areas continues with care group matrons.

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 August 2024 is 91.9, below the national average of 100. .

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

The changes to the coding of palliative care patients have been approved and will be visible from the August data.

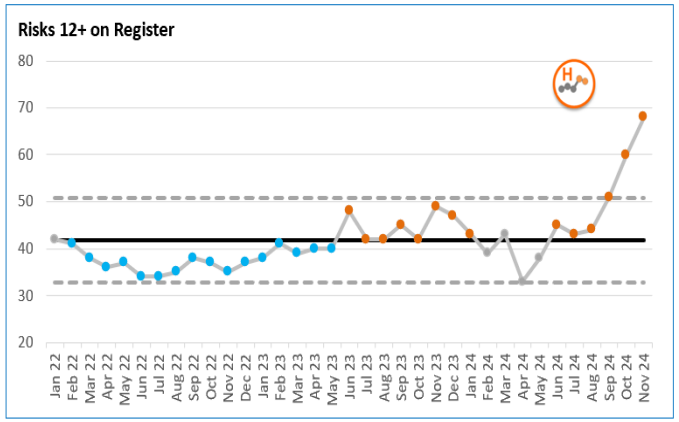
*The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust (within 30 days) and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

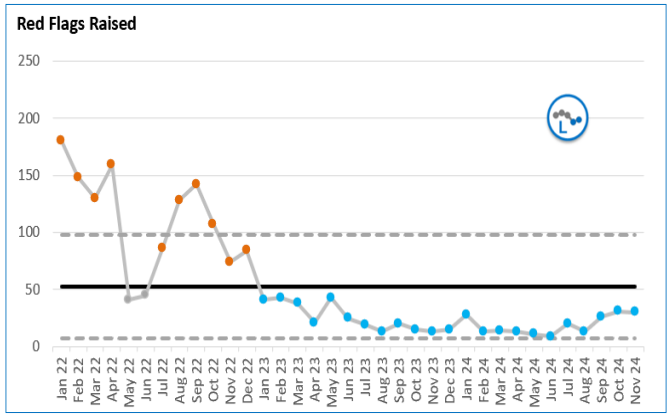
Areas of Focus

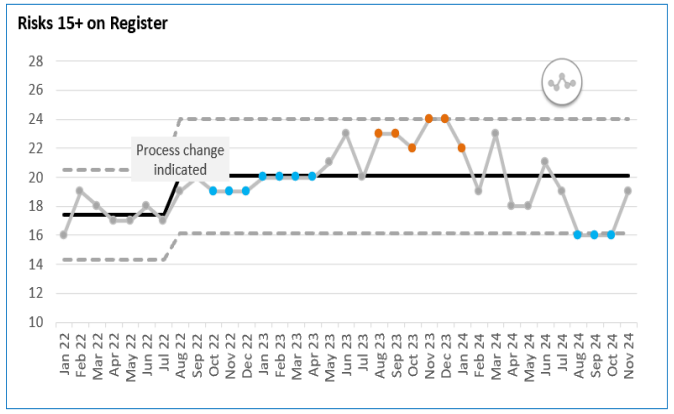
The Learning from Death process changed on the 11 November 2024. Deaths will now be selected against a clear set of criteria set out in the updated Learning from Deaths Policy – the aim is to ensure a sample size of circa 30% of total deaths. This will be monitored and reported down to consultant level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

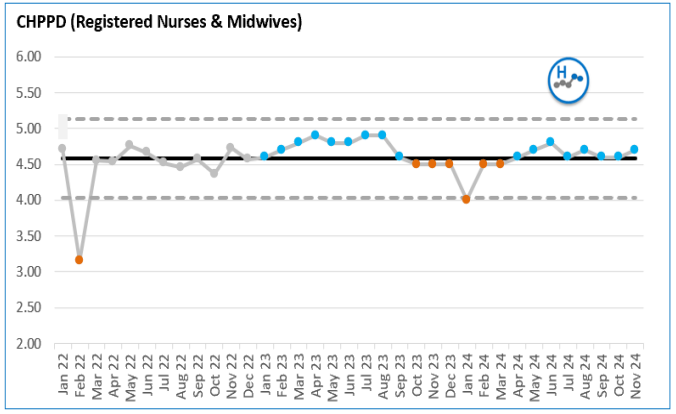
It is essential that care groups enable care group mortality processes. It is also vital that they are appropriately represented at trust wide Mortality Steering Group (MSG) and submit reports in an alert, advise assure framework.

Quality (7) – Well Led









Performance

- November 2024 care hours per patient day (CHPPD) for registered nurses and midwives combined is 4.7. Guidance for organisational level CHPPD for registered nurses and midwives advises this should be >3.
- The Red Flag data for November was 30 raised in month. 47% (14) were raised due to challenges in the provision of enhanced care for patients, 20% (6) were attributed to delays in delivering fundamental care and 10% (3) reported a RN shortfall of more than 8 hours on a shift. 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 94.8% for November 2024.

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 change was introduced in October and has resulted in a significant increase in risks rated 12.
- Risks rated 15-25 now approved at TMG.

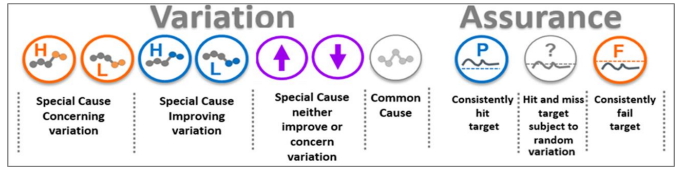
Safe Staffing (Rota Fill Rates and CHPPD) - Total (Day & Night Combined) November 2024/25

Hospital Site name	Patient Count	Registered Nurses/Midwives			
		Total monthly planned staff hours	Total monthly actual staff hours	Fill Rate %	CHPPD
Poole Hospital	15414	83397.2	78075.4	93.6%	5.1
Bournemouth & Christchurch	16505	75298.1	72349.4	96.1%	4.4
UHD Total	31919	158695.3	150424.8	94.8%	4.7

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	Nov 24	34.30	-			37.60	31.73	43.47
Patient Safety Incidents (Moderate +) per 1,000 beddays - Closed only	Nov 24	0.30	-			0.39	0.03	0.76
Medication Incidents (All) per 1,000 beddays	Nov 24	3.60	-			5.00	3.17	6.83
Associated Pressure Ulcers (Cat 3 & 4) per 1,000 beddays	Nov 24	0.40	-			0.29	-0.01	0.59
Inpatient Falls (Moderate +) per 1,000 beddays	Nov 24	0.20	-			0.16	-0.07	0.38
Hospital Associated Infections - MRSA	Nov 24	0	-			0	-1	2
Hospital Associated Infections - MSSA	Nov 24	3	-			4	-1	9
Hospital Associated Infections - C Diff	Nov 24	10	-			8	-1	16
Hospital Associated Infections - E Coli	Nov 24	12	-			9	-2	19
Hospital Associated Infections - Kleb	Nov 24	3	-			4	-3	11
Hospital Associated Infections - Pseudo	Nov 24	2	-			1	-2	5
Hand Hygiene Compliance	Nov 24	96.2%	-	L		96.7%	94.6%	98.9%
Infection Control Mandatory Training Compliance	Nov 24	89.6%	-	H		88.8%	87.8%	89.8%
Friends & Family Test	Nov 24	94.2%	-	H		92.1%	88.8%	95.5%
Complaints Received	Nov 24	63	-			66	38	94
Complaint Response Rate (Grade Based Target)	Nov 24	42%	-			44%	17%	71%
Mixed Sex Accommodation Breaches	Nov 24	11	-	H		9	-12	30
HSMR In Month - UHD (Source: HED)	Aug 24	91.90	100.00		?	106.93	87.07	126.78
Deaths Within 36hrs of Admission	Nov 24	32	-			34	12	56
Deaths Within Readmission Spell (5 day readmission)	Nov 24	18	-			21	8	35
Risks 12+ on Register	Nov 24	68	-	H		42	33	51
Risks 15+ on Register	Nov 24	19	-			20	16	24
Red Flags Raised	Nov 24	30	-	L		53	7	98
CHPPD (Registered Nurses & Midwives)	Nov 24	4.70	-	H		4.58	4.03	5.14
			-					



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: There were 0 incidents in November 2024 that have been escalated for Clinical Incident Reviews in line with PSIRF or PMRT (MBRRACE). **MNSI** There were no new MNSI cases in November.	**Patient Safety Incident Response Framework** (PSIRF) PSIRF is being implemented in maternity and our top 3 areas identified for thematic reviews are 1. Stillbirth 2. Term admissions to NICU - ongoing action plan. 3. PPH greater than 1.5 liters initial quality improvement commenced. **Safety champions reviews this month:** • Safety champions report • ATAIN Q2 report • Discussion regarding elective caesarean section service	**CQC action plan –** **Assure**: Action Plan now closed as completed. **Maternity incentive scheme year 6 –** MIS standards assessment by ICB and auditors – final standards to be verified but SBL assessment and training standards in November data now met so expected to meet full compliance with MIS. **Assure**: **Insight and 3-year delivery plan** End of year 1 report presented and actions for year 2 in place. **Assure:** **MSSP exit criteria.** All actions progressing and reset and review of progress by National team in and now in the sustainable phase. 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
Total number of bookings	Nov 24	347			
% of bookings booked <10 Weeks	Nov 24	57.6%	65%		
% of women smoking at booking	Nov 24	8.65%			
% of women with a CO measurement at time of booking	Nov 24	99.4%	95%		
% of women placed on a continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks' gestation	Nov 24	4.11%			
% of Black and Asian women placed on a continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks' gestation	Nov 24	33.3%			
% of women (IMD-1) placed on a continuity of carer pathway	Nov 24	9.09%			
% of women with a CO measurement at time of 36 weeks gestation	Nov 24	77.9%	95%		
% of women smoking at delivery (previous month)	Nov 24	8.72%	6%		
Rate per 1,000 women with PPH 1500ml or more (previous 3 months aggregated)	Nov 24	42.0	30		
Rate per 1,000 women with 3rd/4th degree tears (current three months aggregated)	Nov 24	16.8	28		
Number of women delivered (all births)	Nov 24	297			
Number of women delivered (unregistrable)	Nov 24	7			
Number of women delivered (multiple births where at least one unregistrable and one registrable)	Nov 24	0			
Number of babies born	Nov 24	303			
No. of registrable babies born	Nov 24	296			
% of babies <3rd birthweight centile, born >37+6 weeks	Nov 24	100%			
Number of still births	Nov 24	0			
Annual rate of stillbirths per 1,000 births - rolling 12mths	Nov 24	2.13	2.5		
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.	Nov 24	9			
Rate per 1,000 births which are preterm (< 37 week's gestation)	Nov 24	101			
% of term babies admitted to NNU	Nov 24	2.99%	5%		
Number of registrable livebirth babies who died < 28 days from birth	Nov 24	1			
Rate per 1,000 registerable live birth babies who died <28 days from birth	Nov 24	3.38			
% of babies receiving breast milk at first feed	Nov 24	78.3%	72%		
% of babies receiving breast milk at discharge from midwifery 10-28 days	Nov 24	57.4%			
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)	Nov 24	0			
Number of women admitted to ITU associated with birth up to 28 days post-natal (any birth, not including any other trust birth)	Nov 24	2			
Apgar score < 7 at 5 mins - term singletons (current three months)	Nov 24	24	13		
Number of incidents of Hypoxic-Ischemic Encephalopathy (HIE) in babies	Nov 24	0			

Data and Target

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

Performance

Areas to note:

- A working party will review the number of readmitted babies within 30 days.
- MIS standards assessment by ICB and auditors – final standards to be verified but SBL assessment and training standards in November data now met so expected to meet full compliance with MIS.

Key Areas of Focus

BEACH move: Staff consultation launched on 4th November continues until 18th December.

Term admissions to NICU: ATAIN levels have reduced for 2nd month in a row and OASI injuries have remained low for 5 consecutive months.

Surveys: 2024 CQC Maternity Survey results published, and the results show continuing improvement since 2022.

Our People

Tina Ricketts
Chief People Officer

Operational Leads:
Irene Mardon - Deputy Chief People Officer

Committees:
People and Culture Committee

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	9030.6				
	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				
	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				
	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	9963.8				
	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

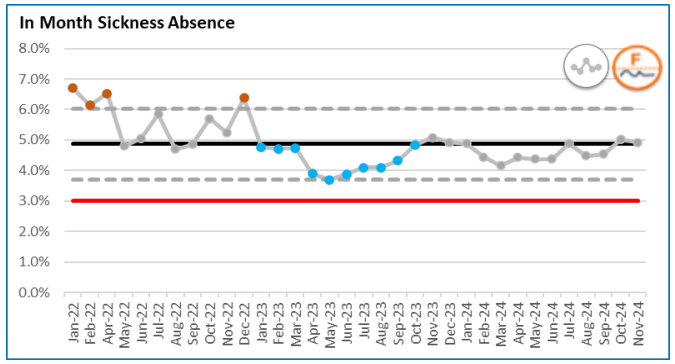
Operational Plan Monitoring

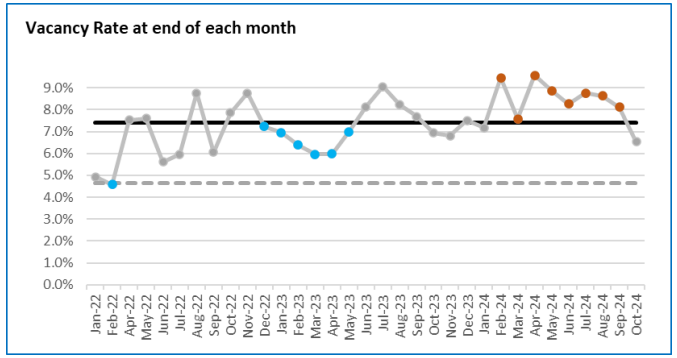
This table shows the performance against the workforce plan as at month 8. It can be seen that we are above plan by 140.9 wte for substantive staff.

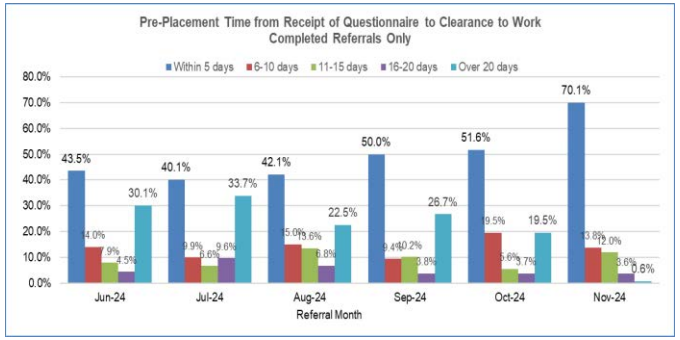
Alignment to our newly qualified staff starting and a reduction in bank usage is now visible and can be seen by the reduction in bank staff in month 8

We remain above plan for bank WTE which is being driven by the use of Healthcare Support Workers for the specialing of patients.

Well Led - Workforce (2)







Performance

Sickness Absence and Wellbeing

- In month sickness absence for November 2024 was 4.92% which is consistent with the rates we are seeing this year. The latest rolling 12-month rate is 4.63% which is similar to the previous month and demonstrates normal variation.
- Self-referrals to the Psychological Support and Counselling Service (PSC) averaged 11 per week in November representing a marked decrease from October. The primary reasons reported for referral remain high stress (95%) and depression (50%) with 18% reported as signed-off work by their GP (this last point being a marked increase since October). Waiting times for an initial assessment are now back within the target of less than 2 weeks. Completed feedback indicates 64% 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.

Vacancy Rate

- The vacancy rate is reported a month in arrears to allow for reconciliation with the ledger. The latest vacancy position is 6.5% (as at end of October) which is a decrease from the 8.1% in September.
- In November 2024, a total of 4209 applications were received for 284 jobs advertised. A high number of candidates were offered posts in month, 307 in total, which is the result of the number of newly qualified staff being recruited at this time of year. The number of new starters during the month was steady, 158 in total, with half of those being internal appointments.

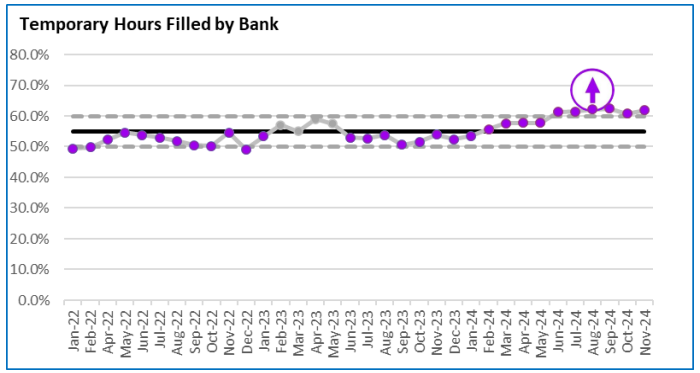
Healthcare Support Worker Recruitment

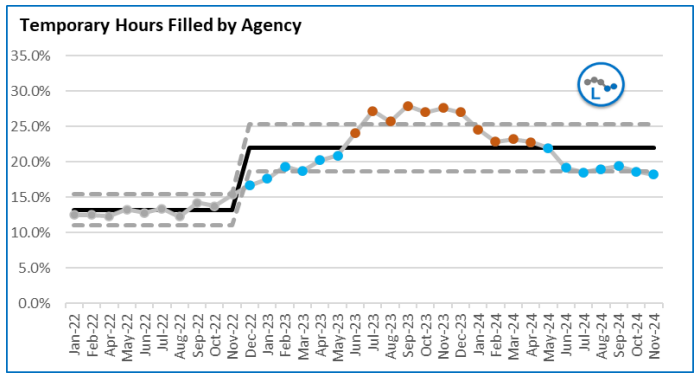
- We continue to monitor our Healthcare Support Worker vacancies, Trust recruitment activity for November was 12%, (124 wte vacancies) and shows month on month improvement.

Occupational Health and Staff Vaccinations

- Covid and Flu vaccinations continue until 31st January 2025
- Referrals in staff MSK service remain high. The current wait for urgent referrals is 11 days and 43 days for routine referrals.
- The OH clinical team have worked together to reduce the waiting times for management referrals to 2 weeks.

Well Led - Workforce (3)



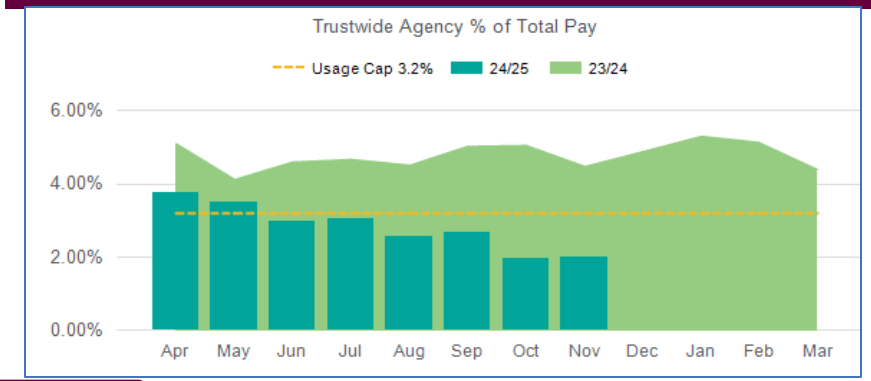


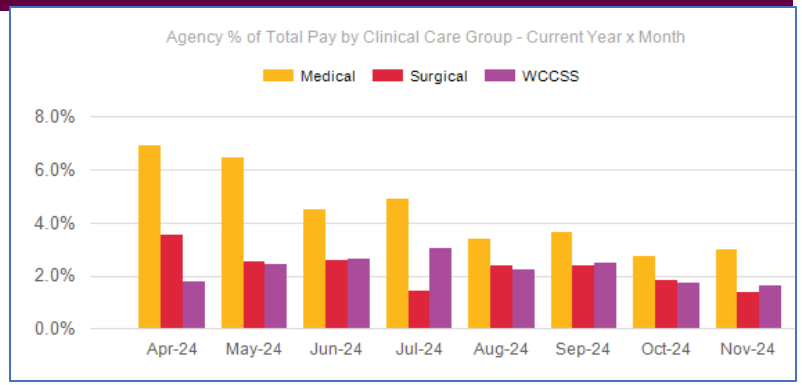
Performance

- We have seen a small increase in in-month agency spend from 1.94% in Month 7 to 1.99% in Month 8. This remains under the national 3.2% target. Year to date agency spend is 2.77%.
- In month agency spend has seen an increase in the Medical Care Group from 2.76% (October 2024) to 3.0% (November 2024) , the Surgical Care Group has seen a decrease 1.8% to 1.4%. Women's, Children, Cancer and Support Services Care Group has decreased from 1.72% to 1.6%.
- The Trust has continued to report zero off-framework agency usage for M8

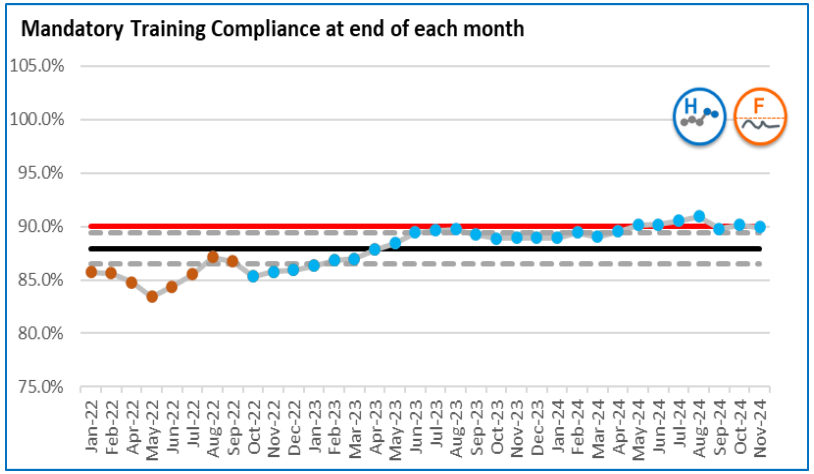
- The Trust currently engages with over 30 Allied Health Professional (AHP) agency workers who cover roles mainly within Pharmacy, Biomedical Sciences, Radiology, and Theatres. As part on the Trust's ongoing drive towards agency price cap compliance and in collaboration with the Southwest region, work is now commencing to bring the supply of these workers into price cap compliance with an expected implementation date of 1st January 2025

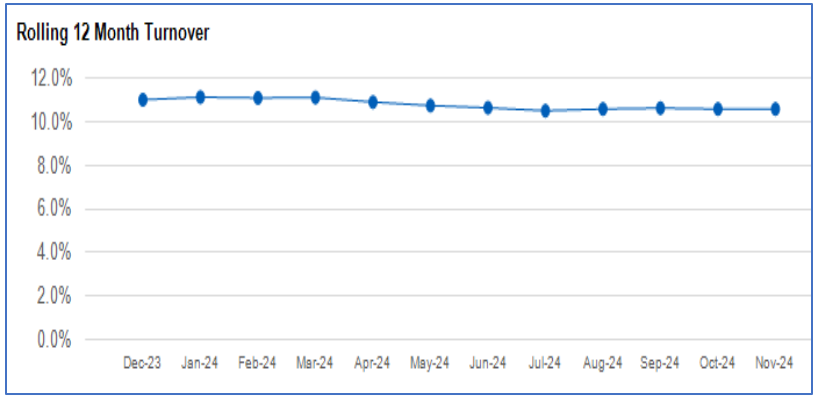
- High-cost locums update – the Trust has achieved 67% compliance of the Southwest regional medical locum agency rate card which was implemented on 1st September 2024, with appropriate 'flight paths' either being formulated or in place for removal or rate reduction of non-compliant locum supply.





Well Led - Workforce (4)





Performance

Mandatory Training

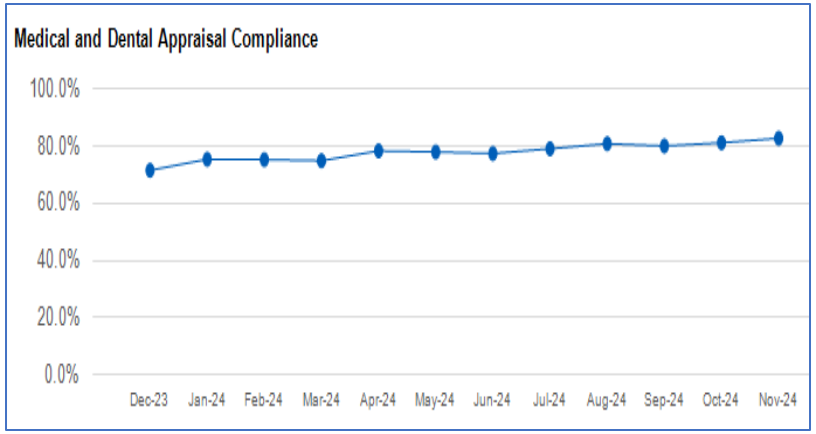
- Mandatory Training compliance has decreased slightly to 89.9% as at end of November 2024

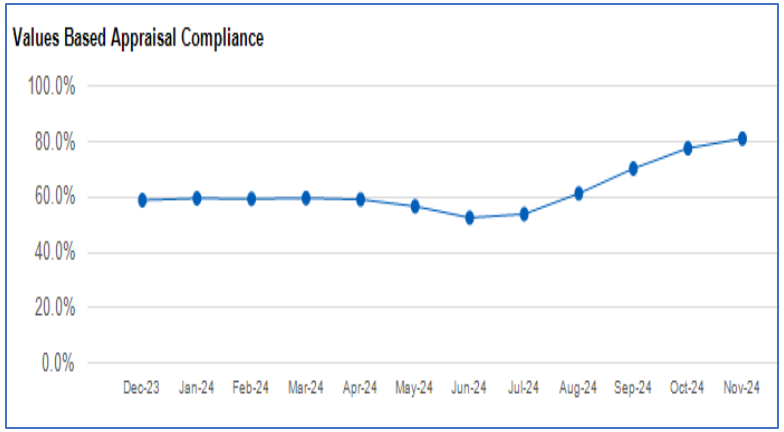
Turnover

- The rolling 12 month staff turnover rate (excluding fixed term temp) is at 10.6% as at end of November 2024, which is in line with previous month.

Appraisal

- Non-medical appraisal compliance has increased since last month from 78.2% at end of October, to 81.2% at end of November. This is now using a rolling 12 month rolling period. Medical and Dental compliance is at 82.8% which is an increase on last month at 81.0%.

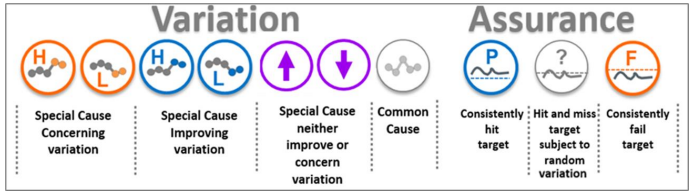




Performance at a glance
Well Led - Key Performance Indicator

UHD Workforce

KPI	Latest month	Actual	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Vacancy Rate at end of each month	Oct 24	6.5%	-			7.4%	4.7%	10.2%
In Month Sickness Absence	Nov 24	4.9%	3.0%		F	4.9%	3.7%	6.0%
Mandatory Training Compliance at end of each month	Nov 24	89.9%	90.0%	H	F	87.9%	86.5%	89.4%
Temporary Hours Filled by Bank	Nov 24	61.8%	-			55.0%	50.1%	60.0%
Temporary Hours Filled by Agency	Nov 24	18.2%	-	L		22.0%	18.7%	25.4%
Agency Pay as Proportion of Total Pay	Nov 24	2.0%		L	?	4.2%	2.8%	5.7%



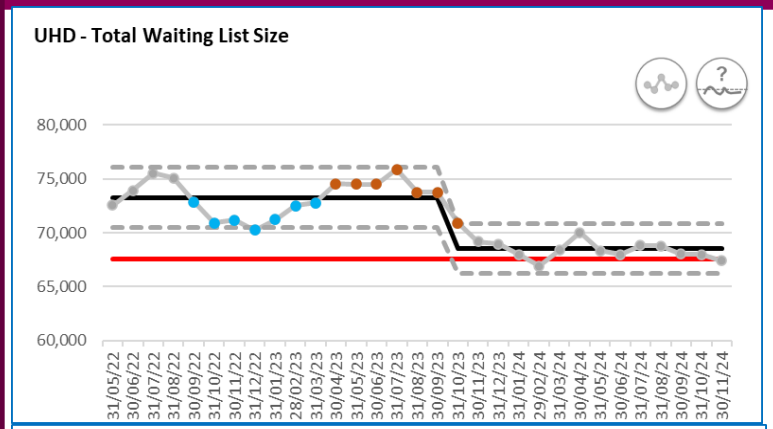
Population Health and System Working

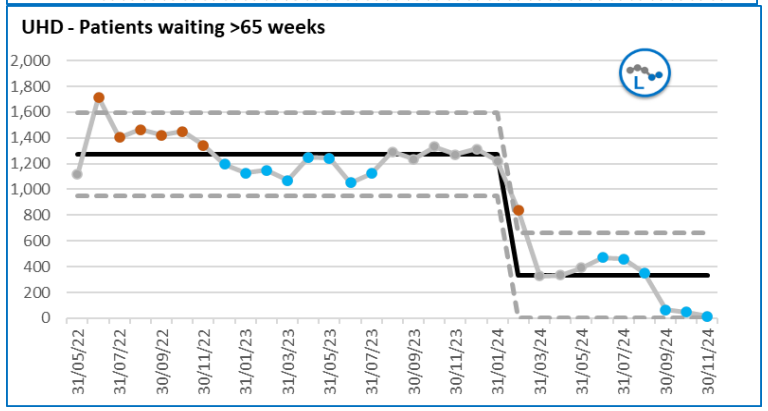
Mark Mould
Chief Operating Officer

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

Responsive – (Elective)
Referral to Treatment (RTT)





	Standard	UHD	% of pathways with a DTA
Referral To Treatment			
18 week performance %	92%	61.1%	
Waiting list size (and trajectory)	67,095	67,413	21%
Waiting List size % variance compared to trajectory		0.5%	
No. patients waiting 26+ weeks		15,544	34%
No. patients waiting 40+ weeks		6,437	42%
No. patients waiting 52+ weeks (and % of waiting list)	3.2%	2,172	51%
No. patients waiting 65+ weeks (and % of waiting list)	0.0%	16	88%
No. patients waiting 78+ weeks (and % of waiting list)	0.0%	0	0%
% of Admitted pathways with a P code		98.04%	

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.

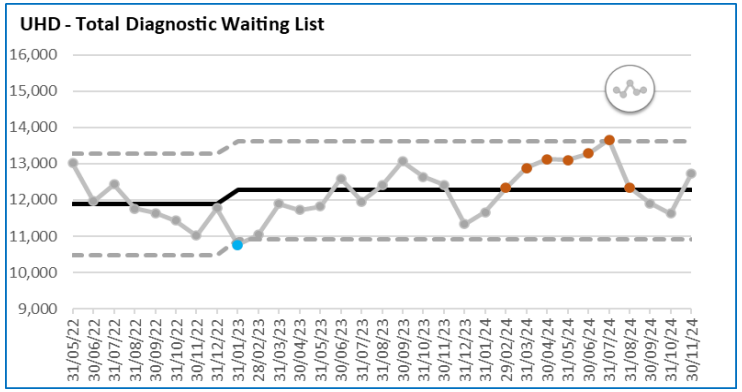
Performance

- The Referral to Treatment (RTT) waiting list size shows a decrease in November 2024 (-580) to 67,413 and the variation to the operational planning trajectory (67,095) has also reduced to 0.5% above trajectory. The target waiting list is within current process control limits; indicating it is achievable.
- The Dorset Integrated Care System (ICS) elective activity data indicates UHD delivered 108.6% (value weight activity year to date) in November compared to the 2019/20 baseline period; this is above the threshold (103.7%), which allows access to elective recovery funding. The Trust is also achieving its operational plan year to date trajectory (108.2%).
- Zero >78 week waits on an RTT pathway have been sustained in November . Waits over 65-weeks decreased to 16 patients. Our ambition remains to eliminate >65 week waits at the end of December except for 12 patients who are waiting material for corneal graft transplants or require surgical mesh to undergo colorectal surgery (supplier shortage). As supply issues are resolved the forecast position for December will reduce.
- Mutual aid is being provided to DCH in Orthopaedics to support deliver of the Integrated Care System-wide longwaiter trajectory.
- Waits greater than 52 weeks are 457 below the operational plan trajectory (2,629).

Key Areas of Focus

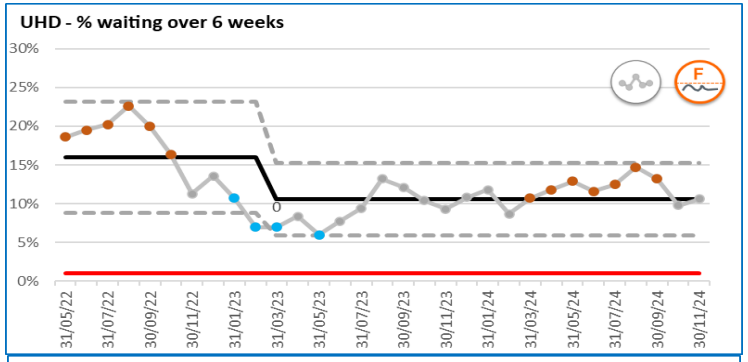
- Utilise UHD & ICB contract capacity with independent sector providers for treatment of long waiters.
- Maintaining elective activity rates above the 2019/20 baseline, increasing to above 109% by March 2025.
- Prioritised booking for all patients in the December and January 65 week cohort into capacity in December for outpatient slots and where possible theatre capacity.
- Increasing productivity within core capacity, including reducing missed appointments (DNAs) and improving theatre and outpatient session utilisation rates.
- Develop business cases for longer term sustainable capacity solutions for key specialities: Dermatology, gynaecology, ENT and Colorectal.

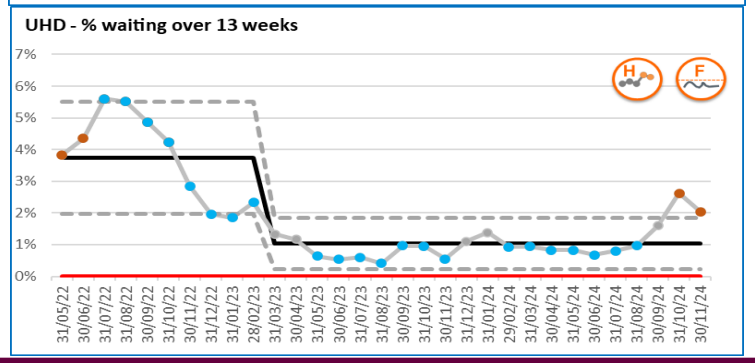
Responsive – (Elective) Diagnostic Waits



Diagnostic Performance (DM01)

% of >6 week performance	*(6+ Weeks / Total)*	1%	1352/12736	10.6%





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

November 2024 performance reduced to 10.6% compared with 9.8% at the end of October 2024.
Performance remains within the upper and lower process control limits; however further improvement is required to meet the 1% target.
There are currently 260 patients waiting more than 13 weeks for a diagnostic test; the majority of these (222) are Neurophysiology patients. Booking these long waiting patients are the focus for all modalities. Overall waiting list is 12,736 patients.

Endoscopy performance moved to 8.3% at the end of November (5.9% at the end of October).

- 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 due to CDC build delays.

Echocardiography performance has improved to 6.3% in November (from 8.8% in October).

- Additional Heart Failure clinic capacity from a visiting GP is now in place. However, there are ongoing vacancy gaps and sickness reducing capacity and a significant increase in referral numbers.

Neurophysiology performance has moved to 50.8% in November (from 46.3% in October).

- 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 moved to 3.8% in November (from 2.5% in October).

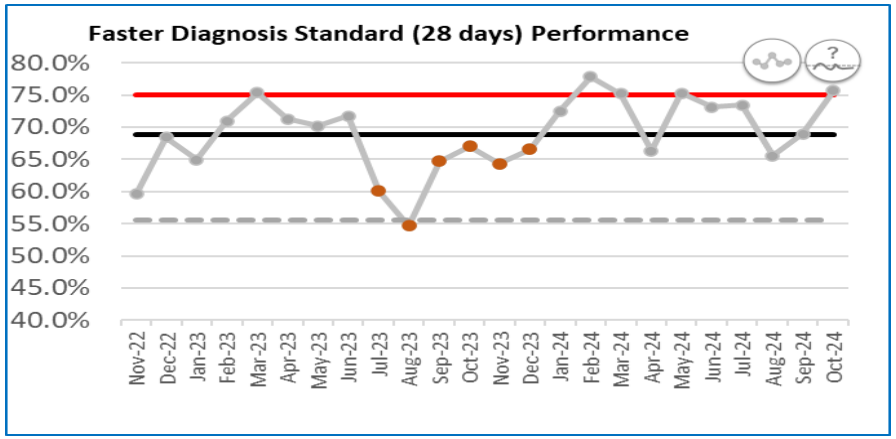
- Target is not being achieved predominately due to sustained increase in number of in-patient MRI referrals.

Key Areas of Focus

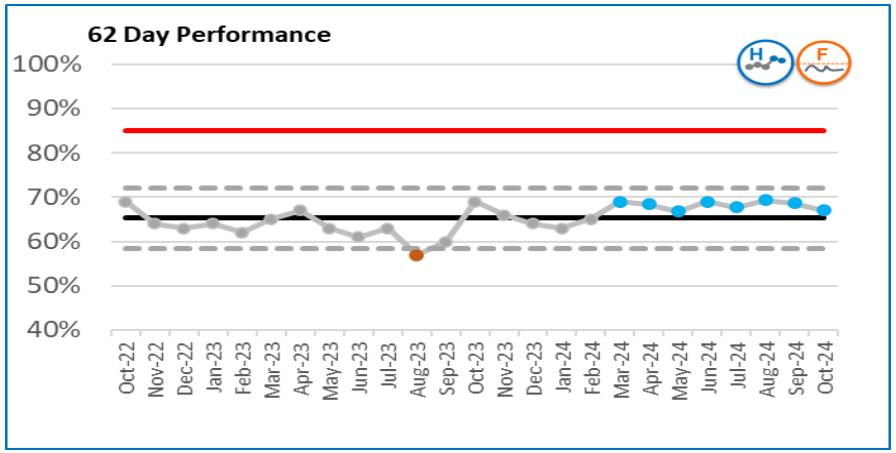
- **Endoscopy:** Additional capacity added from July for rest of the financial year.
- **Echocardiography:** Recovering the stress echo backlog; down to 4 week wait for standard diagnostic echo now.
- **Neurophysiology**: Haven Medical outsourcing to support recovery now commenced, at a rate of 4 lists per week (20 patients). Consultant interview scheduled for January 2025, New physiologist commenced early December.
- **Radiology**: Further additional paediatric MRI (General Anaesthetic) lists added to clear paediatric backlog. There are 279 MRI patients waiting longer than 6 weeks at the end of November; however, we are converting CDC CT activity to MRI which will reduce the backlog over the next couple of months.
- **Cardiology** have provided some additional sessions with a locum helping to recover the cardiac CT/MRI position (currently down to 10 patients breaching 6 weeks), additional weekend scanning and independent sector provision through ERF.

Responsive (Elective) Cancer FDS & 62 Day Standard

28 Day Faster Diagnosis Standard
(National Target 75.0% & Trust Trajectory 76.0%)
Finalised UHD October Performance (75.6%)



62-Day Standard
(National Target 85%, Trust Trajectory 68.5%)
Finalised UHD October 24 Performance (67%)



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 62-day patients waiting 63 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 October 2024 Performance

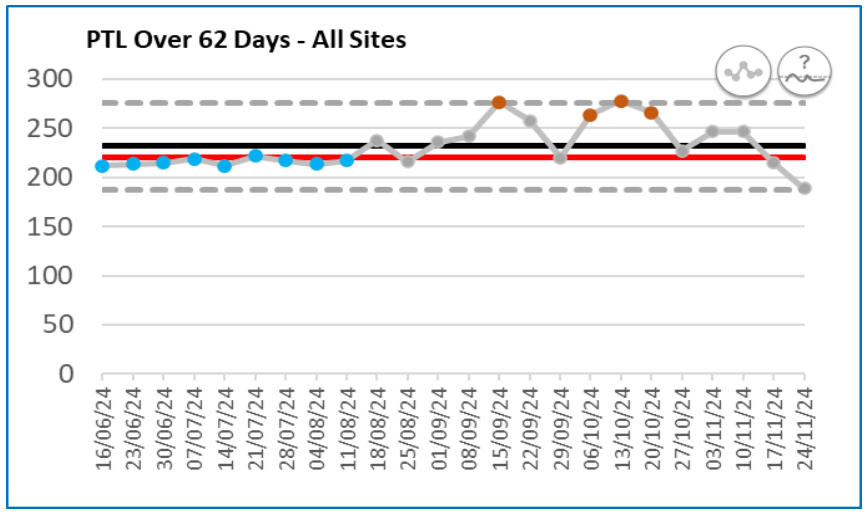
- **28 Day Faster Diagnosis Standard** - Performance in October 2024 increased by 6.6% to 75.6% compared to 69.0% in September 2024. The standard was achieved however performance was 0.4% below the Trust trajectory. Nine out of 14 tumour sites achieved the standard including Gynaecology and Skin. Performance remains within the process limits and is showing a level of natural variation.
- **62 Day Standard** - Performance in October 2024 decreased by 1.0% to 67.0% compared to 68.0% in September 2024. The Trust trajectory of 68.5% was not achieved, however, performance has continued to be above the mean for 8 consecutive months showing special cause improvement. The upper process control limit falls below the national standard. This is a recognised national challenge and therefore the Trust has an internal trajectory to meet 70% by March 2025. The main breach reasons in October 2024 were due to capacity challenges at the front end of the pathways and delays to surgical treatments due to capacity along the pathways.
- **31 Day Standard** - Performance in October 2024 increased by 1.7% to 96.2% compared with 94.5% in September 2024. The main breach reasons were due to Skin surgical capacity at Christchurch and surgical capacity for Gynaecology and Urology.
- **Patient Treatment List (PTL) Over 62 Days** - The total number on the PTL over 62 days increased to 227 patients (7 above the 220 Target).

Provisional November 2024 Performance (un-finalised)

- **28 Day Faster Diagnosis Standard -** Performance in November 2024 is currently compliant at 75.2%. Gynaecology and Skin continue to show improving performance in month due to increased 1st OPA capacity.
- **62 Day Standard -** Performance in November 2024 is currently 65.7% against the Trust trajectory of 68.6%. Performance is expected to increase as further treatments are reported, however due to challenges with FDS standard in Q2 the internal Trust trajectory is unlikely to be achieved.
- **31 Day Standard** - Performance in November 2024 is currently 95.4% which is 0.6% below the standard. The primary challenge is Skin surgical capacity at Christchurch.
- **Patient Treatment List (PTL) Over 62 Days** - The month end position for November decreased to 189 patients over 62 days (31 below the 220 Target).

Responsive (Elective)
Cancer Over 62 Day Breaches

Over 62 Day PTL (Target November: 220)
Finalised UHD November Performance: 189



High Level Performance Indicators

Cancer Standards	Standard	Final	Provisional
		Oct-24	Nov-24
28 Day Faster Diagnosis Standard	75%	75.6%	75.2%
31 Day Standard	96%	96.2%	95.4%
62 Day Standard	85%	67.0%	65.7%
PTL Over 62 Days	220	227	189

Key Areas of Focus

In 2024/25 the focus for Cancer Performance has returned to the 3 main National Standards (28 Day, 31 Day and 62 Day). UHD also remains committed to maintaining the over 62-day PTL under 220. The national standard for 62 Day performance is 85%. However, in 24/25, the operational planning target is to meet 70% by March 25.

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

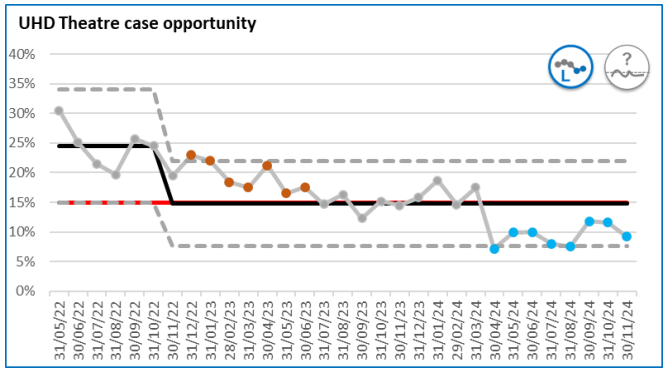
Breast:
- Recovery of 28D FDS performance by January 2025.
- Securing additional radiology capacity to enable delivery of one stop fast track clinics to address the increasing number of patients awaiting a first OPA

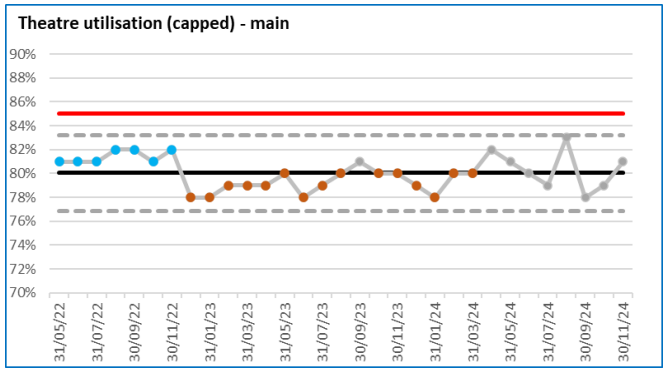
Skin:
- Sustaining recovery of performance in 28D FDS over Christmas period.
- Additional insourcing activity continues to accommodate the year-on-year increase in referrals and associated need for surgical interventions with contract monitoring arrangements in place to ensure the insourcing provider remains able to meet the demands of the service.
- Increasing the use of the Skin Analytics AI pilot to see patients faster.
- Aligning site specific waiting lists for treatment to ensure patients are treated in chronological order.
- Development of a business case to support the future workforce requirements and sustainable delivery.

Colorectal:
- Sustaining improvements in 28 Day FDS over the Christmas period.
- Agreement and implementation of staffing resource plan with Wessex Cancer Alliance (WCA) following the completion of initial Pathway Analyser
- Further Pathway Analyser work in December 24 with WCA to identify opportunities to increase 62 Day performance in line with Wessex-wide service provision.

Iron Deficiency Anaemia (IDA):
- Maintaining prioritisation of clinical reviews to move patients to 'straight to test' where appropriate.

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

Data validation is completed across both UHD theatre sites and Capped Utilisation has been adjusted accordingly. Reporting has been aligned to the Model Hospital data collection and adjustments are reflective of this. This has shown an improvement in capped utilisation, which has been backdated in the reported position in 2024/25.

Performance

- Capped theatre utilisation in November is 82% (81.6%), which is an improvement of 3% from October's position.
- Cancelations on the day and equipment/SSD challenges, remain the two largest constraining factors on meeting the target, resulting in cases per session falling slightly in month from 3.9 to 3.5 in month. The Trust remains above the national target of 2.3 cases per session (exception, 4 cases per 4 hours for arthroplasty).
- Overall Performance is above the operational plan trajectory of 79.12% with a plan to meet 85% target by March 2025.
- Consistent improvements have been delivered by the surgical directorate - achieving in excess of 85% utilisation, at 87% across all sub specialities with Upper Gastroenterology achieving 90%.
- Improved list planning has reduced early finishes, however further improvements are required to support the trajectory being achieved
- Latest published Daycase (BADS) rate (August 2024), demonstrated UHD achieved 86.2%, remaining above the 85% target

Other notable improvements within theatres and theatre planning include:

Surgical day case patients converted to inpatients remains below national target at 6%,
Head & Neck – ENT and Ophthalmology increased utilisation in excess of 82%
Orthopaedics – Increased utilisation to 76%

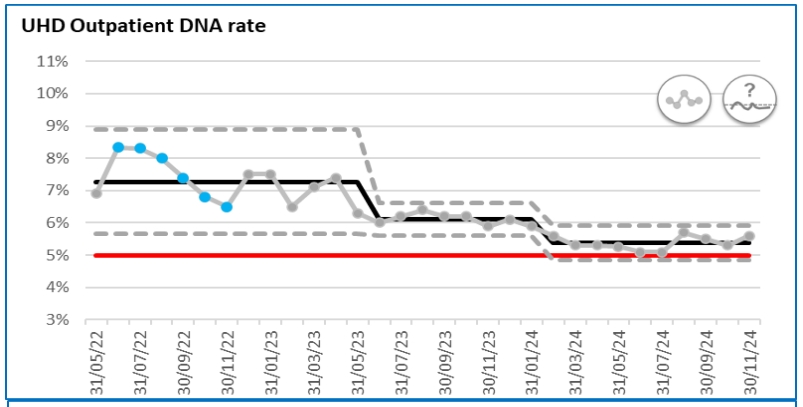
Key Areas of Focus

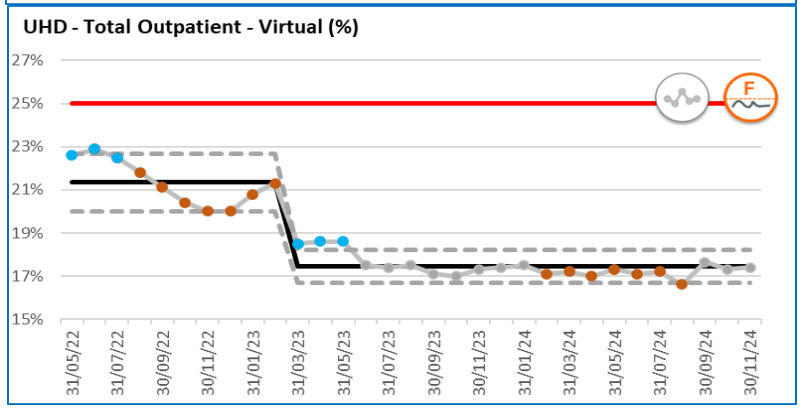
Further work is underway to unlock case opportunity and increase utilisation across all specialities. Key areas of focus

- Speciality activity - focusing on individual speciality level trajectories to meet March 2025 target
- Robust Theatre planning – locking lists at 2 weeks,
- Golden patient, - speciality specific - early identification, robust pre-operative assessment in a timely manner, and clinician's decision shared with anaesthetic colleagues.
- Sterile Services Department (SSD) challenges – working group devised to deliver improvement including decrease in non-compliance, and supporting delivery of SOP and processes to ensure equipment is available when required. Programme of work for new washer/sterilisers also confirmed, however work not due to commence until summer 2025.

Responsive (Elective) Outpatients

		Standard	This Year	Trust Perf
Referral Rates (MRR Return)				
GP Referral Rate year on year		-0.5%	80734	-3.3%
Total Referrals Rate year on year		-0.5%	124860	-1.2%
Outpatient metrics				
Overdue Follow Up Appointments (Cons-Led Only)				25982
New Attendances				22308
Follow-Up Attendances				33028
% DNA Rate	*(Total DNAs / New & Flup Atts)*	5%	3267 / 55336	5.6%
Hospital cancellation rate	*(Hospital Canx / Total Booked Appts)*		12894 / 79315	16.3%
Patient cancellation rate	*(Patient Canx / Total Booked Appts)*		7818 / 79315	9.9%
Reduction in face to face attendances (acute only)				
% telemed/video attendances	*(Total Non F-F / Total Atts)*	25%	9633 / 55336	17.4%





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 November is currently at 5.6% which is a decrease in performance of 0.3% in month. It remains within normal variation and the process control limits indicate the target can be met within existing processes. A six-month pilot using a DNA predictor tool has commenced in the Trust; this will identify people with a high likelihood of a DNA and enable teams to intervene before the appointment date.
- Switch on of services to appointment text reminders is now in place across the Trust and the percentage live will be monitored to ensure it remains above 97%
- 55.4% of patient communication in November was digital.
- The number of patients overdue their target date for a follow up appointment increased by 324 in November. Extension of the overdue follow up reduction project has been rolled out and is expected to impact in December 2024.
- Hospital outpatient clinic cancellation numbers remain high and are being monitored with a focus on reducing cancellations with less than 6 weeks' notice
- E-Outcomes has been launched in the Surgical Care Group
- Scoping of future outpatient clinic capacity requirements underway (to support UHD reconfiguration plans)

Key Areas of Focus

- A review of the National Outpatient Guidelines is underway to align the Trust's Outpatient programme to the national publication and identify improvement opportunities.
- Deliver against the increasing slot utilisation improvement project, which is now a corporate patient first project under the umbrella of the planned care improvement programme.
- Identify specialty areas to participate in DNA predictor project based on best opportunities for improvement
- Continue to deliver Process Mining Interventions and monitor impacts.
- Continue with eOutcomes roll out to Medical and WCCSS Care Groups
- Better understand booking process issues to maximise slot utilisation and identify opportunities to digitalise and automate processes where possible, to mitigate recurrent workforce gaps in administrative teams.
- Develop A3 collaboratively with all stakeholders to reduce short notice requests for additional/reinstated clinics

Responsive - (Elective) Screening Programmes

Breast Screening

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

BREAST SCREENING	STANDARD	ACHIEVED
Round Length within 36 months	90.00%	99%
Screening to first offered assessment appointment within 3 weeks	98.00%	86%
Screening to Normal Results within 14 days	95.00%	99%
Longest Wait Time (Months)	36	36
UPTAKE – QTR 2 (Jul - Sept 24)	70%	57.6%

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

Performance:
- Three monthly targets have been successfully met, the screen to assessment target is now being breached due to reduced assessment clinic availability.

Underlying issues:
- Screen to assessment target has breached this month due to lack of clinic assessment availability (Radiology staffing shortages).
- Radiology staff pressures are increasing due to retirement, resignation, sickness and maternity leave as well as vacancies. This is on the risk register with a risk score of 20. The screen to assessment target is now being breached due to reduced assessment clinic availability.
- 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 communicate better with reminders to clients.

Actions:
- Screening throughput has increased as radiography staffing is now more robust. The round length is now a tighter target due to a slow rate of screening over the year until now. Some breaches are expected in December and January.
- •To effectively manage and maintain the round length target and minimise any future breaches an open appointment invitation process is in operation. It has been announced that using the open appointment invitation method to manage round pressures and breaches is to cease. All services are expected to return to timed invitations from April 25. This will present us with some challenges in maintaining round length without utilising smart clinics.

Bowel Screening

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

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

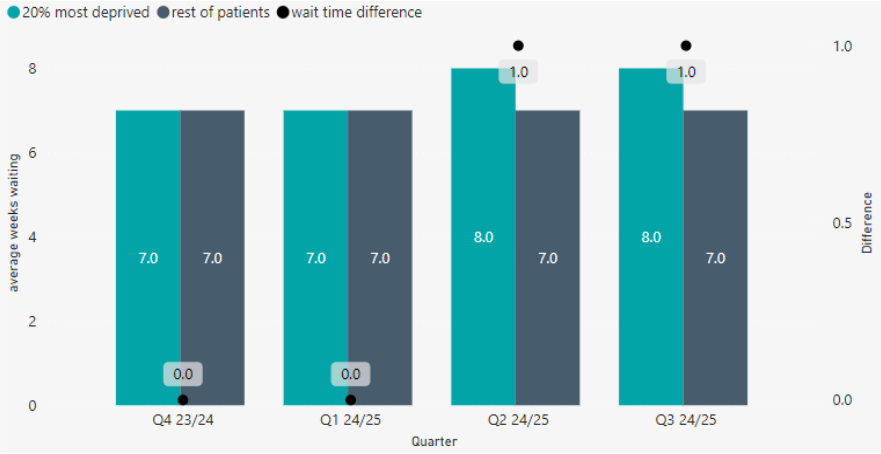
Performance:
- Specialist Screening Practitioner (SSP) Clinic Wait Standard: This standard continues to be maintained at 100%.
- Diagnostic Wait Standard: This standard was delivered at 100% in November 2024.

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 +.

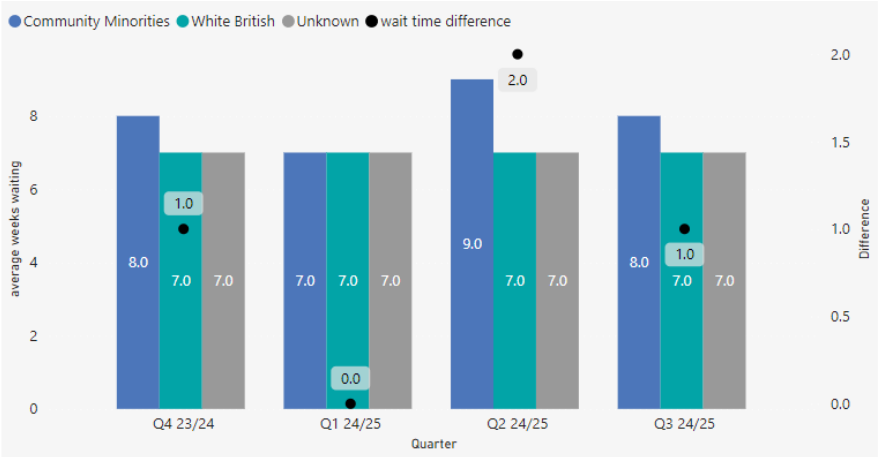
Actions:
- Future planning needed for the future fit@80 roll out. This may increase demand by up to 40% across the system. SSP training needed but awaiting date and funding. Likely roll out April 2026.
- Deliver plans with Dorset County to use additional insourcing capacity in 24/25
- Support accreditation process for 3 potential new screeners and 1 new aspirant screener identified in October from UHD.

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 3 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 continues to show a slight increase in variation by one week compared to people from IMD 3-10. Analysing the same data by age band continues to identify 5 weeks variation for children (<18 yrs). This will remain under review.

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 one week's variation between patients within community minority groups and white British populations in Quarter 3. <18-year-olds from community minority groups are waiting on average the same number of weeks as white British patients. This is a significant improvement compared to Quarter 1 (variation 8.5 weeks longer).

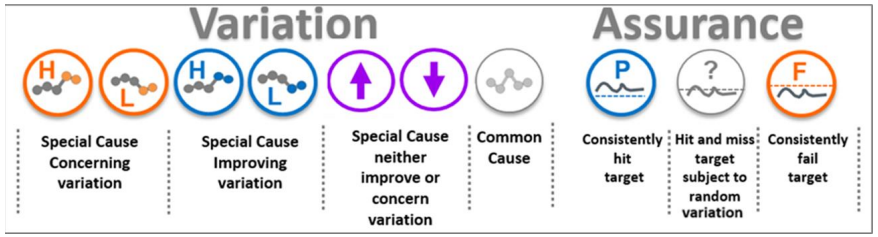
Key Areas of Focus

- 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.
- Commence 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.

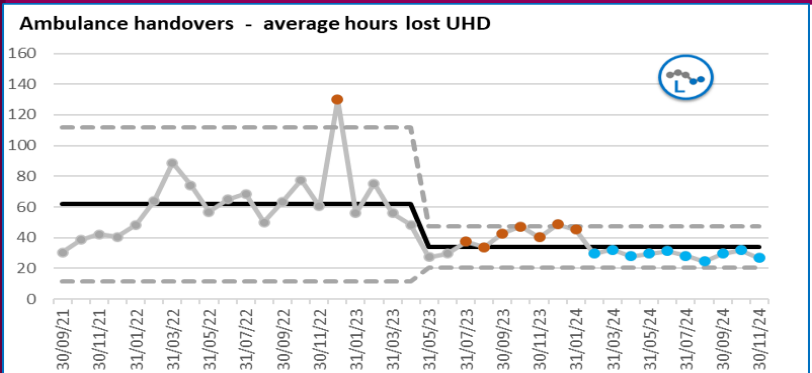
Performance at-a-glance
Responsive (Elective) - Key Performance Indicators Matrix

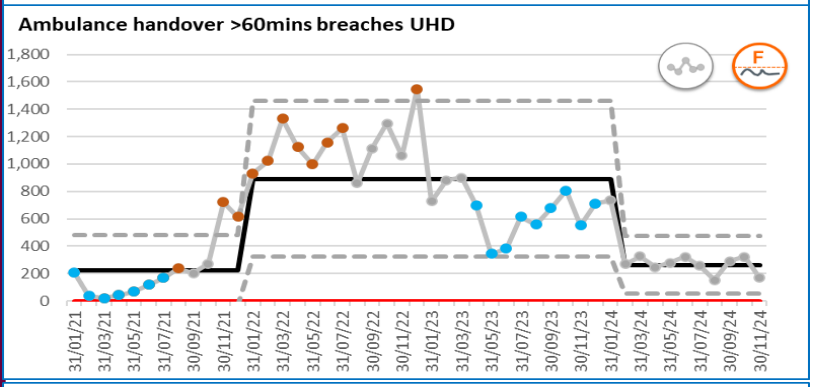
UHD Elective Care

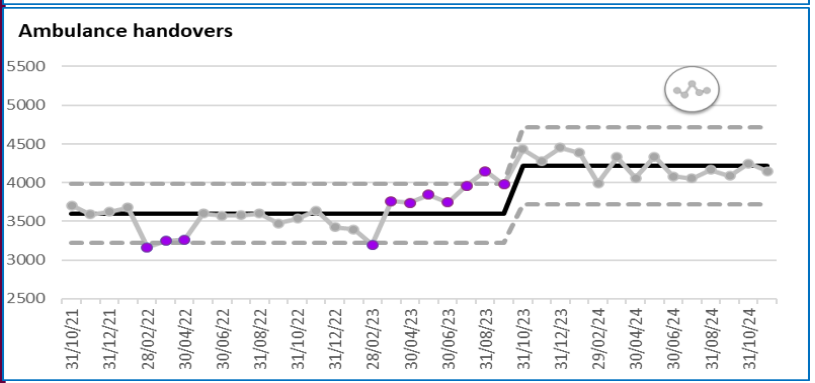
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
UHD - Total Waiting List Size	Nov 24	67413	67548			68549	66216	70883
UHD - Patients waiting >78 weeks	Nov 24	0	0	L	P	0	0	0
UHD - Patients waiting >65 weeks	Nov 24	16	-	L		331	2	659
UHD - Patients waiting >52 weeks	Nov 24	2172	2825	L		2743	2208	3279
UHD - Patients waiting >52 weeks non admitted	Nov 24	1075	0	L	F	1352	1024	1680
UHD - RTT Performance against 18 week standard	Nov 24	61.1%	92.0%		F	61.2%	59.4%	63.1%
UHD - Total Diagnostic Waiting List	Nov 24	12736	-			12273	10926	13620
UHD - % waiting over 6 weeks	Nov 24	10.6%	1.0%		F	10.6%	6.0%	15.2%
UHD - % waiting over 13 weeks	Nov 24	2.0%		H	F	1.0%	0.2%	1.8%
UHD - Faster Diagnosis Standard (FDS) 28 days	Oct 24	75.6%	75.0%			70.5%	58.3%	82.6%
UHD 62 day standard	Oct 24	67.0%		H	F	65.4%	58.3%	72.6%
Trauma Admissions	Nov 24	323	-			372	314	431
% of NOF patients operated on within 36 hrs of admission	Nov 24	72.0%	85.0%			60.6%	33.8%	87.5%
% Outpatient appointments with procedures	Nov 24	17.4%		H		17.3%	15.7%	18.9%
UHD - Total Outpatient - Virtual (%)	Nov 24	17.4%	25.0%		F	17.4%	16.7%	18.2%
UHD Outpatient DNA rate	Nov 24	5.6%	5.0%			5.4%	4.8%	5.9%
Theatre utilisation (capped) - main	Nov 24	81.0%	85.0%		F	80.0%	76.8%	83.2%
UHD Theatre case opportunity	Nov 24	9.2%	15.0%	L		14.8%	7.7%	21.9%



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.

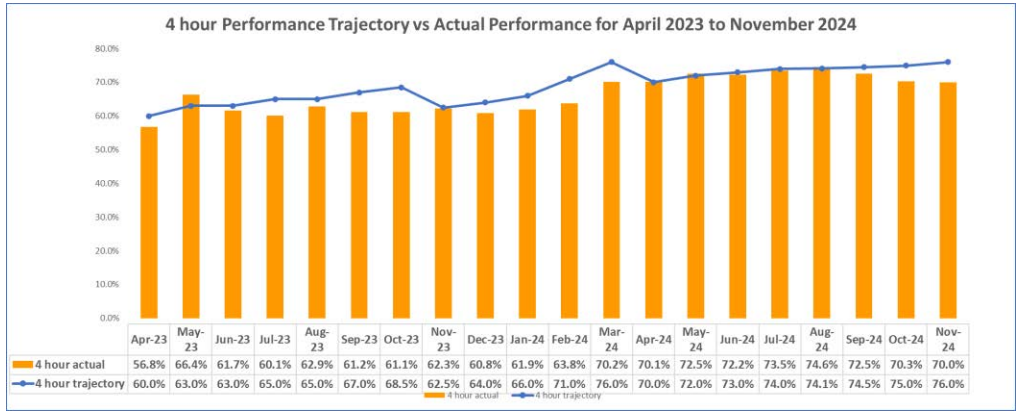
Performance

- The total number of Ambulance handovers remained relatively static in November as compared to October with 4,246 conveyances vs 4,310. Similarly, the rate of ambulance handovers per day were 142 vs 139 in October. Poole Site saw a slight increase from 70 to 74 conveyances per day, whilst Royal Bournemouth Site saw a small drop from 69 to 67 conveyances each day.
- Ambulances waiting longer than 60 minutes dropped significantly to its lowest point since the summer at 170 vs 324 in October and 291 in September. This amounts to only 4 % of total handovers compared to 7.5% in October.
- Average handover duration continues to remain relatively static for the Trust, with Poole seeing a small improvement from 26 minutes to 25, however BH site saw a greater improvement from 35 minutes to 28.5 minutes.
- This continues to be lower than the regional average which remains at circa 60-70 minutes.
- PH continues to see some of the best handover times in the region at number 3 of 18 Trusts and RBH at number 7. Trusts places 1st and 2nd received a third of; or, less than a half of Poole conveyances, respectively.
- Poole saw some improvement for total hours lost. In November, Poole reported a total of 396 hours lost compared to 450 in October. Bournemouth saw a significant improvement reporting 460 lost hours vs 717 in October. This is a total reduction of 311 hours across the sites equating to approximately 10 hours per day.

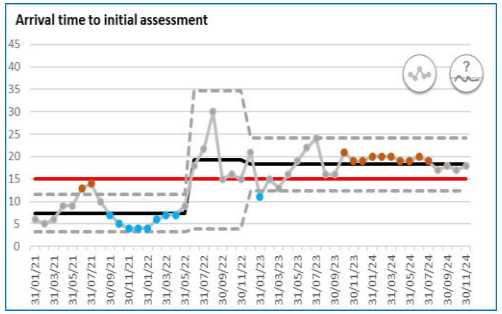
Key Areas of Focus

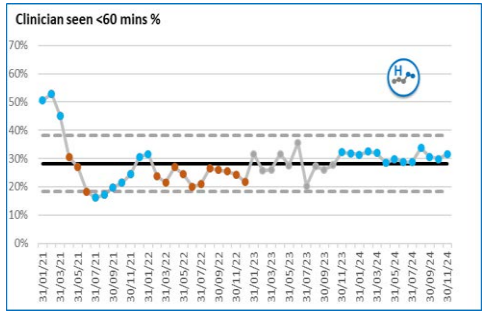
- Key risks: Withdrawal of support from SWAST to support co-horting in non--clinical areas of winter. Also, amendment to HALO function as a recommendation from SWAST to shift to a non-clinical role.
- UHD ownership of XCAD dashboard to improve operational oversight and handover performance. Live UHD Dashboard available for ambulance trusts to review demands each site for attendees allowing to support intelligent onveying
- Review of non-clinical care area provision, currently on risk register with plan to trial “front door flow “ outlining key barriers to offload and opportunities to support ambulance handover flow. 6% of total conveyances spent a period of time in a non-clinical area in November.
- Utilisation of new process bedded in October for measuring utility of ambulance escalation tool, >15mins offload, hours lost and mean handover time - requires focus, resocialisation of the UHD escalation process however initial performance

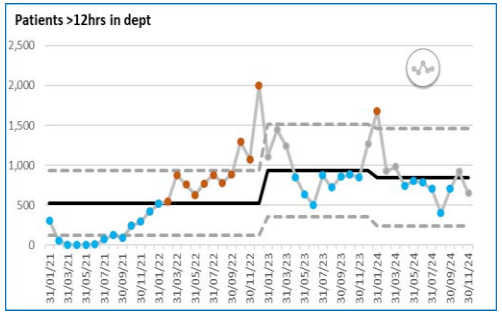
Responsive (Emergency) Care Standards

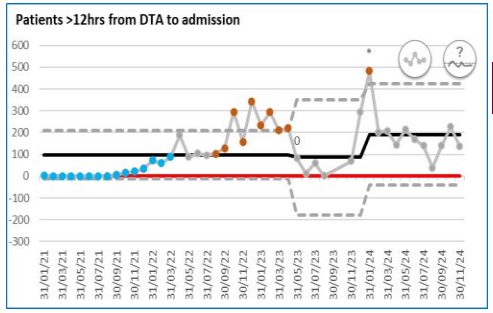


	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
4 hour actual	56.8%	66.4%	61.7%	60.1%	62.9%	61.2%	61.1%	62.3%	60.8%	61.9%	63.8%	70.2%	70.1%	72.5%	72.2%	73.5%	74.6%	72.5%	70.3%	70.0%
4 hour trajectory	60.0%	63.0%	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%









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

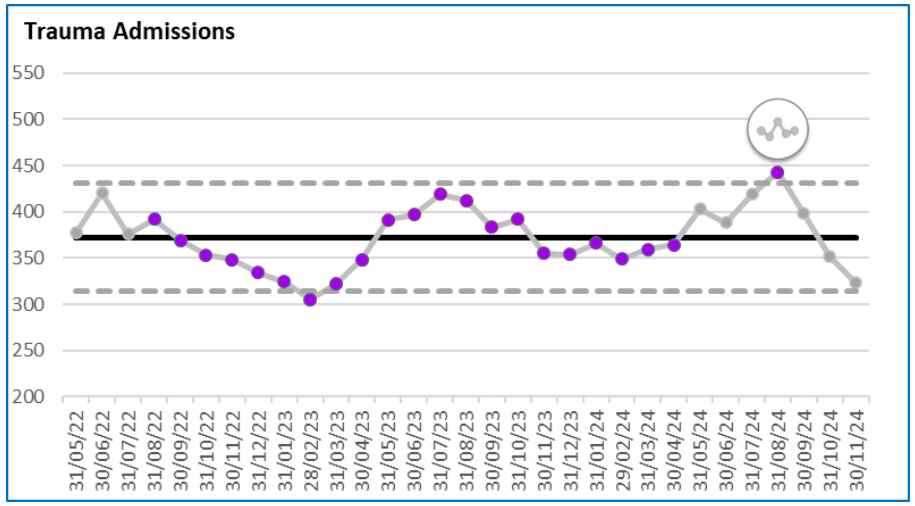
Performance continues to be challenged with performance over the past 3 months being below trajectory. November delivered 70.0% against an internal trajectory of 76%. To note, the drop in trajectory for December to 75%, to reflect the impact of seasonality.

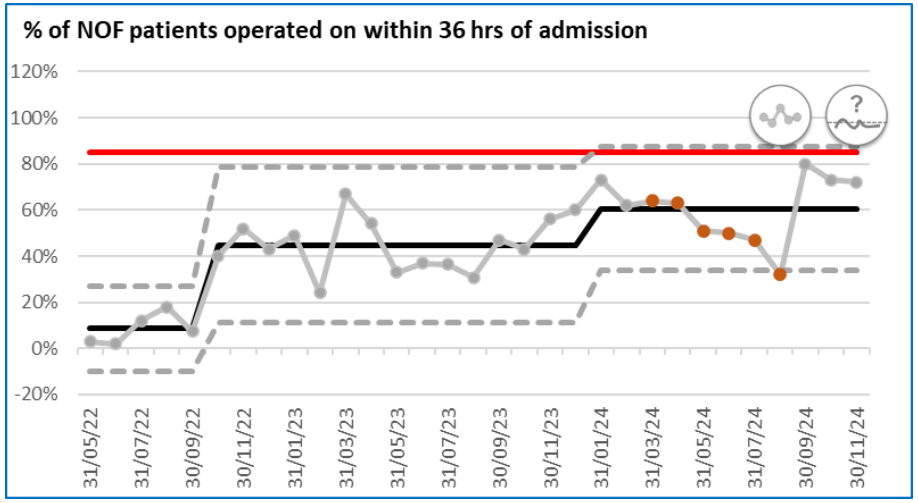
- Total attendances for November remained relatively static at 14,518 attendances vs 15,049 in October. This resulted in 484 attendances a day vs 485 in October. The average number of attendances continued to remain significantly higher than in 2023/24 which were circa 450 a day. Performance is however, 8% greater than the same reporting period in 23/24 (62.4%).
- Arrival time to initial assessment was static at 17.6 minutes vs 17.2 minutes, across the sites.
- However, meantime in the department dropped slightly to 262 minutes from 273 minutes in October. There was a significant reduction in patients waiting more than 12 hours in the department (652 from 924 in October and 705 in September respectively).
- This was mirrored in patients waiting longer than 12 hours following a decision to admit which was 136 in November vs 227 in October.
- Arrival time to decision to admit however remained relatively static and remains within normal variation at 244 minutes vs 253 minutes in October and 244 in September reflecting challenges of admitted flow vs decision to admit.
- Days where performance was less than 70% experienced elongated waiting to be seen times (WTBS) and lack of referrals at 180 minutes to facilitate patient movement. There is correlation between WTBS and occupancy rates with an average of 21 patients waiting for beds across both sites in November vs 15 in October.

Key Areas of Focus

- Breaches decreased by 156 in November equating to approximately 5 patients per day.
- Type 1 Non-Admitted performance was 71.9% at PH and 68.7% at RBH.
- Admitted performance increased slightly in November as compared to October by 4% (33% Poole site and 30% BH Site) which was due to BH Site improving from 26% to 30%.
- Ongoing monitoring and reporting against the winter plan to mitigate seasonal pressures from further impacting performance.

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 admission and being clinically appropriate for surgery.

Performance

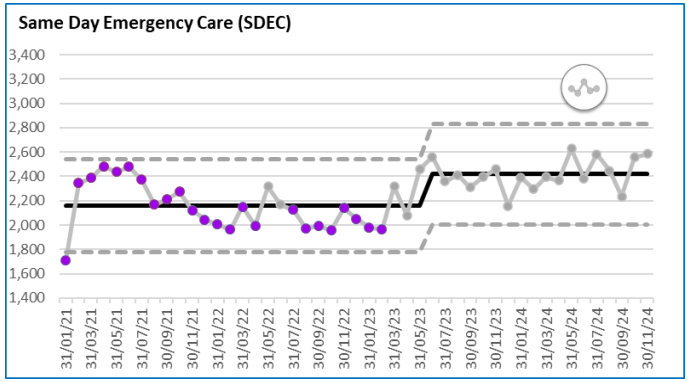
November performance for time to theatre for fractured neck of femur (#NoF) patients: 87% achieving surgery within 36 hours of being fit for surgery and 72% operated on within 36 hours from admission.

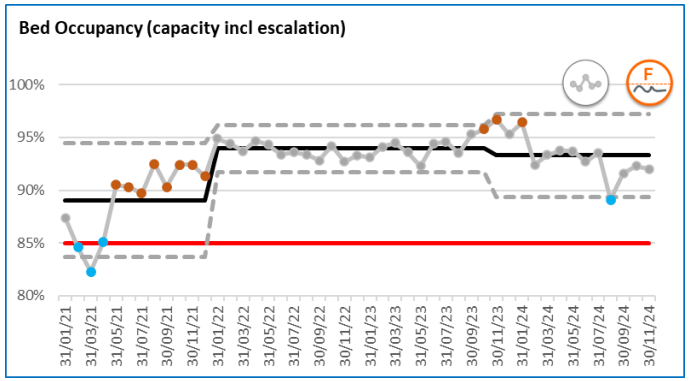
- Overall trauma admissions in November were 323, including 70 with a fractured neck of femur (#NoF).
- 7 of 73 #NoF's were unfit for surgery on admission.
- 15 patients with Shaft of femur (SoF) fractures were admitted in November of which all of whom had surgery, unfortunately 4 of these patients had extended waits partly due to the number of these patients admitted within a week.
- 17 patients required additional operations, equating to an additional 28 theatre cases (complex fractures).
- 13 patients treated through the Hand Hub procedure room in November.

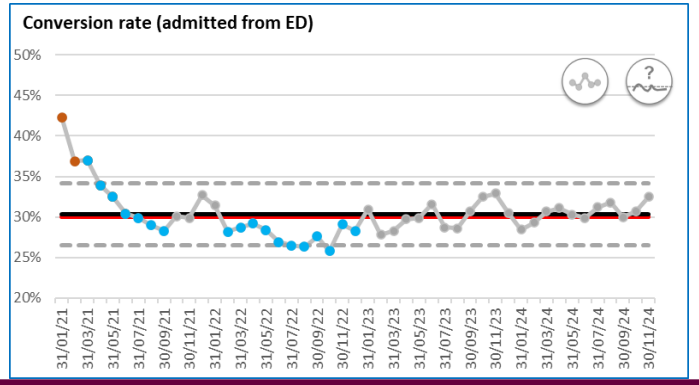
Key Areas of Focus

- Re-connecting Theatre T&O Leads for the Cluster meetings with admission teams to plan more detail into theatre scheduling to ensure plans for T&O instruments/kit is more robust and co-ordinated
- November shows a further reduction in volume of trauma admissions and patients admitted with fractured neck of femur.
- Interim Theatre schedule for Dec 2025 – April 2027 being worked on to look at Trauma capacity being planned for Bournemouth site and options: looking at volume of Trauma weekend theatre sessions; increasing weekday sessions to run 2 3-session theatre lists instead of current 2; and getting access to half a day in the Sandbourne ambulatory theatres .
- CSSD investment for new autoclaves now progressing which will contribute to reducing the non-compliance of instrumentation contamination issues and speed up efficiency for decontamination turnaround time
- Medical workforce establishment review has now started with support from finance/Business Intelligence.
- Trauma and Orthopaedic instrument loan process to move to an e-form to allow process to become more efficient (final form now confirmed and awaiting 'IT' to put into development)

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 November, an average of 998 beds were occupied which is a decrease as compared to October of 14 beds, with an average occupancy of 92.5% (increase of 1.4% compared to October). It is important to note that not all G&A beds are able to be utilised: actual operational occupancy is c3% greater than reported.

The average number of escalation beds open in October was 4.35 compared to 3.2 in November to support specific pathways. There was a short period of additional capacity on the RBH site. The greatest number of escalation beds remains on the RBH site with an average of 6 escalation beds open daily. SDEC usage at the Poole hospital site has increased in November.

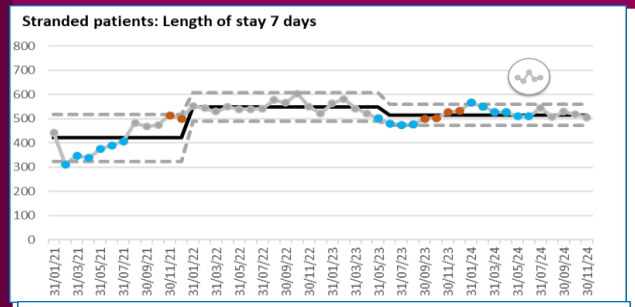
Virtual Ward has increased capacity from 75 beds to 100 beds in November. The occupancy rate for the Virtual Ward was 104.67%. The virtual ward as part of the winter plan is overperforming mitigating 14 beds vs 10 in plan.

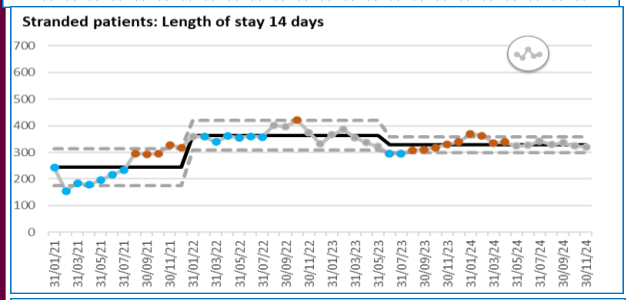
The average number of patients with No Criteria to Reside (NCtR) dropped slightly in November to 192, a decrease of 8 as compared with October's average.

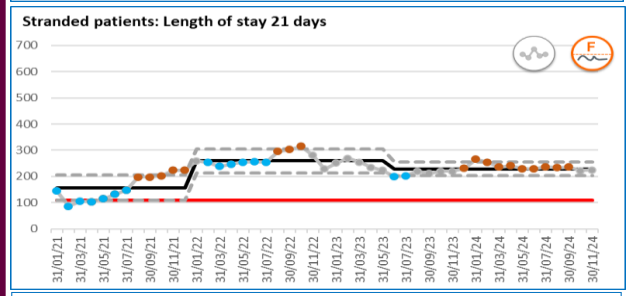
Key Areas of Focus

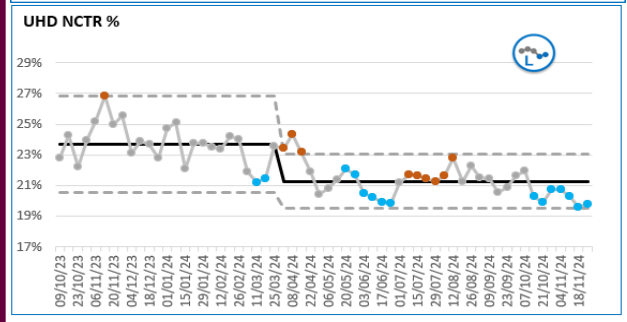
- The 2024 winter plan is to maintain SDEC functions to provide a means of avoiding unnecessary admissions. Some limited escalation capacity remained open in the Cardiology Investigation Unit (CIU) in Bournemouth to maintain cardiology inpatients and access the lab. This has led to some cancellations of planned procedures as a result.
- Same Day Emergency Care (SDEC) continues to make progress with self-assessments being undertaken of 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, noting however the facility is over-performing against plan.
- Ongoing progression of the actions identified in March by the ICB Chief Operating Officer asking for immediate focus on 5 key actions aimed at improving pathways for patients ready to leave hospital. This has been progressed at a 'Place' level with UHD working closely with system partners. This continues with the Transfer of care Hub (ToC) established; however, benefit realisation has not been fully delivered, and work continues to work differently.

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. On average in November 263 patients a day with an over 21-day LLOS, this excludes virtual ward occupancy.

No Criteria to Reside (NCtR) has dropped slightly in November to 192 from an average of 200 in October.

P0 discharges have continued to increase from 107 to 112 in November as compared to October 24, an increase that is in par-due to improved Saturday discharges.. The P1-3 discharges has increased slightly from 14 in October to 16 in November on average, the numbers do drop off at weekends.

Sustained LOS improvement across OPS wards and Orthopaedic ward areas.

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 look at the potentials of alternative pathways by the MDT.

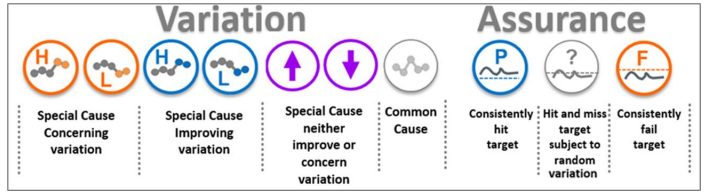
Older People's Services have kicked off an 'SDEC First,' initiative as part of the UHD Winter plan. Progress to be tracked as part of winter plan actuals vs plan.

The trust has started to roll out 'my care needs' across Older People's Wards which supports early discharge planning and looks to intervene earlier to avoid patients becoming delayed and reportable as LLOS. 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.

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	Nov 24	18	15		?	18	12	24
Clinician seen <60 mins %	Nov 24	32%	-	H		28%	18%	38%
Patients >12hrs from DTA to admission	Nov 24	136	0		?	191	-41	423
Patients >12hrs in dept	Nov 24	652	-			846	236	1455
4 hour safety standard	Nov 24	70.0%	74.0%	H	F	66.5%	61.3%	71.6%
Ambulance handovers - average hours lost UHD	Nov 24	26.8	-	L		33.9	20.5	47.4
Ambulance handovers - average hours lost RBH	Nov 24	28.5	-			36.3	20.9	51.8
Ambulance handovers - average hours lost Poole	Nov 24	25.0	-	L		31.5	18.2	44.8
Ambulance handover >60mins breaches	Nov 24	188			F	286	34	539
Ambulance handovers	Nov 24	4151	-			4219	3726	4711
Bed Occupancy (capacity incl escalation)	Nov 24	92%	85%		F	93%	89%	97%
Stranded patients: Length of stay 7 days	Nov 24	505	-			516	473	559
Stranded patients: Length of stay 14 days	Nov 24	320	-			328	299	357
Stranded patients: Length of stay 21 days	Nov 24	225	108		F	229	203	254
Non-elective admissions	Nov 24	6823	-	H		6104	5214	6995
> 1 day non-elective admissions	Nov 24	4238	-			3817	3251	4382
Same Day Emergency Care (SDEC)	Nov 24	2584	-			2417	2000	2834
Conversion rate (admitted from ED)	Nov 24	32.5%			?	30.4%	26.6%	34.2%



Sustainable Services

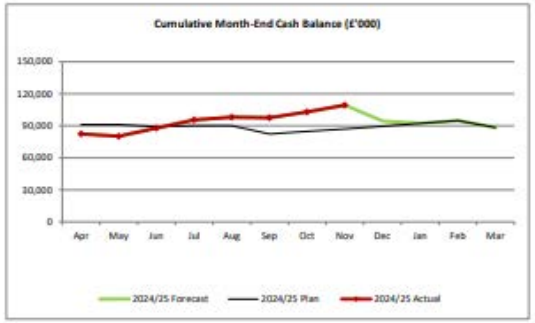
Pete Papworth
Chief Finance Officer

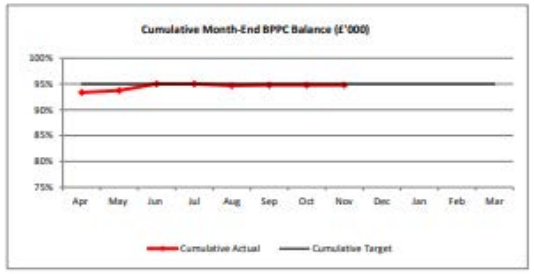
Operational Lead:
Andrew Goodwin, Deputy Chief Finance Officer

Committees:
Finance and Performance Committee

Finance

FINANCIAL INDICATORS	Year to date		
	Budget £'000	Actual £'000	Variance £'000
Control Total Surplus/ (Deficit)	(6,214)	(7,588)	(1,374)
Capital Programme	104,621	82,741	21,880
Closing Cash Balance	87,012	109,332	22,320
Public Sector Payment Policy	95.0%	94.9%	(0.1)%





At the end of November 2024 the Trust has reported a deficit of £7.588 million against a planned deficit of £6.214 million, resulting in an adverse variance of £1.374 million. The variance is due to the phasing of the recovery actions compared to the original plan.

Income is £2.3 million favourable to plan year to date. Included within this is a favourable position against Dorset ICB, a £435,000 favourable variance against NHSE and a £187,000 adverse variance against Hampshire and Isle of Wight ICBs. Other patient care income is £90,000 favourable due to low volume activity income (£137,000 favourable), RTA income (£79,000 favourable) and overseas parient income (£59,000 favourable), partially offset by a shortfall in private patient income of £181,000.

Operating expenditure is £5.483 million adverse to plan year to date. Pay is £3,898 million adverse to plan year to date, primarily due to premium nursing agency expenditure. Clinical supplies expenditure is £1.895m adverse to plan year to date mainly due to CDC costs (offset by income). Drugs expenditure is £3.673million adverse to plan year to date mainly due to Dorset ICS block contract drugs. Purchase of healthcare is £2.537 million adverse to plan year to date mainly due to CDC costs (offset by income). Premises and fixed plant expenditure is £2.839 million favourable to plan year to date due to energy costs.
Agency spend in month is £0.973 million and is under the cap value equating to 3.2% of total pay expenditure. This is a reduction when set against the expenditure in March.

Efficiency savings of £27.673 million have been achieved against a target £25.128 million. As of 31 November 2024, EIP (Efficiency Improvement Plans) are reporting a forecast risk adjusted saving of £41.2 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 £82.7 million against a plan of £104.6 million. The underspend is due to slippage on committed schemes due to phasing delays, primarily NHP (New Hospital Programme) and CDC (Community Diagnostics Centre). The forecast shows an unmitigated underspend of £18.4 million which is currently being reviewed with work ongoing in conjunction with NHSE to mitigate this risk.

CAPITAL	Year to date		
	Budget £'000	Actual £'000	Variance £'000
Estates	4,983	2,752	2,231
IT	7,393	4,709	2,684
Medical Equipment	2,079	568	1,511
Donated Assets	357	945	(588)
Strategic Capital	89,809	73,767	16,042
Total	**104,621**	**82,741**	**21,880**

As at 30 November 2024 the Trust is holding a consolidated cash balance of £109.3 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 94.4% against the national standard of 95%.

The Trust now produces a monthly forecast as detailed in the report. At the end of November, 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

NHS
University Hospitals Dorset
NHS Foundation Trust

Information Technology

IT Tickets logged

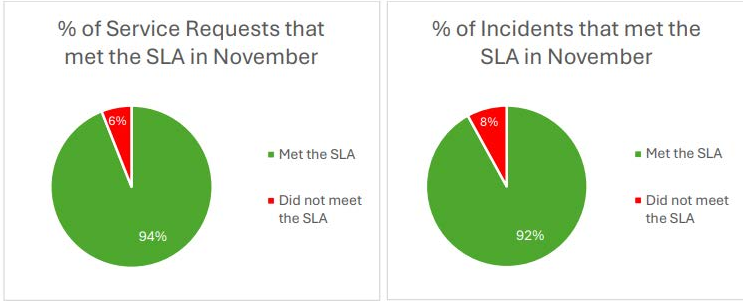
Top Tickets logged per Service			
Service	Service Requests	Incidents	Total
Clinical Application	1428	1753	3,181
Password	0	1461	1,461
Service Desk	1148	110	1,258
Non-Clinical Software	777	299	1,076
Email	497	106	603
Hardware	247	320	567
Printing	0	223	223
Telecoms	67	82	149
Network	52	54	106
Mobile Device	12	40	52
IT / Cyber Security	1	17	18

Monthly P1 Position

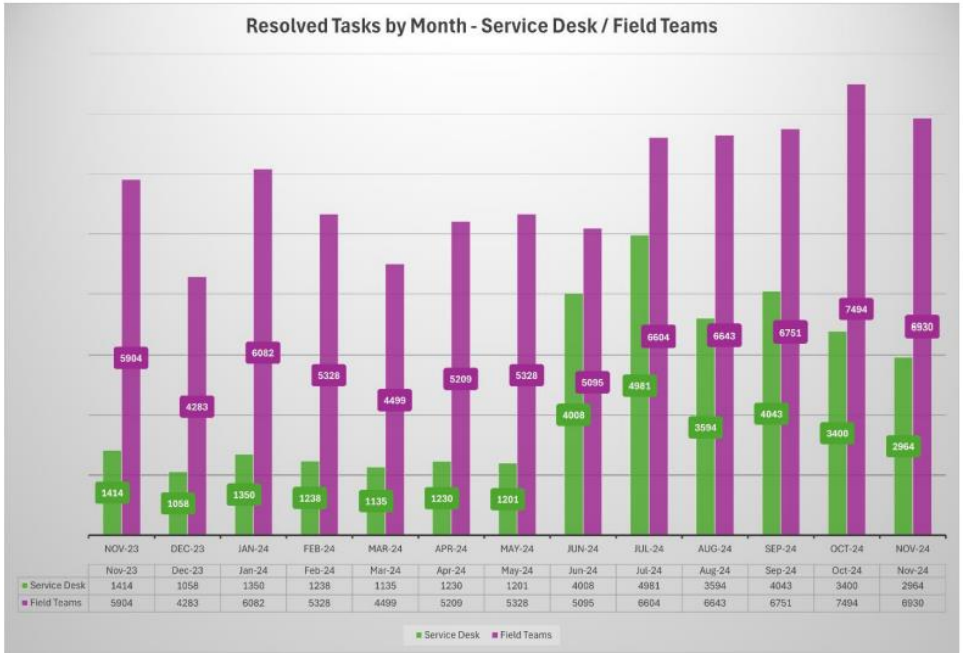
Priority 1 Incidents					
Incident Description	Ref Number	Fixed within current SLA?	Actual Fix Time (Hours)	Cause Resolution	3rd Party assistance
EPR outage	1223591	Yes	2	Server 1 taken out of load balancer	Yes
EPR Server Issues	1221611	Yes	4	Server 1 taken out of load balancer	Yes
EPR very slow	1222449	No	21	Server Reboot	Yes

*Priority 1 SLA (Service Level Agreement) is 4 Hours

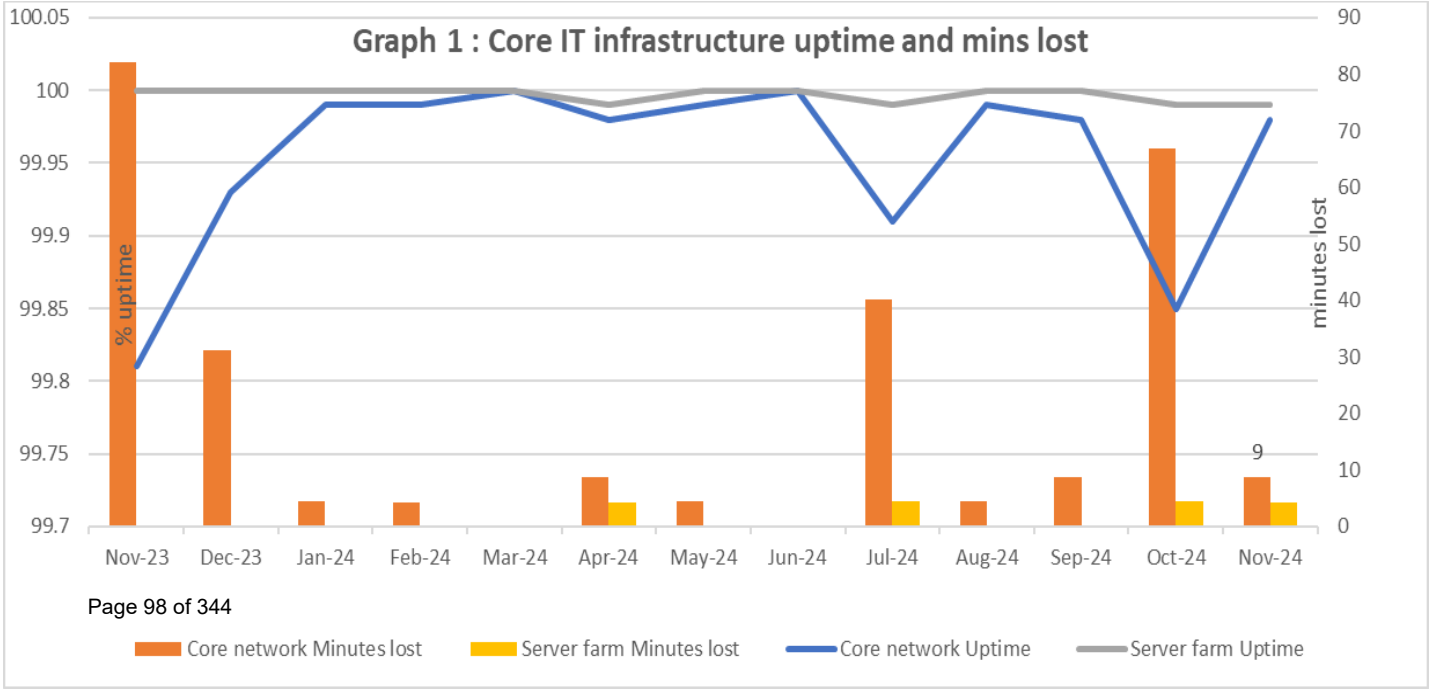
Service Call SLA Position



Resolved IT Tasks



Core Infrastructure Uptime



Information Governance & Cyber

Table 4: Freedom of Information compliance

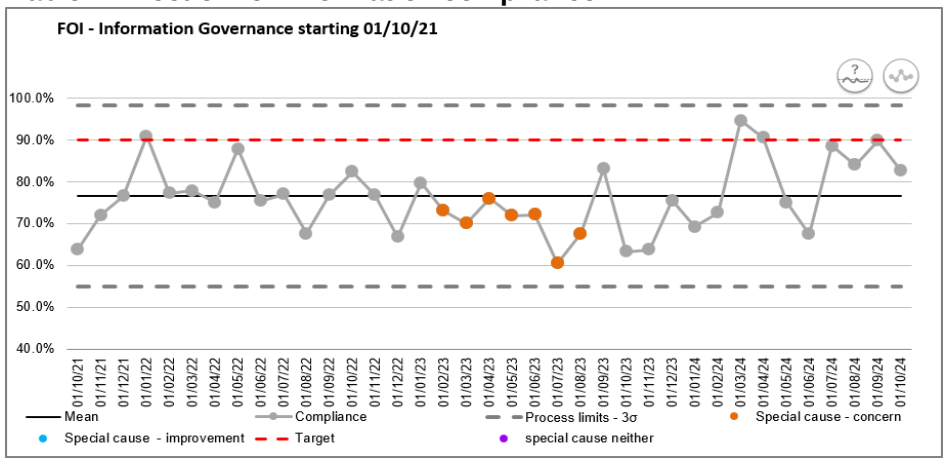
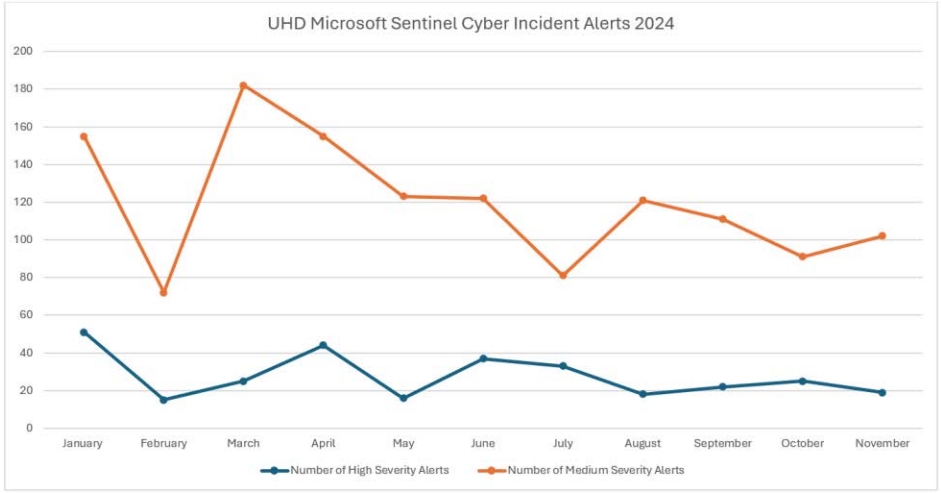


Table 5: SIEM Incident Alerts

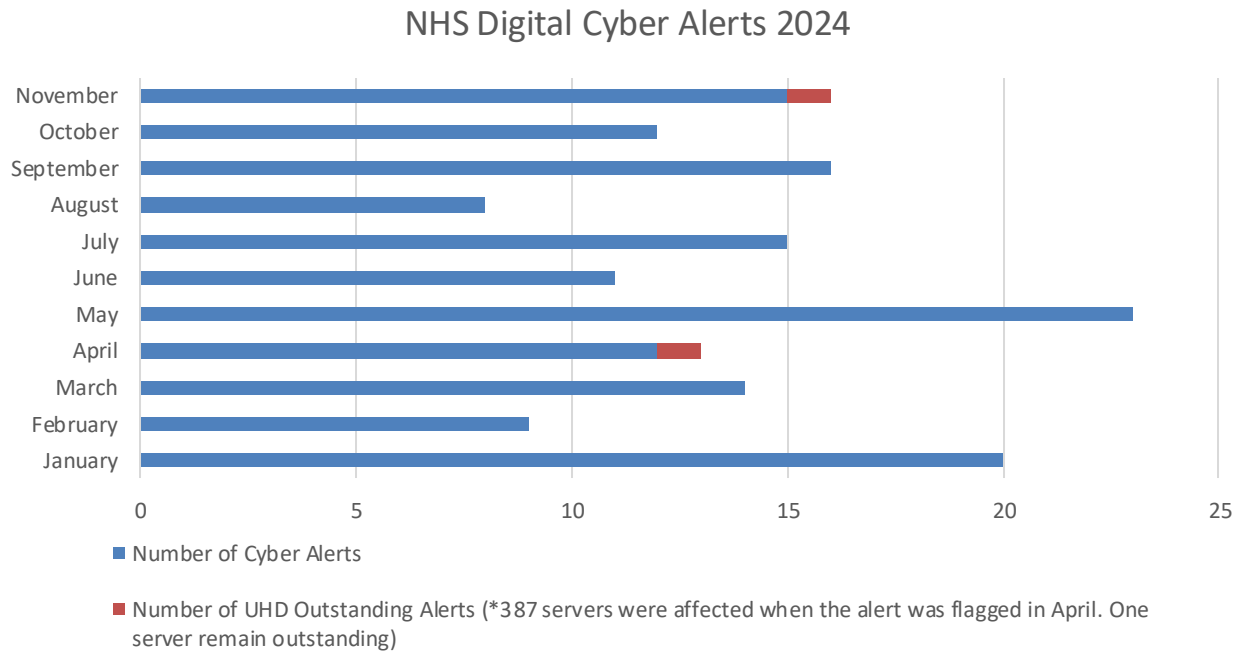


Microsoft Sentinel is a cloud-native security information and event management (SIEM) platform that uses built-in AI to help analyse large volumes of data across an enterprise. The alerts are based on potential suspicious activities.

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

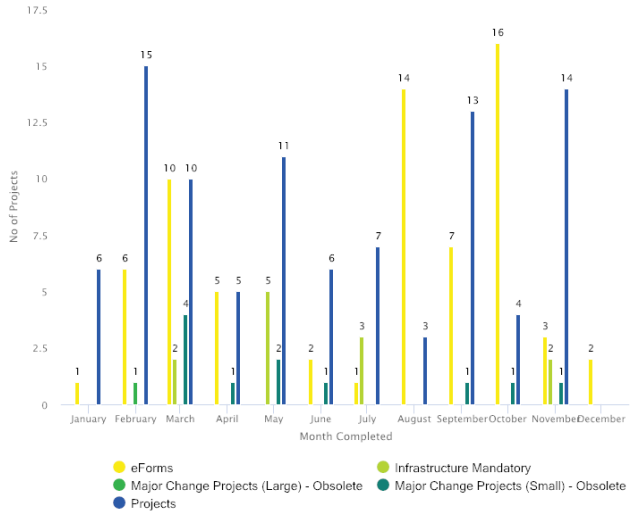


Development & Medical Records

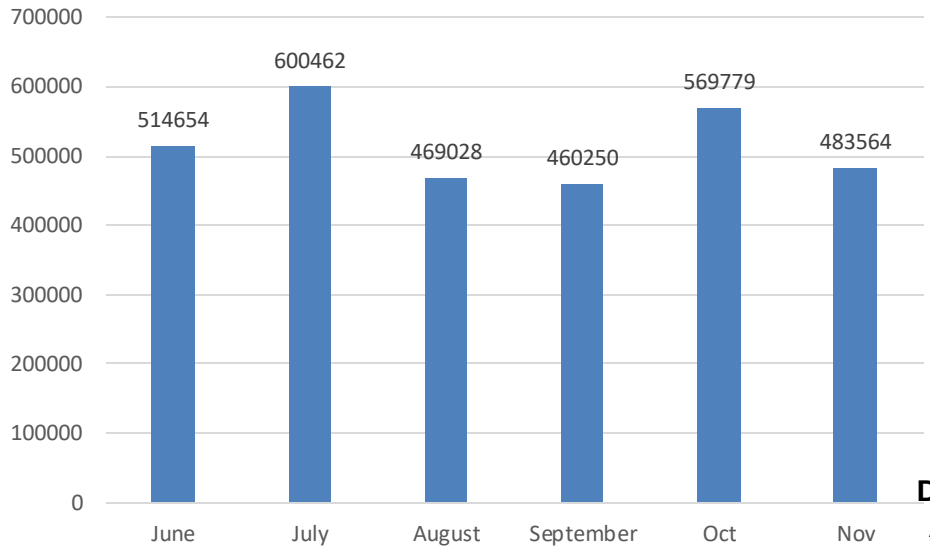
EHR Programme Timeline

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

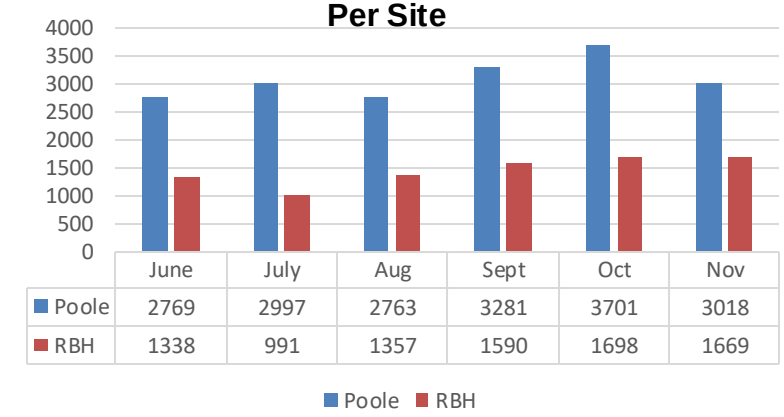
IT Projects Completed by Month for 2024



Number of Pages Scanned - Paperless Indication



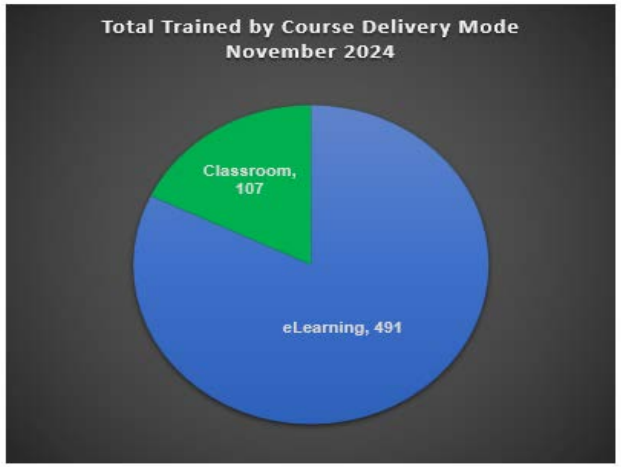
Number of Blank Case-notes Returned from Clinic Per Site



	June	July	Aug	Sept	Oct	Nov
Poole	2769	2997	2763	3281	3701	3018
RBH	1338	991	1357	1590	1698	1669

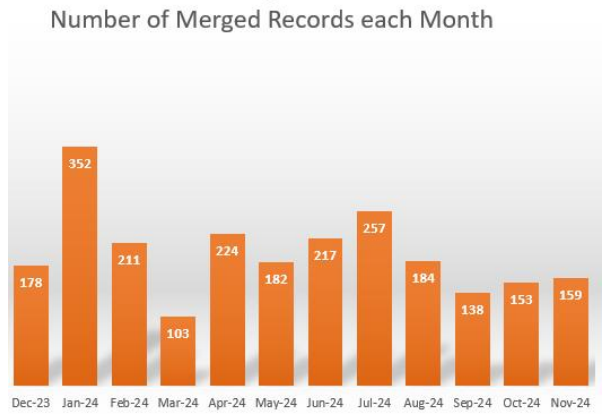
Training Statistics
Face to Face or eLearning Delivered

Total Trained in November: 598



Data Quality - Numbers of Merged Records per Month

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



University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 08 January 2025

Agenda item: 7.2

Subject:	Key Issues and Assurance Report to Board of the Quality Committee meetings held on 26 November 2024 and on 17 December 2024
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 26 November 2024, the Committee received the following: • Risk Register: risks rated 12 – 25 (Quality & Safety) • Integrated Performance Report • Maternity Safety Champions Report • Falls Report • CQC Urgent and Emergency Care Survey • National Standards for Healthcare Food and Drink • Assurance/alerts from the Clinical Governance Group. At its meeting on 17 December 2024, the Committee received the following: • Risk Register: risks rated 12 – 25 (Quality & Safety) • Integrated Performance Report • Organisational Health Review • Progress against Quality Priorities • Deep Dive on Opthamology • Maternity Safety Champions Report • Maternity Incentive Scheme Submission • Safeguarding Report • Dementia Report • Complaints and Patient Experience Report • Assurance/alerts from the Clinical Governance Group.
Significant issues for escalation to Board for action:	<u>Matters for Board awareness:</u> In addition to reports that would be presented to the Board (including new risks rated 15 and above and Maternity Incentive Scheme): • At its November 2024 meeting, the Committee agreed that there were no matters to escalate to

	the Board. However, for awareness, it was agreed to highlight the following matters to the Board as they were discussed in detail: ○ Maternity Safety Champions Report ○ Inpatient Falls Report ○ CQC Urgent and Emergency Care Survey ○ National Standards for Healthcare Food and Drink • At its December 2024 meeting, the Committee agreed that there were no matters to escalate to the Board. However, for awareness, it was agreed to highlight the following matters to the Board as they were discussed in detail: ○ Deep dive on Opthamology Service ○ Organisational Health Review ○ Clinical Audit Effectiveness review ○ Maternity Incentive Scheme submission ○ Safeguarding Report ○ Dementia Report ○ Complaints and Patient Experience Report
Progress of Board Assurance Key Risks Assigned to Committee:	BAF Risk 4 – score remained constant at 6 for November 2024 and December 2024, target of 6 BAF Risk 5 – score remained constant at 8 for November 2024 and December 2024, target of 6 BAF Risk 6 – score remained constant at 9 for November 2024 and December 2024.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 2 MEETING

Meeting Date: 08 January 2025

Agenda item: 7.2.2

Subject:	Maternity incentive scheme (MIS) year 6 submission
Prepared by:	Lorraine Tonge Director of Midwifery and Neonatal Services
Presented by:	Lorraine Tonge Director of Midwifery and Neonatal services James Balmforth Clinical Director

Strategic themes that this item supports/impacts:	Population & System Our People Patient Experience Quality Outcomes & Safety Sustainable Services	☒ ☒ ☒ ☒ ☒
BAF/Corporate Risk Register: (if applicable)	None	
Purpose of paper:	Review and Discussion	
Executive Summary:	The Clinical Negligence Scheme for Trusts (CNST) is a scheme for handling clinical negligence claims against NHS Trusts. The Trust pays an annual premium to the CNST scheme, plus an additional 10% towards the Maternity Incentive Scheme. The Maternity Incentive Scheme (MIS) establishes 10 safety actions for Maternity services providers to support safer maternity care. Trusts that can demonstrate they have achieved all 10 safety actions in full, recover the additional 10% of the maternity contribution charged under the scheme with the potential for a further share of unallocated funds. **The audit identified that the Trust is compliant with all 10 safety actions.** BDO auditors and the ICB have undertaken a review of the required evidence to support the Trust's self-assessment for Year 6 of the CNST Maternity Incentive Scheme. Subject to the availability of final evidence (Expected in Dec) the review has demonstrated that the Trust has	

	sufficient evidence to support its intended position on declaring full compliance with all ten safety actions.
Background:	▸ Now in its sixth year of operation, NHS Resolution's Maternity Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025. ▸ The MIS applies to all acute Trusts that deliver maternity services and are members of the Clinical Negligence Scheme for Trusts (CNST). As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. ▸ Trusts that can demonstrate they have achieved all ten of the safety actions in full will recover the element of their contribution relating to the CNST maternity incentive fund and they will also receive a share of any unallocated funds. ▸ Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund but may be eligible for a small discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund and is subject to a cap decided annually by the Collaborative Advisory Group (CAG). ▸ The original ten safety actions were developed in 2017 and have been updated annually by a CAG including NHS Resolution, NHS England, Royal College of Obstetricians and Gynecologists (RCOG), Royal College of Midwives (RCM), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), Royal College of Anesthetists (RCoA), the Neonatal Clinical Reference Group (CRG), the Care Quality Commission (CQC) and the Maternity and Newborn Safety Investigation Program (MNSI). ▸ For Year 5, the Trust declared non-compliance with three of the ten safety actions. Compliance was not met for SA4 – Medical Workforce Planning, SA6 – Saving Babies Lives Care Bundle and SA8 – In House Training. ▸ To be eligible for payment under year 6 of the scheme, Trusts must submit their completed Board Notification Form to NHS Resolution by 12 noon on 3rd March 2025. This form must be completed in full and signed by both the Trust Chief Executive Officer and Integrated Care Board Accountable Officer.

Key Recommendations:	Approve • The Board must give their permission to the Chief Executive Officer to sign the Board Notification Form prior to submission to NHS Resolution.
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**
WCCSS board	19/12/2024	Reports will be noted and presented to Trust Board in January
Quality Committee	17/12/2024	Meeting has not yet taken place at time of submission of the report.
Trust Management Group	17/12/2024	Meeting has not yet taken place at time of submission of the report.

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

MATERNITY INCENTIVE SCHEME
YEAR 6
SUBMISSION REPORT

Author: Lorraine Tonge

Director of Midwifery and Neonatal Services

12/12/24

1: Executive Summary

- The Clinical Negligence Scheme for Trusts (CNST) is a scheme for handling clinical negligence claims against NHS Trusts. The Trust pays an annual premium to the CNST scheme, plus an additional 10% towards the Maternity Incentive Scheme.

- The Maternity Incentive Scheme (MIS) establishes 10 safety actions for Maternity services providers to support safer maternity care. Trusts that can demonstrate they have achieved all 10 safety actions in full, recover the additional 10% of the maternity contribution charged under the scheme with the potential for a further share of unallocated funds.

- **The audit identified that the Trust is compliant with all 10 safety actions.**

- BDO auditors and the ICB have undertaken several reviews of the required evidence to support the Trust's self-assessment for Year 6 of the CNST Maternity Incentive Scheme.

- Subject to the availability of a final evidence collection (12 outstanding pieces expected in Dec) the review has demonstrated that the has sufficient evidence to support its intended position on declaring full compliance with all ten safety actions.

2: Background

- Now in its sixth year of operation, NHS Resolution's Maternity Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025.
- The MIS applies to all acute Trusts that deliver maternity services and are members of the Clinical Negligence Scheme for Trusts (CNST). As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.
- Trusts that can demonstrate they have achieved all ten of the safety actions in full will recover the element of their contribution relating to the CNST maternity incentive fund and they will also receive a share of any unallocated funds.
- Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund but may be eligible for a small discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund and is subject to a cap decided annually by the Collaborative Advisory Group (CAG).
- The original ten safety actions were developed in 2017 and have been updated annually by a CAG including NHS Resolution, NHS England, Royal College of Obstetricians and Gynaecologists (RCOG), Royal College of Midwives (RCM), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), Royal College of Anaesthetists (RCoA), the Neonatal Clinical Reference Group (CRG), the Care Quality Commission (CQC) and the Maternity and Newborn Safety Investigation Programme (MNSI).
- For Year 5, the Trust declared non-compliance with three of the ten safety actions. Compliance was not met for SA4 – Medical Workforce Planning, SA6 – Saving Babies Lives Care Bundle and SA8 – In House Training.
- To be eligible for payment under year 6 of the scheme, Trusts must submit their completed Board Notification Form to NHS Resolution by 12 noon on 3rd March 2025. This form must be completed in full and signed by both the Trust Chief Executive Officer and Integrated Care Board Accountable Officer.

3: ASSURANCE PROCESS

- All safety actions have been robustly reviewed as per NHSR recommendations and guidance.
- The evidence has been collected monthly and reviewed through the maternity governance process.
- BDO auditors has undertaken reviews of the required evidence to support the Trust's self-assessment for Year 6 Maternity Incentive Scheme. The Trust is complaint for all 10 safety actions. Report attached (see appendix A)
- The ICB/LMNS Hannah Leonard has also reviewed all evidence and confirmed all standards are met.

4: MIS COMPLIANCE OVERVIEW

Safety Action	Red	Amber	Green	Blue	Total Requirements
1	0	0	1	5	6
2	0	0	0	2	2
3	0	0	0	4	4
4	0	0	4	16	20
5	0	0	0	6	6
6	0	0	0	6	6
7	0	0	2	5	7
8	0	0	1	20	21
9	0	0	4	5	9
10	0	0	0	8	8
Total	0	0	12	77	89

Not compliant

Partial compliance, work underway

Full compliance, evidence not yet reviewed

Full compliance, final evidence reviewed

5: EVIDENCE REVIEWED

Maternity Safety Action	Required details	Evidence reviewed	Comments / Further Action required	
Safety Action 1	**Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?**	▸ MBRRACE / PMRT Cases Open/Closed Email ▸ PMRT Database ▸ Q4, Q1 & Q2 PMRT Reports ▸ Maternity And Neonatal Safety Report – Q1 & Q2 ▸ Maternity Quality and Safety Champions Report – Q1 & Q2 ▸ IPR Slides – Q4 & Q2 ▸ MBBRACE Report 30/11/24.	The Maternity Team are using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard. This is reported on a regular basis through the Maternity & Neonatal Safety Report to the Quality Committee (which includes the Trust maternity safety and Board level safety champions). Quarterly PMRT reports also reviewed at Safety Champion's meetings. Outstanding – Section 1.6 compliance will be fully evidenced in Jan 2025 when Trust board minutes from November meeting will be available.	Evidence provided appears robust to satisfy safety action.
Safety Action 2	**Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?**	▸ Results seen on NHSE website (25 Oct'24); full compliance reported. ▸ Email / screenshot of MSDS Jul'24 reported position.	The Trust are submitting data to the Maternity Services Data Set (MSDS) to the required standard. Note that the Trusts data is compliant as of July 2024 as required by MIS.	Evidence provided appears robust to satisfy safety action.
Safety Action 3	**Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimize separation of parents and their babies?**	▸ Transitional Care Unit Operational Policy ▸ Clinical Audit – Organization of Transitional Care Babies Against Operational Policy (Nov 2023 - Mar 2024) – Ref 082-2425. ▸ Updated data for Apr 2024 – Jun 2024 and July 24-Sept 24 also provided. ▸ Email re ATAIN QI Project (Reduce avoidable admissions to NICU resulting from	Transitional Care Policy and quarterly audits in place covering the requirements of this safety action. Quality Improvement work underway linked to reducing avoidable admissions to NICU.	Evidence provided appears robust to satisfy safety action.

		Hypoglycemia -or Hypothermia to meet National target of <6% of births). • Email confirmation of QI Project registration on Patient First Portal • ATAIN Q1 & Q2 Reports (Safety Champions Update) • LMNS Safety Meeting Agenda & QI Slides (Sep'24)		
Safety Action 4	**Can you demonstrate an effective system of clinical workforce planning to the required standard?**	**<u>Obstetric Workforce</u>** • 6-month locum audit spreadsheet (short and long-term) • Appraisal evidence for long term locum • When to Call a Consultant Guidance (inc on Trainee Induction Slides) • Obstetric Consultant Attendance Audit • Maternity And Neonatal Safety Report – Q2 • Directorate Quality and Risk Meeting Agenda (Sep'24) • Consultant attendance audit presentation and Datix reports • Sharing of Consultant Attendance audits with Board, Safety Champions and LMNS. **<u>Anesthetic Workforce</u>** • Example Rota provided (24-hour cover and on-call). **<u>Neonatal Medical Workforce</u>** • LMNS Transformation Group Meeting Agenda & Minutes (Sep'24) • Trust MIS Year 6 BAPM ODN Update • Evidence of updated advert for permanent 7th Consultant. Evidence of Board receiving confirmation of neonatal medical workforce BAPM compliance	Work has been undertaken since last year to ensure that effective systems of clinical workforce planning to the required standards could be appropriately evidenced. Outstanding – Actions 4.9 4.10, 4.14, 4.19 compliance will be fully evidenced in Jan 2025 when trust board minutes and safety champions December minutes will be available.	Evidence provided appears robust to satisfy safety action.

		Neonatal Nursing Workforce • LMNS Transformation Group Meeting Agenda & Minutes (Sep'24) • Trust MIS Year 6 BAPM ODN Update • Q4 Nurse Staffing Metrics • Maternity and neonatal safe staffing report (Jan-Jun 2024)		
Safety Action 5	**Can you demonstrate an effective system of midwifery workforce planning to the required standard?**	• Maternity Safe Staffing Paper Jul – Dec'23 • IPR Slides Jan'24 • Mar'24 Trust Board Paper - Maternity quality and safety champions report January and February • Maternity Transformation Workforce Plan (Jan'24) • Birth Rate+ letter re Maternity (and Perinatal) Incentive Scheme Year 6, Safety action 5, point a confirmation. • Maternity Safety Champions Report (Jun'24) • Escalation of Maternity Services Plan • Maternity Safe Staffing Paper Jan - Jun'24 and evidence of Board review • Maternity Transformation Workforce Plan – evidence of Board (or equivalent) review	The Trust can demonstrate it has an effective system of midwifery workforce planning to the required standard, noting this will be enhanced once the Birthrate+ formal report and outcomes are received.	Evidence provided appears robust to satisfy safety action.
Safety Action 6	**Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?**	• Maternity And Neonatal Safety Report - Quarter 1 April-June 2024 • Calendar Invites for ICB SLB 1/4ly Review Meetings • Q1 SBL Formal Review Email from ICB Saving Babies Lives: Reducing Stillbirth and Implementing SBLv3, 21 May Q2 SBL ICB Visit Outcome (7 Nov'24)	The Trust has continued to focus on demonstrating improved compliance with all the elements of the Saving Babies' Lives Care Bundle Version Three.	Evidence provided appears robust to satisfy safety action.

Safety Action 7	**Listen to women, parents and families using maternity and neonatal services and coproduce services with users**	▸ Maternity Neonatal Voices Partnership PROMPT Training Visit ▸ MNVP Annual Report 23/24 ▸ Terms of Reference - Avoiding Term Admissions to NICU ▸ Terms of Reference - Perinatal Mortality Review Tool (PMRT) Meeting ▸ Terms of Reference - Maternity and Neonatal Safety Champions Meeting ▸ Terms Of Reference - Labour Ward & Maternity Theatres Forum ▸ Terms Of Reference - Maternity and Neonatal Quality and Safety Meeting ▸ Terms Of Reference - AUDIT ▸ MNVP Update Emails ▸ CQC patient survey action plan 2024 ▸ MNVP Risk Register Entry ▸ MNVP Evidence Folder ▸ Safety Champion Meeting Agenda and Minutes (Jun'24) ▸ LMNS Strategic Board Meeting – Meeting Notes ▸ CQC Maternity Survey Presentation ▸ CQC Maternity Survey Action Plan (archive) ▸ Maternity Safety Champions Agenda ▸ LMNS Board Meeting – Aug'24	Dorset MNVP in place that has a clear agenda to demonstrate engagement and seeking feedback for this safety action. Outstanding – Action 7.2 compliance will be fully evidenced when all Terms of reference have gone through all governance meetings, January 2025. Action 7.4 will be fully evidenced on receiving the ICB risk register and ICB minutes in December 2024.	Evidence provided appears robust to satisfy safety action.
Safety Action 8	**Can you evidence the following 3 elements of local training plans and 'in-house', one day multi-professional training?**	▸ Maternity Safety Champions Report (Q1 and Q2) ▸ 2024 PROMPT Course Programme ▸ All Staff Training Records ▸ Medical NLS Training Records ▸ NLS Refresher Training Records	Significant work undertaken on ensuring compliance levels are achieved. Identification of staff who are required to attend training and provision of planned sessions to facilitate this has been undertaken. Outstanding – Action 8.22 will be fully complaint when neonatal and paediatric medical staff 90% neonatal resuscitation training is reviewed by ICB, expected December 2024.	Evidence provided appears robust to satisfy safety action.

Safety Action 9	**Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?**	▸ LMNS Strategic Board Update (Apr'24) ▸ Safety Champions Poster ▸ Safety Champion Diary Invite ▸ Handover Huddles Reminder ▸ Maternity Safety Champions Report (May'24) – Staff Feedback from Safety Champion Walkarounds (You Said, We Did) ▸ IPR Slides ▸ Maternity and Neonatal Safety Champions Meeting Agenda	A NED undertakes the role of Board Safety Champion and minutes demonstrate there is close working with the Perinatal Leadership Team to demonstrate any quality issues are being addressed. The relevant datasets are being presented to the Quality Committee which is triangulated with further patient safety data including incidents and complaints. Robust processes in place to provide assurance that maternity and neonatal safety and quality issues are identified, reported and acted upon. Outstanding – Actions 9.4 will be fully compliant awaiting ICB provide PQSSG workplan and LMNS governance structure. Expected December 2024. Action 9.3, 9.8, 9.9 will be fully compliant when Trust board minutes available January 2025.	Evidence provided appears robust to satisfy safety action.
Safety Action 10	**Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme?**	▸ LERN Forms ▸ NHSR Litigation Email ▸ NHSR Patient Information Leaflet ▸ Patient Duty of Can dour Letters ▸ Maternity And Neonatal Safety Report Quarter 2 - July-September 2024 ▸ Email Evidence re CMS completion (to 9/8)	The Trust have reported 100% of qualifying cases to HSIB and NHSR EN Scheme.	Evidence provided appears robust to satisfy safety action.

6:Next Steps

- The paper is to be presented at the public Trust Board on the 8th of January The Board Notification Form (Appendix B) must be submitted to Trust Board which describes the progress made against the maternity safety actions by the Director of Midwifery and Clinical Director for Maternity Services.

- The Board must give their permission to the Chief Executive Officer to sign the Board Notification Form prior to submission to NHS Resolution. The Trust Board declaration form must be signed by the Trust's CEO and the Integrated Care Board Accountable Officer.

- The Board declaration form must be signed and dated by the Trust's CEO to confirm that:

- The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions sub-requirements as set out in the safety actions and technical guidance document included in this document.

- There are no reports covering either year 2022/23 or 2023/24 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration (e.g. Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.). All such reports should be brought to the MIS team's attention before 01/02/2024.

7: Conclusion

- The BDO auditors and LMNS assurance processes have satisfied the Director of Midwifery, Clinical Lead for Obstetrics and the Board Level Safety Champions that the evidence provided demonstrates achievement of the ten maternity safety actions as set out in NHSR (2024).

- The Board is therefore asked to review the content and the CEO is requested to sign the Board Notification Form (Appendix B) form prior to submission to NHS Resolution.

8: References

https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/

9: Appendix A

BDO auditors report

BDO Auditors report

Appendix B

UHD MIS Board Notification form for submission

UHD MIS year 6 notification form.xls

UNIVERSITY HOSPITALS DORSET NHS FT

INTERNAL AUDIT REPORT – PROPOSED FINAL

MATERNITY INCENTIVE SCHEME – YEAR 6
DECEMBER 2024

Design Opinion	N/A - Advisory
Design Effectiveness	N/A - Advisory

IDEAS | PEOPLE | TRUST

CONTENTS

DISTRIBUTION	
Sarah Herbert	Chief Nursing Officer
Lorraine Tonge	Care Group Director of Midwifery
Cherie Wells	Obstetric Administration Manager
Pete Papworth	Chief Finance Officer

BDO LLP APPRECIATES THE TIME PROVIDED BY ALL THE INDIVIDUALS INVOLVED IN THIS REVIEW AND WOULD LIKE TO THANK THEM FOR THEIR ASSISTANCE AND COOPERATION.

REPORT STATUS	
Auditors:	Mark Stabb, Senior Audit Manager
Dates work performed:	23 October – 25 October 2024
Draft report issued:	1 November 2024
Final report issued:	

EXECUTIVE SUMMARY

BAF REFERENCE: RISK OF NOT RETURNING TO RECURRENT FINANCIAL SURPLUS FROM 2026/27

Design Opinion	N/A - Advisory	**Design Effectiveness**	N/A - Advisory

SCOPE

BACKGROUND

- Now in its sixth year of operation, NHS Resolution's Maternity Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025.
- The MIS applies to all acute Trusts that deliver maternity services and are members of the Clinical Negligence Scheme for Trusts (CNST). As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.
- Trusts that can demonstrate they have achieved all ten of the safety actions in full will recover the element of their contribution relating to the CNST maternity incentive fund and they will also receive a share of any unallocated funds.
- Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund but may be eligible for a small discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund and is subject to a cap decided annually by the Collaborative Advisory Group (CAG).
- The original ten safety actions were developed in 2017 and have been updated annually by a CAG including NHS Resolution, NHS England, Royal College of Obstetricians and Gynaecologists (RCOG), Royal College of Midwives (RCM), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), Royal College of Anaesthetists (RCoA), the Neonatal Clinical Reference Group (CRG), the Care Quality Commission (CQC) and the Maternity and Newborn Safety Investigation Programme (MNSI).
- For Year 5, the Trust declared non-compliance with three of the ten safety actions (SA4,6 & 8).

PURPOSE

- Following on from the Year 5 submission process, we will work with the Trust to ensure systems and processes are in place for the Year 6 submission to capture the required evidence and undertake an independent review of this prior to the 2025 submission date.

AREAS REVIEWED

- This was a review undertaken by the BDO Senior Manager to independently assess the process for the compilation of evidence supporting the Trust's self-certification.
- As part of this review, we critically analysed the evidence provided (recognising this was as at a point in time), providing challenge and requesting further supporting documentation to agree to the assertions as required.
- We provided a high-level assessment of the evidence against each of the ten safety action standards to aid the Trust as it prepares to request the Board's approval of self-certification in February 2025.

AREAS OF STRENGTH

- Use of the audit tool provided by NHS Resolution that was designed to support Trusts on their MIS compliance journey, along with the maintenance of supporting and clearly referenced evidence folders.
- Setting up of the MIS Working Group with attendance of nominated leads for each of the Safety Actions. Ongoing review of each safety action, documentation of progress, evidence and any potential compliance issues as they arose.
- Regular reporting of the forecasted MIS compliance position, along with mitigating action plans, to Trust Board during the year (via Quality Committee).

AREAS OF CONCERN

As at the time of writing the draft report:

- There are still two safety actions where we have identified that some additional evidence could still be provided to fully support their successful completion.
- It is also acknowledged that there is additional evidence that will be added to evidence folders as the Q3 reports are presented through the governance structure; these will enhance and complete the evidence required up to the time of Board certification .

ADDED VALUE

- Ongoing liaison with the Trust and ICB Leads to ensure a consistent system-wide approach (and compliance) with the MIS Safety Actions.
- Sharing of IA experience of previous MIS submissions from Trusts outside of Dorset.

CONCLUSION

- Overall, the Trust has made strong progress in ensuring the successful and accurate submission of its Maternity Incentive Scheme year 6 self-certification and this is supported by appropriate evidence. There has been early warning of potential areas of non-compliance, with mitigating actions implemented and focus given to these particular safety actions, and this is consistent with the findings of our work.
- A robust evidence tracking and retention process and associated reporting is now fully embedded, aided by the completion of the audit tool provided by NHS Resolution. There has been ongoing liaison and review with both BDO and the ICB on the robustness of the evidence in place to support the reported compliance position.

- Subject to resolving the availability of the evidence for two of the safety actions, the review has demonstrated that the Trust has sufficient evidence to support its intended position on declaring full compliance with all ten safety actions.
- Declaration of full compliance will result in the Trust recovering its element of contribution relating to the CNST maternity incentive fund (£700k approx) and potentially a further share of any unallocated funds.

SUMMARY OF WORK UNDERTAKEN

We were provided with a copy of the Trust's Maternity Incentive Scheme Audit Tool as at 24 October 2024. This showed the following reported position against which the evidence was reviewed:

Overview of progress on safety action requirements

Safety Action Requirements:

Safety Action	Red	Amber	Green	Blue	Total Requirements
1	0	0	6	0	6
2	0	0	2	0	2
3	0	1	3	0	4
4	0	7	13	0	20
5	0	0	6	0	6
6	0	3	3	0	6
7	0	3	4	0	7
8	0	9	12	0	21
9	0	0	9	0	9
10	0	0	8	0	8
Total	0	23	66	0	89

Key:

Red	Not compliant
Amber	Partial compliance - work underway
Green	Full compliance - evidence not yet reviewed
Blue	Full compliance - final evidence reviewed

At the time of the follow up review on 10 December 2024, the updated reported position was as follows:

Safety Action	Red	Amber	Green	Blue	Total Requirements
1	0	0	5	1	6
2	0	0	0	2	2
3	0	0	2	2	4
4	0	0	8	12	20
5	0	0	0	6	6
6	0	0	6	0	6
7	0	0	4	3	7
8	0	0	20	1	21
9	0	0	9	0	9
10	0	0	8	0	8
Total	0	0	62	27	89

Summarised below is our analysis of the supporting documents for each of the maternity safety actions @ 10 December 2024

Maternity Safety Action	Required details	Evidence reviewed	Comments / Further Action required	BDO Assessment
Safety Action 1	**Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?**	▸ MBRRACE / PMRT Cases Open/Closed Email ▸ PMRT Database ▸ Q4, Q1 & Q2 PMRT Reports ▸ Maternity And Neonatal Safety Report – Q1 & Q2 ▸ Maternity Quality and Safety Champions Report – Q1 & Q2 ▸ IPR Slides – Q4 & Q2 ▸ PMRT Cases and MIS Compliance, Period 08/12/2023 – 30/11/2024 ▸ MBBRACE Report @ 30/11/24 (Case List Download) ▸ PMRT Agendas and Minutes ▸ Safety Champions Meeting Agenda & Minutes (Nov'24)	The Maternity Team are using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard. This is reported on a regular basis through the Maternity & Neonatal Safety Report to the Quality Committee (which includes the Trust maternity safety and Board level safety champions). Quarterly PMRT reports also reviewed at Safety Champion's meetings.	Evidence provided appears robust to satisfy safety action.
Safety Action 2	**Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?**	▸ Final results seen on NHSE website (25 Oct'24); full compliance reported ▸ Screenshot of MSDS Jul'24 reported position.	The Trust are submitting data to the Maternity Services Data Set (MSDS) to the required standard. Note that the Trusts data is compliant as at July 2024 as required by MIS.	Evidence provided appears robust to satisfy safety action.
Safety Action 3	**Can you demonstrate that you have transitional care (TC) services in place and undertaking quality**	▸ Transitional Care Unit Operational Policy ▸ Clinical Audit - Organisation of Transitional Care Babies Against Operational Policy (Nov 2023 - Mar 2024) – Ref 082-2425. Updated data for Apr 2024	Transitional Care Policy and quarterly audits in place covering the requirements of this safety action. Quality Improvement work underway linked to reducing avoidable admissions to NICU.	Evidence provided appears robust to

	improvement to minimise separation of parents and their babies?	– Jun 2024 also provided. Jul-Sep audit also provided ▸ Email re ATAIN QI Project (Reduce avoidable admissions to NICU resulting from Hypoglycaemia or Hypothermia to meet National target of <6% of births). ▸ Email confirmation of QI Project registration on Patient First Portal ▸ ATAIN Q1 & Q2 Reports (Safety Champions Update) ▸ LMNS Safety Meeting Agenda & QI Slides (Sep'24) ▸ Safety Champions Meeting Agenda & Minutes (Nov'24)		satisfy safety action.
Safety Action 4	**Can you demonstrate an effective system of clinical workforce planning to the required standard?**	**<u>Obstetric Workforce</u>** ▸ 6-month locum audit spreadsheet (short and long-term) ▸ Appraisal evidence for long term locum ▸ When to Call a Consultant Guidance (inc on Trainee Induction Slides) ▸ Obstetric Consultant Attendance Audit (Nov'23 – Oct'24) ▸ Maternity And Neonatal Safety Report – Q2 ▸ Directorate Quality and Risk Meeting Agenda (Sep'24) ▸ Directorate Quality & Risk Meeting (Obstetrics) Minutes (Nov'24) ▸ Local Maternity and Neonatal System Transformation Meeting Report (Nov'24) **<u>Anaesthetic Workforce</u>** ▸ Example rota provided (24 hour cover and on-call).	Work has been undertaken since last year to ensure that effective systems of clinical workforce planning to the required standards could be appropriately evidenced. ***Additional Evidence Required*** <u>Obstetric Workforce</u> 4.9 – 4.10 Evidence (agenda / minutes) of sharing of Consultant Attendance audit with Board and Safety Champions. <u>Neonatal Medical Workforce</u> 4.14 Evidence of Board receiving confirmation of neonatal medical workforce BAPM non-compliance. This is included in Q2 Maternity And Neonatal Safety Report presented to Board on 6 Nov'24 – minutes required to evidence compliance position. <u>Neonatal Nursing Workforce</u> 4.19 Evidence of Board receiving confirmation of neonatal nursing workforce BAPM compliance. This is included in Q2	Opportunities to enhance the quality of the evidence provided to demonstrate compliance with the safety action.

		Neonatal Medical Workforce • LMNS Transformation Group Meeting Agenda & Minutes (Sep'24) • Trust MIS Year 6 BAPM ODN Update • Advert for permanent 7th Consultant • Q2 Maternity And Neonatal Safety Report presented to Board in Nov'24 **Neonatal Nursing Workforce** • LMNS Transformation Group Meeting Agenda & Minutes (Sep'24) • Trust MIS Year 6 BAPM ODN Update • Q4 Nurse Staffing Metrics • Maternity and neonatal safe staffing report (Jan-Jun 2024) • Q2 Maternity And Neonatal Safety Report presented to Board in Nov'24	Maternity And Neonatal Safety Report presented to Board on 6 Nov'24 – minutes required to evidence compliance position.	
Safety Action 5	**Can you demonstrate an effective system of midwifery workforce planning to the required standard?**	• Maternity Safe Staffing Paper Jul – Dec'23 • Maternity and neonatal safe staffing report Jan – Jun'24 • Nov'24 Trust Board Agenda Papers • IPR Slides Jan'24 • Mar'24 Trust Board Paper - Maternity quality and safety champions report January and February • Maternity Transformation Workforce Plan (Jan'24) • BirthRate+ letter re Maternity (and Perinatal) Incentive Scheme Year 6, Safety action 5, point a confirmation • BirthRate+ Report • Monthly Maternity Safety Champions Reports • Escalation of Maternity Services Plan	The Trust can demonstrate it has an effective system of midwifery workforce planning to the required standard, noting this will be enhanced now that the Birthrate+ formal report and outcomes have been received. ***Additional Evidence Required*** 5.3 Maternity Transformation Workforce Plan – evidence of Board (or equivalent) review	Opportunities to enhance the quality of the evidence provided to demonstrate compliance with the safety action.

Safety Action 6	**Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?**	• Maternity And Neonatal Safety Reports - Quarters 1 & 2 • Calendar Invites for ICB SLB 1/4ly Review Meetings • Q1 & Q2 SBL Formal Review Email from ICB • Saving Babies Lives: Reducing Stillbirth and Implementing SBLv3, 21 May 2024 • LMNS Safety Meeting Agendas • Local Maternity and Neonatal System Transformation Meeting Reports • Fetal Surveillance Monitoring Shared Learning Report	The Trust has demonstrated continuous improved compliance with all the elements of the Saving Babies' Lives Care Bundle Version Three.	Evidence provided appears robust to satisfy safety action.
Safety Action 7	**Listen to women, parents and families using maternity and neonatal services and coproduce services with users**	• Maternity Neonatal Voices Partnership PROMPT Training Visit • 15 Steps MNVP Visit to UHD 26 Jul' 24 Action Plan • Maternity and Neonatal Voice Partnership (MNVP) Board Update • MNVP Walk the Patch Report • Dorset Maternity & Neonatal Voices Community Engagement Report • MNVP Annual Report 23/24 • New Look MatNeo Governance for 2025 • Terms of Reference - Avoiding Term Admissions to NICU • Terms of Reference - Perinatal Mortality Review Tool (PMRT) Meeting • Terms of Reference - Maternity and Neonatal Safety Champions Meeting • Terms Of Reference - Labour Ward & Maternity Theatres Forum • Terms Of Reference - Maternity and Neonatal Quality and Safety Meeting • Terms Of Reference - Audit • MNVP Update Emails	Dorset MNVP in place that has a clear agenda to demonstrate engagement and seeking feedback for this safety action.	Evidence provided appears robust to satisfy safety action.

		• MNVP Risk Register Entry • MNVP Evidence Folder • Safety Champion Meeting Agenda and Minutes (Jun'24) • LMNS Strategic Board Meeting – Meeting Notes • CQC Maternity Survey Presentation • CQC Maternity Survey Action Plan (archive) • CQC Maternity Survey 2024 (Provisional Results) • Maternity Safety Champions Agenda • LMNS Board Meeting – Aug'24		
Safety Action 8	**Can you evidence the following 3 elements of local training plans and 'in-house', one day multi-professional training?**	• Maternity Safety Champions Report (Q1 and Q2) • 2024 PROMPT Course Programme • All Staff Training Records • Medical NLS Training Records • NLS Refresher Training Records • Safety Champions Data for Dec 2024 • Projected PROMPT compliance • Training and Development Guideline (Maternity)	Significant work undertaken on ensuring compliance levels were achieved. Ongoing identification of staff who were required to attend training and provision of planned sessions to facilitate this was undertaken. Training compliance as at 30 Nov'24 demonstrated the required compliance levels had been achieved for all staff groups.	Evidence provided appears robust to satisfy safety action.
Safety Action 9	**Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues.**	• LMNS Strategic Board Update (Apr'24) • Safety Champions Poster • Safety Champion Diary Invite • Handover Huddles Reminder • Maternity Safety Champions Report (May'24) – Staff Feedback from Safety Champion Walkarounds (You Said, We Did) • IPR Slides • Maternity and Neonatal Safety Champions Meeting Agenda • Quarterly Maternity & Neonatal Safety Reports • Monthly Maternity Safety Champions Reports • LMNS Safety Meeting Agendas	A NED undertakes the role of Board Safety Champion and minutes demonstrate there is close working with the Perinatal Leadership Team to demonstrate any quality issues are being addressed. The relevant datasets are being presented to the Quality Committee which is triangulated with further patient safety data including incidents and complaints. Robust processes in place to provide assurance that maternity and neonatal safety and quality issues are identified, reported and acted upon.	Evidence provided appears robust to satisfy safety action.

Safety Action 10	**Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme?**	• LERN Forms • NHSR Litigation Email • NHSR Patient Information Leaflet • Patient Duty of Candour Letters • Maternity And Neonatal Safety Report Quarter 2 - July-September 2024 • Email Evidence re CMS completion (to 9/8) • Maternity Safety Champions Reports • Maternity Claims And Early Notification Scheme Report •	The Trust have reported 100% of qualifying cases to HSIB and NHSR EN Scheme.	Evidence provided appears robust to satisfy safety action.

Maternity incentive scheme - Year 6 Guidance

Trust Name	**University Hospitals Dorset NHS Foundation Trust**
Trust Code	**T694**

This document must be used to submit your trust self-certification for the year 6 Maternity Incentive Scheme safety actions.
A completed action plan must also be submitted for any safety actions which have not been met (tab C).

Please select your trust name from the drop-down menu above. The trust code will automatically be added below. Your trust name will populate each page. If the trust name box above is coloured pink please update it.

Tabs A - safety actions entry sheets (1 to 10) - Please select 'Yes', 'No' or 'N/A' to demonstrate compliance as detailed each element of the safety action. Please complete these entries starting at the top.
'N/A' (not applicable) is available only for set questions and may only be visible following a response to a previous question.
The information which is added on these pages, will automatically populate onto tabs B & D which is the board declaration form.

Tab B - safety action summary sheet - This will provide you with a detailed overview of the information entered so far on the board declaration form and will outline on how many Yes/No/N/A and unfilled assessments you have. Please review any pages that show there are responses that require checking, or are showing as not filled in.
This will feed into the board declaration sheet - tab D.

Tab C - action plan entry sheet – If you are declaring non-compliance with any safety actions, this sheet will enable your Trust to insert action plan details and bid for discretionary funding. If you are declaring full compliance, you do not need to complete this tab.
All action plans for non-compliant safety actions must be:
•Submitted on the action plan template in the Board declaration form.
•Specific to the safety action(s) not achieved by the Trust (these do not need to be added in numerical order).
•Details of each action should be SMART (specific, measurable, achievable, realistic and timely) and should include details of the funding requested (please enter 0 if no funding is required).
•Any new roles to be introduced as part of an action plan must include detail regarding banding and Whole Time Equivalent (WTE) with associated costs.
•Action plans must be sustainable - Funding is for one year only, so Trusts must demonstrate how future funding will be secured.
•Action plans should not be submitted for achieved safety actions.
If you require any support with this process, please contact **nhsr.mis@nhs.net**

Tab D - Board declaration form - This is where you can view your overall reported compliance with all of the maternity incentive scheme safety actions. This sheet will be protected and compliance fields cannot be altered manually.
If there are anomalies with the data entered, then comments will appear in the validations column (column I) this will support you in checking and verifying data before it is discussed with the Trust Board, ICB and before submission to NHS Resolution.

Upon completion of your submission please add electronic signatures into the allocated spaces within this page. Signatures of both the Trust's Chief Executive Officer (CEO) and Accountable Officer (AO) of the Integrated Care System (ICS) will be required in Tab D in order to confirm compliance as stated in the board declaration form with the safety actions and their sub-requirements. Both signatures will show that they are 'for and on behalf of' the trust name, rather than the ICS. The signatories will be signing to confirm that they are in agreement with the submission, the declaration form has been submitted to Trust Board and that there are no external or internal reports covering either 2023/24 financial year or 2024/25 that relate to the provision of maternity services that may subsequently provide conflicting information to your Trust's declaration. Any such reports should be brought to the MIS team's attention before 3 March 2025

Any queries regarding the maternity incentive scheme and or action plans should be directed to **nhsr.mis@nhs.net**

Technical guidance and frequently asked questions can be accessed in the year 6 MIS document:
MIS-Year-6-v1.1-20240716.pdf (resolution.nhs.uk)

The Board declaration form must be sent to NHS Resolution via **nhsr.mis@nhs.net** between 17 February 2025 and 3 March 2025 at 12 noon. An electronic acknowledgement of Trust submissions will be provided within 48 hours from 3 March 2025.

Submissions and any comments/corrections received after 12 noon on 3 March 2025 will not be considered.
This document will not be accepted if it is not completed in full, signed appropriately and dated.
Please do not send evidence to NHS Resolution unless requested to do so.

Version Name: MIS_SafetyAction_2025

Safety action No. 1

Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?

From 8 December 2023 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all eligible perinatal deaths from 2 April 2024 onwards been notified to MBRRACE-UK within seven working days? (If no deaths, choose NA)	Yes
2	For at least 95% of all deaths of babies who died in your Trust from 8 December 2023, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Yes
3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 2 April 2024 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Yes
4	Were 60% of the reports published within 6 months of death?	Yes
5	Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 8 December 2023 including reviews, any themes identified, and consequent action plans.	Yes
6	Were quarterly reports discussed with the Trust maternity safety and Board level safety champions?	Yes

Safety action No. 2

Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Was your Trust compliant with at least 10 out of 11 MSDS-only Clinical Quality Improvement Metrics (CQIMs) by passing the associated data quality criteria in the “Clinical Negligence Scheme for Trusts: Scorecard” in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2024?	Yes
2	Did July's 2024 data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	Yes

Safety action No. 3
Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Was the pathway(s) of care into transitional care which includes babies between 34+0 and 36+6 in alignment with the BAPM Transitional Care Framework for Practice jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies?	Yes
2	Or Is there a Transitional Care (TC) action plan signed off by Trust and LMNS Board for a move towards the TC pathway (as above) based on BAPM framework for babies from 34+0 with clear timescales for implementation and progress from MIS Year 5.	N/A
Drawing on insights from themes identified from any term admissions to the NNU, undertake at least one quality improvement initiative to decrease admissions and/or length of stay.		
3	By 6 months into MIS year 6, register the QI project with local Trust quality/service improvement team.	Yes
4	By the end of the reporting period, present an update to the LMNS and safety champions regarding development and any progress.	Yes

Safety action No. 4

Can you demonstrate an effective system of clinical workforce planning to the required standard?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Obstetric medical workforce		
1	Has the Trust ensured that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas following an audit of 6 months activity: Locum currently works in their unit on the tier 2 or 3 rota OR They have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual review of Competency Progrssion (ARCP)? OR They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	Yes
2	Has the Trust implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance	Yes
3	Has the Trust monitored their compliance 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' into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ when a consultant is required to attend in person.	Yes
4	Were the episodes when attendance has not been possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.	Yes
Do you have evidence that the Trust position regarding question 3 & 4 has been shared:		
5	At Trust Board?	Yes
6	With Board level safety champions?	Yes
7	At LMNS meetings?	Yes
b) Anaesthetic medical workforce		
8	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) - Representative month rota acceptable.	Yes
c) Neonatal medical workforce		
9	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing? And is this formally recorded in Trust Board minutes?	Yes
10	If the requirements are not met, Trust Board should agree a workforce action plan and evidence progress against any workforce action plan developed previously to address deficiencies.	N/A
11	Was the above workforce action plan shared with the LMNS?	N/A
12	Was the above workforce action plan shared with the ODN?	N/A
d) Neonatal nursing workforce		
13	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing?	Yes
14	If the requirements are not met, Trust Board should agree a workforce action plan and evidence progress against any workforce action plan developed previously to address deficiencies.	N/A
15	Was the above workforce action plan shared with the LMNS?	N/A
16	Was the above workforce action plan shared with the ODN?	N/A

Safety action No. 5

Can you demonstrate an effective system of midwifery workforce planning to the required standard?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period. It should also include an update on all of the points below.	Yes
2	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years? Evidence should include: A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated. If this process has not been completed due to measures outside the Trust's control, evidence of communication with the BirthRate+ organisation (or equivalent) should demonstrate this.	Yes
3	Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated? Evidence should include: ● Meeting midwifery staffing recommendations from Ockenden and evidence of the funded establishment being compliant with outcomes of birthrate+ or equivalent calculations. ● Where Trusts are not compliant with a funded establishment based on the above, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. ● Where deficits in staffing levels have been identified, the plan to address these findings must be shared with the local commissioners. ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall. ● The midwife to birth ratio ● The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.	Yes
4	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty **at the start of every shift.** An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.	Yes
5	A workforce action plan should be produced detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Completion of the workforce action plan will NOT enable the Trust to declare compliance with this sub-requirement.**	N/A
6	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with the provision of one-to-one care in active labour	Yes
7	A workforce action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Completion of the workforce action plan will enable the Trust to declare compliance with this sub-requirement.**	N/A

Safety action No. 6

Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you agreed with the ICB that Saving Babies' Lives Care Bundle, Version 3 is fully in place or will be in place, and can you evidence that the Trust Board have oversight of this assessment? (where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory.)	Yes
2	Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 5, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 6 to track compliance with the care bundle? **These meetings must include agreement of a local improvement trajectory against these metrics for 24/25, and subsequently reviews of progress against the trajectory.**	Yes
3	Have these quarterly meetings included details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.	Yes
4	Is there a regular review of local themes and trends with regard to potential harms in each of the six elements.	Yes
5	**Following these meetings, has the LMNS determined that sufficient progress have been made towards implementing SBLCBv3, in line with a locally agreed improvement trajectory?**	Yes
6	Is there evidence of sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate?	Yes

Safety action No. 7

Listen to women, parents and families using maternity and neonatal services and coproduce services with users

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.	Yes
2	Terms of Reference for Trust safety and governance meetings, showing the MNVP Lead as a member (Trusts should work towards the MNVP Lead being a quorate member), **such as:** •Safety champion meetings •Maternity business and governance •Neonatal business and governance •PMRT review meeting •Patient safety meeting •Guideline committee	Yes
3	Evidence of MNVP infrastructure being in place from your LMNS/ICB, such as: •Job description for MNVP Lead •Contracts for service or grant agreements •Budget with allocated funds for IT, comms, engagement, training and administrative support •Local service user volunteer expenses policy including out of pocket expenses and childcare cost	Yes
4	**If evidence of funding support at expected level (as above) is not obtainable, there should be evidence that this has been formally raised via the Perinatal Quality Surveillance Model (PQSM) at Trust and LMNS level, and discussed at ICB Quality Committee as a safety concern due to the importance of hearing the voices of women and families, including the plan for how it will be addressed in response to that escalation is required.**	N/A
5	Show evidence of a review of annual CQC Maternity Survey data, such as the documentation of actions arising from CQC survey and, if available, free text analysis, such as an action plan.	Yes
6	Has progress on the coproduced action above been shared with Safety Champions?	Yes
7	Has progress on the coproduced action above been shared with the LMNS?	Yes

Safety action No. 8

Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Can you demonstrate the following at the end of 12 consecutive months ending 30 November 2024?		
	Fetal monitoring and surveillance (in the antenatal and intrapartum period)	
1	90% of Obstetric consultants?	Yes
2	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2024) contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor)	Yes
3	For rotational medical staff that commenced work in obstetrics on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	N/A
4	90% Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres?	Yes
	Maternity emergencies and multiprofessional training	
5	90% of obstetric consultants	Yes
6	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2024) including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows, foundation year doctors and GP trainees contributing to the obstetric rota	Yes
7	For rotational medical staff that commenced work in obstetrics on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	N/A
8	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives	Yes
9	90% of maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum).	Yes
10	90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors	Yes
11	90% of all other obstetric anaesthetic doctors (commencing with the organisation prior to 1 July 2024) including anaesthetists in training, SAS and LED doctors who contribute to the obstetric anaesthetic on-call rota. This updated requirement is supported by the RCoA and OAA.	Yes
12	For rotational anaesthetic staff that commenced work in obstetrics on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	N/A
13	At least one emergency scenario is to be conducted in the clinical area, ensuring full attendance from the relevant wider professional team, including theatre staff and neonatal staff	Yes
	Neonatal basic life support (NBLS)	
14	90% of neonatal Consultants or Paediatric consultants covering neonatal units	Yes
15	90% of neonatal junior doctors (commencing with the organisation prior to 1 July 2024) who attend any births	Yes
16	For rotational medical staff that commenced work in neonatology on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	N/A
17	90% of Neonatal nurses (Band 5 and above)	Yes
18	90% of advanced Neonatal Nurse Practitioner (ANNP)	Yes
19	90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)	Yes

Safety action No. 9

Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded?	Yes
2	Has a non-executive director (NED) has been appointed and is visibly working with the Board safety champion (BSC)?	Yes
3	Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) at every meeting using a minimum data set, and presented by a member of the perinatal leadership team to provide supporting context.	Yes
4	Does the regular review include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback.	Yes
5	Do you have evidence of collaboration with the local maternity and neonatal system (LMNS)/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM.	Yes
6	Ongoing engagement sessions with staff as per year 5 of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2024.	Yes
7	Is the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period)?	Yes
8	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.	Yes
9	Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.	Yes

Safety action No. 10

Have you reported 100% of qualifying cases to the Maternity and Newborn Investigation (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you reported of all qualifying cases to MNSI from 8 December 2023 to 30 November 2024.	Yes
2	Have you reported of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 until 30 November 2024.	Yes
3	Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme	Yes
4	Has there been compliance, for all eligible cases, with regulation 20 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014 in respect of the duty of candour?	Yes
5	Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution.	Yes
6	Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme?	Yes
7	Has Trust Board had sight of evidence of compliance with the statutory duty of candour?	Yes
8	Have you completed the field on the Claims reporting wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.	Yes

Section A : Maternity safety actions - University Hospitals Dorset NHS Foundation Trust

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes
9	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?	Yes
10	Have you reported 100% of qualifying cases to the Maternity and Newborn Investigation (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?	Yes

Section B : Action plan details for University Hospitals Dorset NHS Foundation Trust

An action plan should be completed for each safety action that has not been met

Action plan 1

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 2

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 3

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 4

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 5

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 6

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 7

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 8

Safety action		**To be met by**	

Work to meet action	*Brief description of the work planned to meet the required progress.*

Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	

Action plan owner	*Who is responsible for delivering the action plan?*
Lead executive director	*Does the action plan have executive sponsorship?*
Amount requested from the incentive fund, if required	
Reason for not meeting action	*Please explain why the trust did not meet this safety action*
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*
Risk assessment	*What are the risks of not meeting the safety action?*

	How?	**Who?**	**When?**
Monitoring			

Action plan 9

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 10

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Maternity Incentive Scheme - Year 6 Board declaration form

Trust name	**University Hospitals Dorset NHS Foundation Trust**
Trust code	**T694**

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Clinical workforce planning	Yes		-	
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	Yes		-	
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**10**	**-**		
Total sum requested			**-**	

Sign-off process confrming that:

* The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

* The content of this form has been discussed with the commissioner(s) of the trust's maternity services
* There are no reports covering either **this year (2024/25) or the previous financial year (2023/24)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports must be brought to the MIS team's attention.
* If declaring non-compliance, the Board and ICS agree that any discretionary funding will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
* We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of Board governance which will be escalated to the appropriate arm's length body/NHS System leader.

Electronic signature of Trust Chief Executive Officer (CEO):	
For and on behalf of the Board of	University Hospitals Dorset NHS Foundation Trust
Name:	
Position:	
Date:	

Electronic signature of Integrated Care Board Accountable Officer:	
In respect of the Trust:	University Hospitals Dorset NHS Foundation Trust
Name:	
Position:	
Date:	

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 08 January 2025

Agenda item: 7.4

Subject:	Key Issues and Assurance Report to Board of the People and Culture Committee meeting held on 11 December 2024
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 11 December 2024, the Committee received the following:
	• Staff Story presentation from the Trust's Culture Champions
	• Board Assurance Framework: Breakthrough Objectives & Strategic Initiatives
	• People & Culture Strategy
	• Chief People Officer's Report including well-led reports
	• Transforming Care Together "People Ready" Update
	• Safe Staffing – Nursing
	• Guardian of Safe Working Hours Report
	• GMC Survey Results and Action Plan
	• Modern Slavery Statement
	• Equality, Diversity & Inclusion:
	  ○ Annual Report
	  ○ Diverse Ethnicity Network update
	• Freedom to Speak Up Report
	• Assurance/Alerts/Escalations (including from Care Groups)
	• Integrated Performance Report – People & Culture
	• Risk Register: risks rated 12-25 (new and current) relating to Workforce and Organisational Development
	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 for escalation.

	The Committee would like to highlight the following reports which were discussed in detail and likely to be presented at the next Board meeting. 1. Staff Race Allegations Report – Provided an overview of the Employee Race related complaints and investigations in UHD since June 2022. The committee discussed the need for diversity amongst investigators to ensure the nuances of these complaints were understood and taken in to account during the investigation. There was assurance about the management of ongoing cases that were under investigation. The trust does need to formulate an approach to publishing the results of these investigations which can build trust and confidence amongst members of the Global Majority that their complaints will be taken seriously (a concern highlighted in the 'Too hot to Handle' report) 2. People and Culture Strategy – 2024-27 – The committee approved the draft strategy which will be presented at the next Board of Directors. The committee commended Tina Ricketts and her team for the collaborative approach to the development of this strategy. It has clear areas of priorities, underpinned by programmes of work that will deliver the expected Key Performance Indicators over the next two years. There will be new BAF risks as a result of this strategy. 3. Annual In-Patient Establishment Review – The committee noted this report which will also be presented to the Board. The annual assessment using the Shelford Safer Nursing Care tool has provided a number of recommendations. The reinstatement of Band 6 uplift in admission areas requires financial investment and will have an impact on our budget for 2025/26. The authors of the report did not find any current staffing levels which would be deemed unsafe.
Progress of Board Assurance Key Risks Assigned to Committee:	BAF Risk 3 – score remained constant at 12 for December 2024 meeting, with a target of 8.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 08 January 2025

Agenda item: 7.4.1

Subject:	Guardian of Safe Working (GoSW), Quarterly Report
Prepared by:	Paul Froggatt, Guardian of Safe Working Julie Mantell, Medical Education Manager
Presented by:	Paul Froggatt

Strategic themes that this item supports/impacts:	Population & System Our People Patient Experience Quality Outcomes & Safety Sustainable Services	☐ ☒ ☐ ☒ ☐
BAF/Corporate Risk Register: (if applicable)	None	
Purpose of paper:	Information	
Executive Summary:	There has been a further fall in the number of exception reports at Poole Hospital, however RBH has seen an increase of 60 reports. This may have been due to under reporting in the previous quarter. In addition there were a total of 7 Immediate Safety Concerns for the Trust.	
Background:	Resident doctors are employed by the trust as per 2016 TCS. A mandatory component is the role of the GoSW and the preparation of quarterly & annual reports regarding exception reports & the junior doctors forum (JDF)	
Key Recommendations:	The main reason for reporting remains hours worked in excess of the rota and this in addition to the immediate safety concerns invariably relates to acute specialties at times of high workload. This can be difficult to mitigate against but I am in contact with the rota coordinators and will keep this under review as we enter winter.	
Implications associated with this item:	Council of Governors Equality, Equity, Diversity & Inclusion Financial Health Inequalities Operational Performance People (inc Staff, Patients) Public Consultation Quality Regulatory	☐ ☐ ☐ ☐ ☒ ☒ ☐ ☐ ☐

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

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Trust Management Group	19/11/2024	Shared for information
People and Culture Committee	11/12/2024	Noted

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

University Hospitals Dorset
NHS Foundation Trust

GUARDIAN OF SAFE WORKING REPORT

1st July to 30th September 2024

UNIVERSITY HOSPITALS DORSET

CONTENTS:

Of note for this report:
Due to the implementation of HealthRota for Exception reporting, the data has been merged. The data when exported does not split this by site and therefore using rota names and job titles alongside staffing lists, we have split this into Poole and Bournemouth data. As the system went through significant testing, any of these which have 'test' in the notes have therefore been removed.

The categories on HealthRota and Allocate are also different which has meant a more detailed set of specialties have been provided with this quarters data. This however has meant it has been harder to accurately compare the difference in exceptions raised between each quarter.

POOLE AND ROYAL BOURNEMOUTH HOSPITALS OVERVIEW

As described above most specialties/rotas are now exception reporting via Healthrota. This is conveyed to new resident doctors upon starting with the trust and continues to form part of my induction presentation as GoSW.

As GoSW I receive copies of all exception reports and the feedback I have sought and received would indicate that most resident doctors find the new software easy to use. Initially there were delays in the ERs being allocated to correct supervisor & actioned; however, this has steadily improved over the past 6 to 8 weeks.

For this quarter there has been a reduction in reports from Poole and an increase for Bournemouth. The main reason for reporting remains hours worked in excess of the rota and this in addition to the immediate safety concerns invariably relates to acute specialties at times of high workload. This can be difficult to mitigate against but as described below I am in contact with the rota coordinators and will keep this under review as we enter winter.

Resident Doctors Forum Meetings

There were two Resident Doctor Forum meetings during the last quarter:

7th June 2024
Allocate exception reporting: Allocate where shifts times are auto populated and not in keeping with the shifts worked by the doctor. Has affected shift times with move from PGH to RBH OPS where shift times differ. Medical staffing aware of the issue, working to resolve this.

Poole Penthouse: Long term building work and disruption to the penthouse residence. There have been multiple issues, closure of bathrooms, blockage of corridors to replace skylights, blocked sinks, being unable to use the kitchen and water being off/ no hot water. Alternative accommodation is offered. Tried to escalate for compensation. FY1 will forward existing correspondence to take forward with estates CMO is happy to be copied into the correspondence.

Locum break payments- DCMO: Trust aims to promote health and wellbeing which includes promoting breaks. Going forward it will be assumed that breaks is a rest period, and breaks will not be paid. Trust recognises that this isn't always the case. When breaks were missed can complete time sheet to explain why breaks missed. DCMO is happy for feedback and review of this plan.

Rotas- DME
Discussion around involving clinicians and consultants in rota planning. Aiming set up to a system to allow rota to feedback from junior doctors.

Durston Ward Staffing
Issue with the new Durlston rota which has been circulated, Poole A4/5 doctors will be staffing Durlston ward being moved from their base wards when Durlston re-opens. However, some shifts that were rest days are now on the rota as locums. Not clear if this is a suggestion or an expectation. DME reassured that locum shifts cannot be enforced. Was done in oncology as a way of keeping the rota line open and then the shift is advertised, if this is the case, should a non-staff name be used to avoid confusion? Medical Staffing will forward email to DME who will liaise with Medicine Workforce Lead and PGH medicine rota coordinator.

Dr Peter Wilson- Invitation for strike discussions
Dr Wilson opened an invitation to speak with junior doctors about strike plans.

30th August 2024
The following items were agenda items and were discussed:

Formation of new UHD committee, Ongoing merger transition, Exception reporting, RBH mess and Guidelines improvement project.

The minutes were not available in time for this meeting.

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 July to 30th September 2024	Exceptions raised outside of 14 days from event	Outcome agreed (*not closed*)	Number of exceptions closed	Number of exceptions outstanding
Cardiology	3	0	0	3	0
Emergency Medicine	6	0	0	6	0
Gastroenterology	3	0	1	2	0
General Medicine	12	5	3	6	3
General Surgery	10	0	0	10	0
Geriatrics	16	0	1	12	3
Haematology	2	0	0	1	1
Paediatrics	4	1	0	4	0
Respiratory	12	6	0	12	0
Vascular	1	0	0	1	0
Total	**69**	**12**	**5**	**57**	**7**

(Source: Allocate and HealthRota)

Brief Overview of Exception Reports Raised

There was a total of 69 exception reports for the quarter 1st July to 30th September, this is a decrease of 11 compared to the last quarter.

There were four immediate safety concerns raised during this quarter, an increase from zero raised during the previous quarter.

Immediate Safety Concerns (ISC) Raised

There were four ISCs within this period, all of which occurred with general medicine, OPS & gastroenterology. There was a common theme of inadequate staffing during a high volume of patient workload and on one occasion compounded by staff sickness. This is not uncommon & the rota coordinators, with whom I attend a regular meeting, are doing their best to prevent this from happening. I am hopeful that this should improve the situation but will keep this under review.

Exception Reports – Previous Quarter Comparisons

Speciality	Exceptions raised 1st April to 30th June 2024	Exceptions raised 1st July to 30th September 2024	Increase/Decrease
Cardiology	0	3	↑
Emergency Medicine	0	6	↑
Gastroenterology	0	3	↑
General Medicine	45	12	↓
General Surgery	1	10	↑
Geriatrics	26	16	↓
Haematology	8	2	↓
Paediatrics	0	4	↑
Respiratory	0	12	↑
Vascular	0	1	↑
Total	**80**	**69**	↓ 14%

Reasons for Exceptions Raised

Over 94% 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 24 doctors during this period.

Working over contracted hours	Access to Education	Shift Pattern	Service Support	Natural Breaks/Rest
65	0	0	1	3

(Source: Allocate)

Reporting Grades for this Period

FY1	FY2	GP/ST1/2	Trust SHO	IMT1/CT1/ST1	IMT2/CT2/ST2	IMT3/ST3	ST4+
53	0	0	6	8	2	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
19	42	1	0	0	0	7

(Source: Allocate)

Fines

There were no fines this quarter.

Vacancies – Doctors in Training

Department	Number of vacancies
ED	2
Gastro	2
OPS	1
Respiratory	1

(Source: Medical Staffing)

Locum Bookings via Bank – by Dept; by Grade; by Reason

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	13 ↑	13 ↑	89 ↑	89 ↑
Emergency Medicine	443 ↓	333 ↑	4,107 ↓	3,077 ↑
ENT	100 ↑	71 ↓	846 ↓	595 ↓
General Surgery	59 ↓	17 ↓	647 ↓	160 ↓
Intensive Therapy Unit	0 ↓	0 ↓	0 ↓	0 ↓
Maxillo-facial Surgery	2 ↓	2 ↓	25 ↓	25 ↓
Medicine	762 ↑	493 ↑	6,961 ↑	4,512 ↑
Obstetrics and Gynaecology	164 ↓	147 ↑	1,453 ↓	1,299 ↑
Oncology	124 ↓	90 ↓	1,090 ↓	770 ↓
Ophthalmology	0 ↓	0 ↓	0 ↓	0 ↓
Orthopaedic Surgery	742 ↑	620 ↑	6,625 ↑	5,675 ↑
Paediatrics	128 ↓	57 ↓	1,226 ↓	563 ↑
Psychiatry	0 ↓	0 ↓	0 ↓	0 ↓
Urology	0 ↓	0 ↓	0 ↓	0 ↓
TOTAL	**2,537 ↑**	**1,843 ↑**	**23,069 ↑**	**16,763 ↑**

(Source Temp Staffing Office)

During this quarter there was an increase of 6% in the overall number of locum shifts requested from 2393 last quarter to 2537 this quarter. As per the previous quarter, Emergency Department has continued to fall this time from 454 to 443 shifts. The most notable decrease during this quarter has been within General Surgery a 43% decrease from 103 to 59 shifts and Oncology by 38% from 201 to 124. Alongside this there was a significant increase of 32% in General Medicine (576 to 762 shifts) and 22% in Orthopaedic Surgery from 607 to 742 shifts.

The most unfilled shifts were within General Surgery and Paediatrics which is a theme continued from the last quarter. Of note, over half of the General Surgery (71%) and Paediatric (55%) 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	14 ↑	10 ↑	137 ↑	95 ↑
F2	44 ↑	26 ↑	300 ↑	112 ↑
ST/CMT1/2	1,867 ↑	1,391 ↑	17,232 ↓	12,883 ↓
ST3+	612 ↑	416 ↑	5,400 ↑	3,673 ↑
TOTAL	**2,537 ↑**	**1,843 ↑**	**23,069 ↑**	**16,763 ↑**

(Source Temp Staffing Office)

Once again, the majority of shifts (74%) have been requested at ST/CMT 1/2 grades. Although there was an increase in the total number of shifts requested this quarter, we also saw an increase in the number of these worked. Raising from 72% between April and June to 73% between July and September.

Locum Bookings (Bank) by Reason				
Reason	**Number of shifts Requested**	**Number of shifts worked**	**Number of hours Requested**	**Number of hours Worked**
Adhoc	0 ↓	0 ↓	0 ↓	0 ↓
Annual Leave	316 ↓	244 ↓	2,512 ↓	1,997 ↓
Coronavirus	0 ↓	0 -	0 ↓	0 -
Covering Absent Colleagues	36 ↑	27 ↑	296 ↑	216 ↑
Deanery Vacancy	431 ↑	319 ↑	4,063 ↑	3,012 ↑
Escalations	6 ↓	2 ↓	65 ↓	23 ↓
Industrial Action	1 ↑	1 ↑	8 ↑	8 ↑
LTFT Cover	118 ↑	69 ↑	1,240 ↑	716 ↑
Maternity/Paternity Leave	19 ↑	16 ↑	179 ↑	146 ↑
Service Demand (e.g winter pressures)	377 ↑	286 ↑	3,454 ↑	2,688 ↑
Sickness	206 ↑	97 ↑	1,747 ↑	802 ↑
Study Leave	87 ↑	63 ↑	743 ↑	523 ↑
Trust vacancy	786 ↑	627 ↑	7,409 ↑	5,818 ↑
Urgent Clinical Need	147 ↓	86 ↓	1,302 ↓	778 ↓
WLI (Waiting List Initiative)	7 ↑	6 ↑	51 ↑	38 ↑
TOTAL	**2,537 ↑**	**1,843 ↑**	**23,069 ↑**	**16,763 ↑**

(Source Temp Staffing Office)

This quarter, the biggest increase has been for Absent Colleagues (increase of 800% from 4 to 36 shifts) and Study Leave (increase of 164% from 33 to 87 shifts). The highest number of shifts worked were for Industrial Action, Maternity/paternity Leave and Waiting List Initiative.

Locum Bookings via Agency

Grade	**Number of shifts requested**	**Number of shifts worked**
Foundation Year 1	0 -	0 -
Foundation Year 2	1 ↓	1 ↓
ST1/2 - CT1/2	37 ↓	30 ↓
ST3+	33 ↓	23 ↓
TOTALS	**71 ↓**	**54 ↓**

(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 July to 30th September 2024	Exceptions raised outside of 14 days from event	Outcome agreed (*not closed*)	Number of exceptions closed	Number of exceptions outstanding
Acute	2	0	0	2	0
Colorectal	4	0	0	4	0
Gastroenterology	7	0	0	6	1
General Medicine	7	0	2	5	0
General Surgery	3	0	0	3	0
OPS	7	0	0	7	0
Haematology	1	0	0	0	1
Palliative	1	0	0	1	0
Psychiatry	18	13	0	18	0
Respiratory	4	0	2	2	0
Stroke	2	0	0	2	0
Upper GI	22	0	0	22	0
Urology	4	0	0	3	1
Vascular	6	0	0	6	0
Total	**88**	**13**	**4**	**81**	**3**

(Source: Allocate and HealthRota)

Brief Overview of Exception Reports Raised

There was a total of 88 exceptions raised during the quarter 1st July to 30th September, an increase of 60 compared to the previous quarter.

There were four immediate safety concerns raised during this quarter.

Three exceptions which were entered in error have been included in the exceptions closed figures (1 each for Upper GI, Gastroenterology and OPS). As previously noted, due to the changes in reporting systems the specialty categories have changed, making it difficult to compare to the past quarters figures.

Immediate Safety Concerns (ISC) Raised

All of the exception reports which were categorised as ISCs related to the level of senior support which was available during shifts by resident doctors. Three of these occurred within general surgery and relate to changes in the number of Upper GI consultants who are available to look after emergencies. The Foundation Programme Director, Director of Medical Education and Deputy CMO have been involved, with myself and the Clinical Director for Surgery. There has now been a further locum consultant surgeon appointed and it is hoped a further more substantive appointment to be advertised which should help to improve this situation. However it is being kept under review, to evaluate the effect upon ERs.

Speciality	Exceptions raised 1st April to 30th June 24	Exceptions raised 1st July to 30th Sept 24	Increase/Decrease
A&E	0	0	
Cardiology	4	0	
Diabetes & Endo	1	0	
Gastroenterology	5	7	
General Medicine	10	9*	
General Surgery	5	33**	
Geriatrics	3	7	
Haematology	0	1	
Palliative	0	1	
Psychiatry	0	18	
Respiratory	0	4	
Stroke	0	2	
Vascular	0	6	
Total	**28**	**88**	**214%**

*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 86% 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
76	8	0	1	3

(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+
57	22	0	2	5	2	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
38	33	1	3	0	0	2

(Source: Allocate and HealthRota)

Eleven exception reports have been marked as approved on HealthRota, however the outcome types agreed have not been recorded. The reasons for these reports are for being unable to take breaks, attend teaching and inadequate supervision, this information is not held within the Workflow notes or on the system.

Vacancies

Department	Number of vacancies
Cardiology	2
ED	1
Gastroenterology	1
Haematology	1
OMF	5
OPS	2
Paediatrics	2
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	4 ↑	4 ↑	32 ↑	32 ↑
Emergency Medicine	547 ↓	481 ↓	4942 ↓	4346 ↓
General Surgery	250 ↓	178 ↓	2600 ↓	1853 ↓
Maxillo-facial Surgery	0 ↓	0 ↓	0 ↓	0 ↓
Medicine	611 ↓	457 ↓	6051 ↓	4654 ↓
Oncology	1 ↓	0 -	13 ↓	0 -
Ophthalmology	18 ↑	14 ↑	432 ↑	336 ↑
Orthopedic Surgery	231 ↓	176 ↓	1648 ↑	1222 ↓
Urology	34 ↓	32 ↓	334 ↓	315 ↓
Vascular surgery	51 ↑	45 ↑	505 ↑	453 ↑
TOTAL	**1,747 ↓**	**1,387 ↓**	**16,556 ↓**	**13,211 ↓**

(Source Temp Staffing Office)

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

There was a decrease of 15% in the number of shifts requested from 2060 to 1747, with 79% of these worked compared to 78% during the previous quarter. There have been significant increases in the number of shifts requested in Vascular Surgery, from 6 shifts to 51 shifts. In Medicine a decrease of 28% and in Urology, a decrease of 51% has been noted.

Locum bookings (Bank) by Grade				
Grade	**Number of shifts requested**	**Number of shifts worked**	**Number of hours requested**	**Number of hours worked**
F1	8 ↓	5 ↓	78 ↓	40 ↓
F2	7 ↑	4 -	64 ↑	33 ↑
ST/CMT1/2	1,567 ↓	1,257 ↓	14,416 ↓	11,581 ↓
ST3+	165 ↓	121 ↓	1,998 ↓	1,557 ↓
TOTAL	**1,747 ↓**	**1,387↓**	**16,556 ↓**	**13,211 ↓**

(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 hours Requested**	**Number of hours Worked**
Adhoc	0 ↓	0 ↓	0 ↓	0 ↓
Annual Leave	94 ↑	80 ↑	813 ↑	685 ↑
Civil Duty	0 ↓	0 ↓	0 ↓	0 ↓
Covering Absent Colleagues	55 ↑	46 ↑	583 ↑	492 ↑
Deanery Vacancy	46 ↑	42 ↑	519 ↓	469 ↑
Escalations	4 ↓	1 ↓	50 ↓	12 ↓
Industrial Action	2 -	2 -	20 -	20 ↑
LTFT Cover	0 ↓	0 ↓	0 ↓	0 ↓
Maternity/Paternity Leave	15 ↑	14 ↑	161 ↑	153 ↑
Service Demand (e.g winter pressures)	210 ↑	171 ↑	1,783 ↑	1,484 ↑
Sickness	194 ↓	131 ↓	1,832 ↓	1,257 ↓
Study Leave	32 ↑	26 ↑	300 ↑	242 ↑
Trust vacancy	799 ↓	660 ↓	7,477 ↓	6,165 ↓
Urgent Clinical Need	287 ↓	206 ↓	2,957 ↓	2,178 ↓
WLI (Waiting List Initiative)	9 -	8 ↓	64 ↑	56 ↑
TOTAL	**1,747 ↓**	**1,387 ↓**	**16,556 ↓**	**13,211 ↓**

(Source Temp Staffing Office)

This quarter, the biggest bank locum bookings increase has been for Service Demand rising by 30% from 162 to 210 shifts and Covering Absent Colleagues which was not featured in previous reports. Shifts required due to sickness has decreased by 27% from 267 to 194.

Locum Bookings via Agency

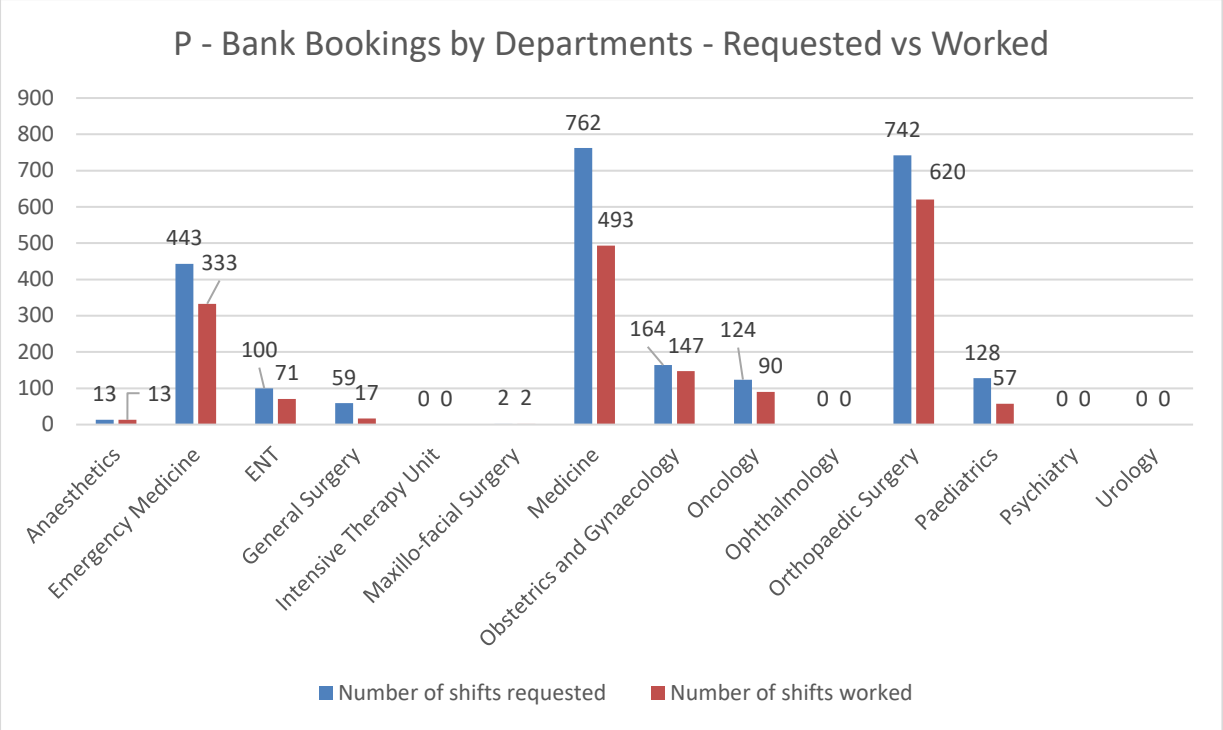
Locum bookings by Grade		
Grade	**Number of shifts requested**	**Number of shifts worked**
Foundation Year 1	0 -	0 -
Foundation Year 2	0 ↓	0 ↓
ST/CMT1/2	0 -	0 -
ST3+	31 ↓	24 ↓
TOTALS	**31 ↓**	**24 ↓**

(Source Temp Staffing Office)

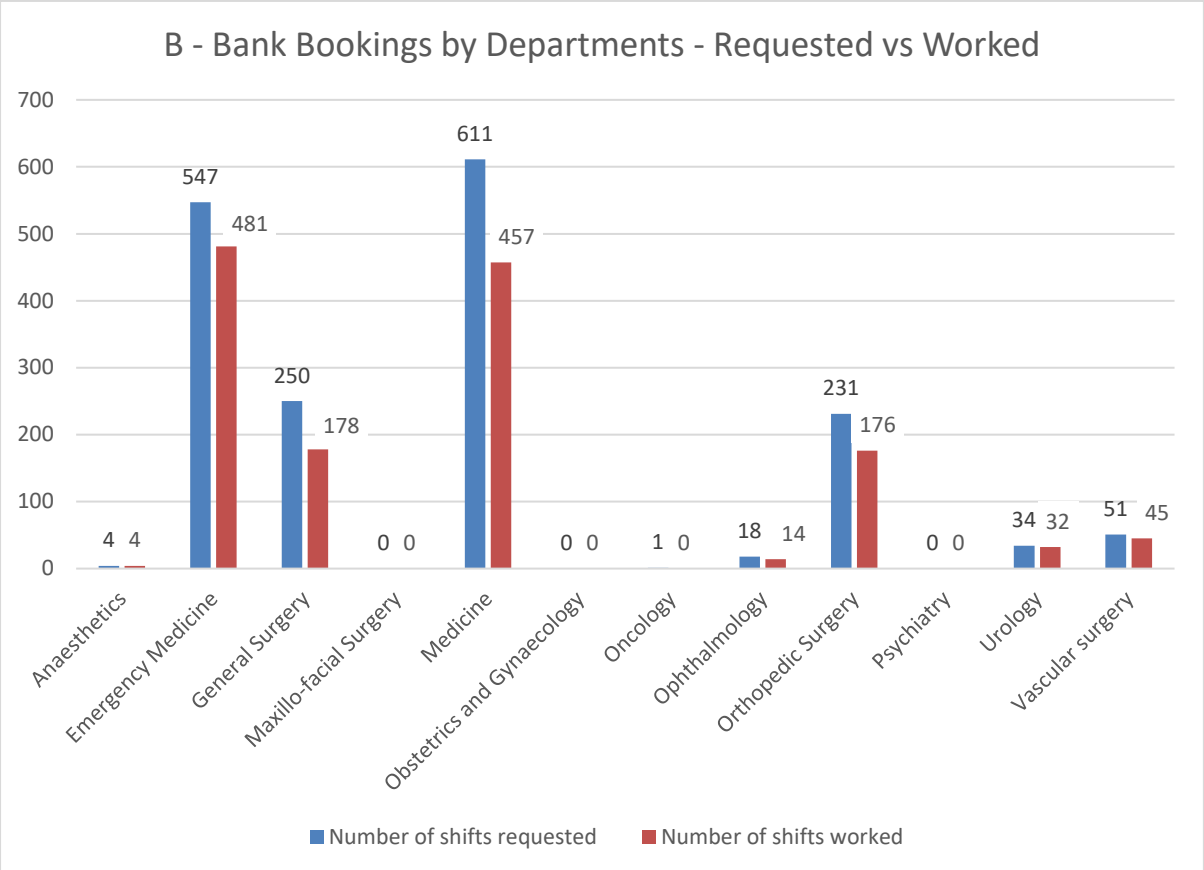
The number of locum bookings via agency has decreased by 75% from 126 to 31 shifts.

Visual Data Representations

Poole



Bournemouth



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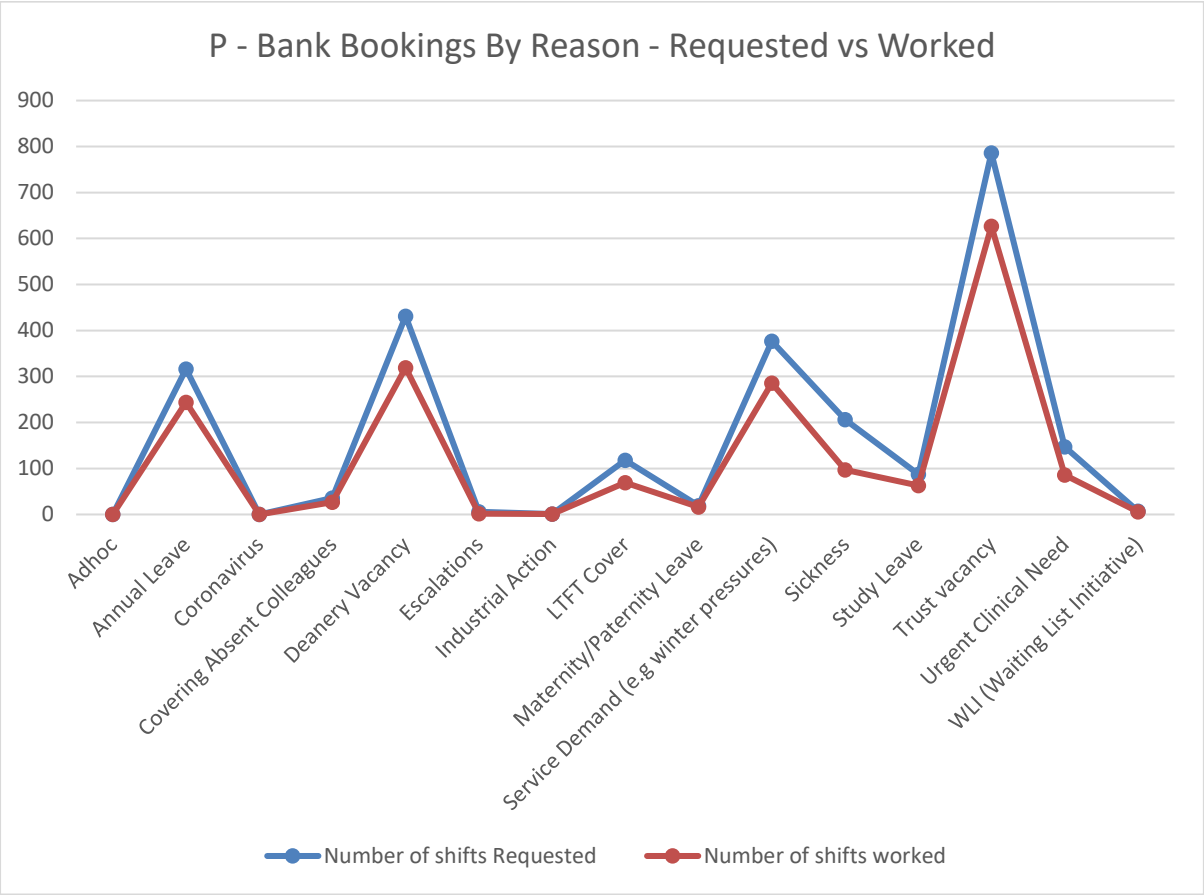

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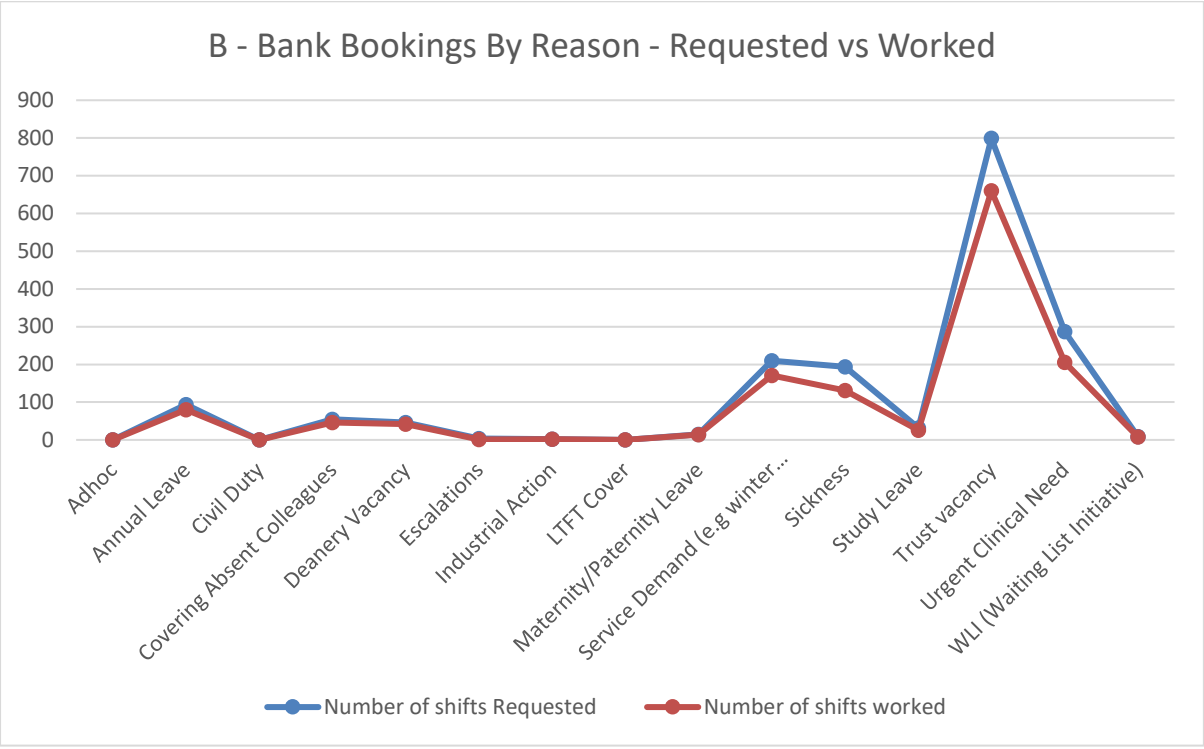

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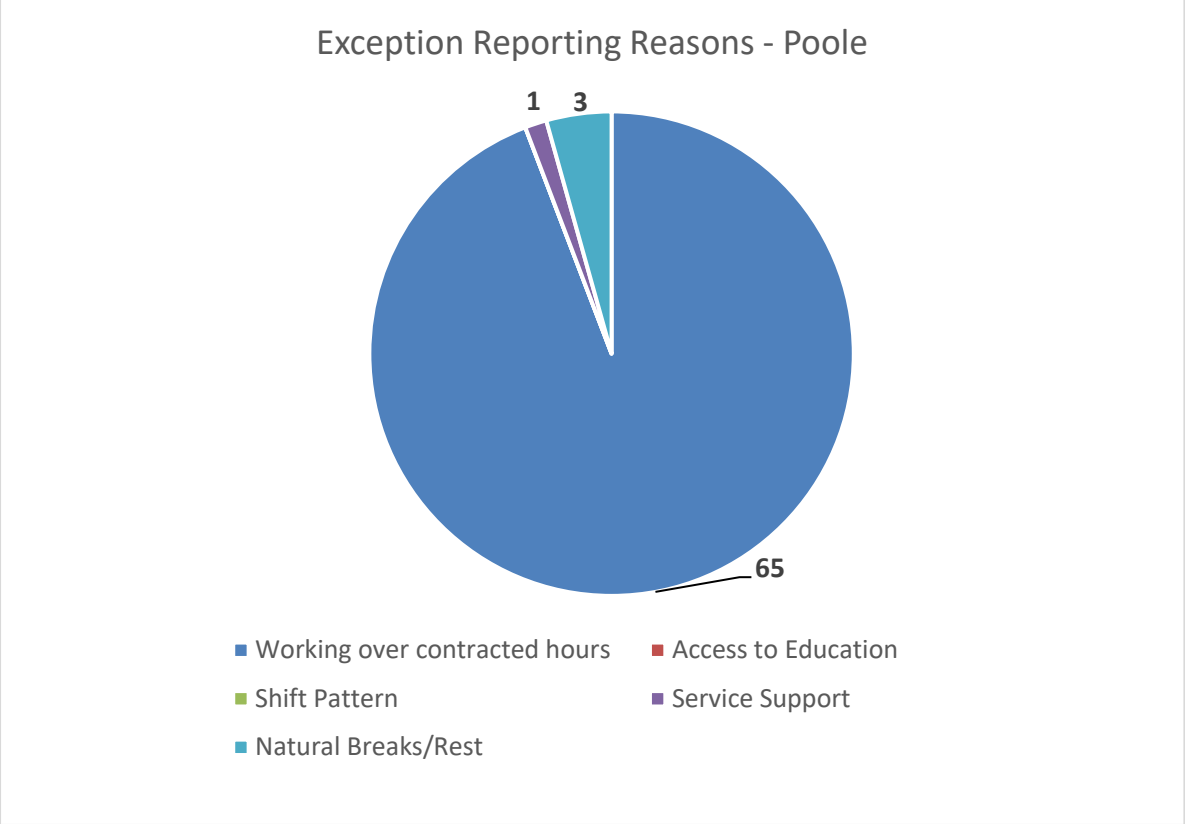
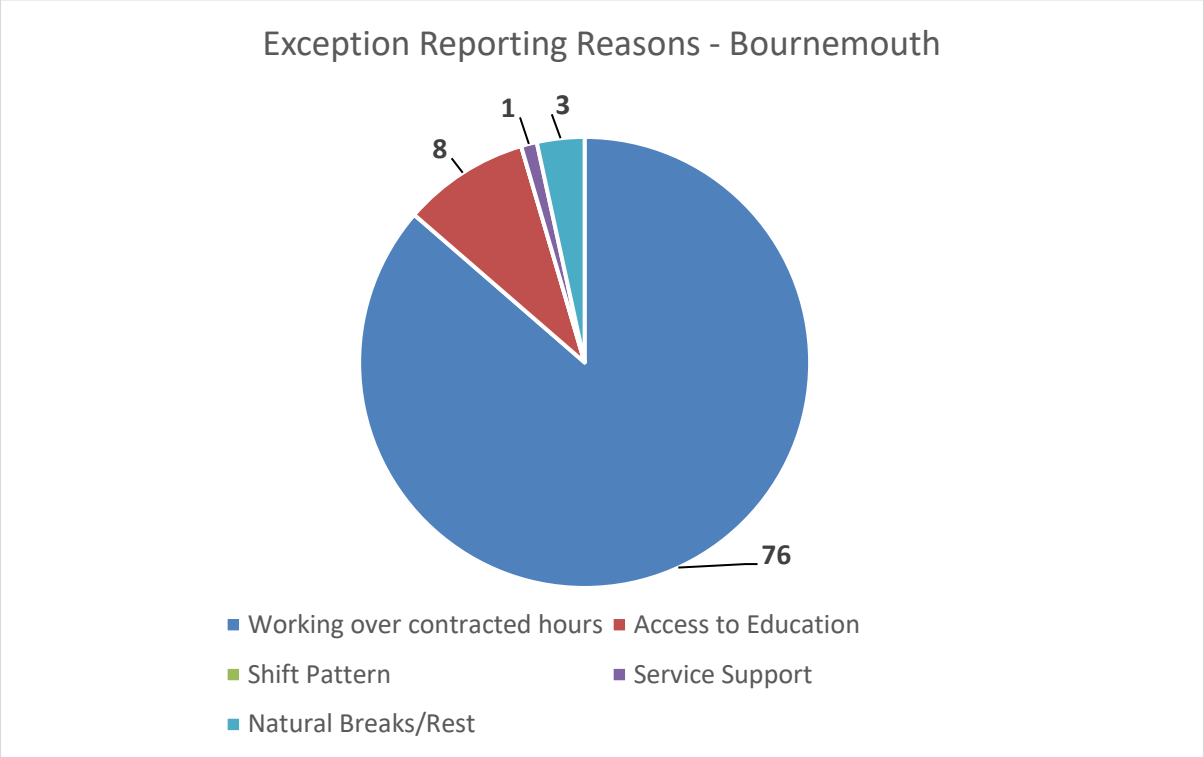


Bournemouth



University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 8 January 2025

Agenda item: 7.4.2

Subject:	24/25 Annual In-Patient Establishment Review
Prepared by:	Matthew Hodson, Deputy Chief Nursing Officer Tracy Moran, Lead Nurse Workforce Andy Rhodes, Finance Business Partner
Presented by:	Sarah Herbert – Chief Nursing Officer

Strategic themes that this item supports/impacts:	Systems working and partnership ☐ Our people ☒ Patient experience ☒ Quality: outcomes and safety ☒ Sustainable services ☒ Patient First programme ☐ One Team: patient ready for reconfiguration ☒
BAF/Corporate Risk Register: (if applicable)	Risk 1056 (9) Inability to provide a fully established nursing workforce in accordance with the agreed establishment template (currently under review)
Purpose of paper:	Review and Discussion
Executive Summary:	This paper sets out the methodology, finding, and outcome of the 2024 annual establishment review, undertaken between August - November 2024, using the Shelford Safer Nursing Care Tool. This the second full annual establishment review to be undertaken since merger and following the pandemic in 2022. This report is presented in full to the Workforce and People committee and Trust Board as an expectation of the National Quality Board guidance on staffing, which requires presentation and discussion at open board on all aspects of the staffing reviews. There are several key recommendations and a number of areas identified for follow-up within Care Groups, these being: Reinstate the Band 6 uplift in admission areas, including Stroke, CCU, AMU, RACE, OPAU, SAU and E3.

	In a number of areas there was a change identified in the staffing requirement following release of the updated Shelford Safer Nursing Care Tool (October 2023) with additional levels of care for patients requiring enhanced therapeutic observation 1c (1:1) and 1d (2:1) To note findings of the annual ward establishment review and the trust position in relation to adherence to the monitoring metrics on staffing levels within inpatient wards and units - UHD nursing establishments are set to achieve a range of 1:2 to 1:7 registered nurses to patient ratio in most areas during the day with 71% set between 1:4 and 1:6. - Differences relate to specialty and overall staffing model. The majority of wards (48) are staffed at between 1:2 and 1:3 registered/unregistered ratios or above. - 22 wards are below the 60:40 Registered Nurse: Unregistered Nurse minimum recommended ratio. - Planned total Care Hours Per Patient Day (CHPPD) range from 4.42 – 14.07 and average at 8.31 To note the Care Group requirements for consideration as part of their budget setting 2025/26 process. To support the continued Trust wide commitment and momentum on actions to fill ward based vacancies and further reduce the reliance on agency, against the backdrop of rising acuity and emergency and elective recovery.
Background:	The National Quality Board (2018) paper 'Developing workforce safeguards' sets out the requirement for the Board of Directors to receive at least annually, a report that outlines the assessment and/or resetting of nursing establishments and skill mix by ward or service area. This report is written in line with this requirement.
Key Recommendations:	It is recommended that the report and recommendations of the 2024/25 establishment review are noted and considered as part of budget setting.
Implications associated with this item:	Council of Governors ☐ Equality and Diversity ☐ Financial ☒ Operational Performance ☒ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☒

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

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
People and Culture Committee Trust Management Group		Noting Review of asks made by care groups as part of the establishment reviews.

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	☐ ☐ ☐ ☐

UHD Inpatient Ward Establishment Review 24/25

December 2024

Index

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Glossary of Terms

Term	**Definition**
Health Roster	The electronic tool that sets out staffs working patterns against the agreed planned staffing requirements for the clinical area.
Template	The number whole time equivalent of staff required to deliver the Healthroster
WTE	Whole time equivalent
Funded Establishment	The establishment as reflected in the Ledger
Shelford SNCT	Shelford Safer Nursing Care Tool: an evidence based audit tool that supports the review of nurse staffing levels using patient acuity and dependency
ICS	Integrated Care System (Dorset NHS ICS).
SafeCare Allocate	Electronic acuity and dependency tool that is linked to Eroster and provides here and now advice around whether staffing levels match demand.
CNO	Chief Nursing Officer
CFO	Chief Finance Officer

1. Introduction and Background

1.1 The purpose of this paper is to report on the outcomes of the second UHD annual review of ward staffing nursing establishments undertaken from August - November 2024. This review forms part of the Trust's evolving approach to the systematic review of staffing resources to ensure safe staffing levels effectively meet patient care needs. The first full UHD review was presented in November 2023 and roster templates adjusted in February 2024.

1.2 This paper focuses specifically on a review of nursing levels for in-patient ward areas. Areas such as maternity, critical care, theatres, recovery and the emergency departments have been reviewed separately as part of the on-going transformation workforce projects. The Outpatient service is also excluded as they are developing a bespoke staffing model as part of a Southwest Regional Workforce Planning programme.

1.3 This paper is produced to support the Chief Executive, Chief Nursing Officer, and Chief Finance Officer regarding their accountability to assure the Board of a safe and affordable nurse staffing model at University Hospitals Dorset.

1.4 In 2023 UHD established and completed its first systematic, evidence based and triangulated methodological approach to reviewing staffing levels since merger in October 2020. This was aimed to align funding and staffing levels across the legacy organisations and provide safe, competent and fit for purpose staffing to deliver efficient, effective and high-quality care.

1.5 All ward establishments and nurse staffing levels are continuously reviewed during this yearly period as ward functions, specialty and acuity/dependency levels have continued to fluctuate due to operational challenges and on-going service reconfiguration.

2. National context

2.1 This paper fulfils expectation 1 and 2 of the National Quality Board NQB (2018) requirements for Trusts in relation to safe nurse staffing and fulfils some requirements outlined in the NHS Improvement 'Developing Workforce Safeguards' guidance (October 2018) which sets out to support providers to deliver high quality care through safe and effective staffing. This review also meets standards outlined in the RCN Nursing Workforce Standards (May 2021).

2.2 Within the NQB framework, expectation one sets out the need to ensure that all establishment reviews include the following key factors:

- Use of a validated/accredited decision support tool
- Professional judgement
- Patient factors

- Ward factors
- Nursing staff factors
- Nursing care activities

2.3 The NQB guidance is further supported by a suite of national guidance documents and recommendations that support the governance process required to demonstrate the delivery of safe staffing in practice, set out in the reference list.

2.4 Organisations are expected to be compliant with the recommendations in these reports and are subject to review on this as part of the CQC inspection programme under both the 'safe' and 'well led' domains.

2.5 Shelford Safer Nursing Care Tool (SNCT)

2.5.1 The Shelford SNCT is a licensed evidence-based methodology which is NICE (2014) endorsed and nationally recognised as a reputable decision support tool for safe staffing decisions. The tool enables indicative nursing establishments to be calculated. The methodology for this process is a combination of:

- Patient acuity and dependency assessment scores (Levels of Care)
- Accurate data collection
- Nursing multipliers
- Consideration of nurse sensitive indicators and resource requirements

2.5.2 It is recommended that at least two Shelford SNCT audits are undertaken to ensure that a full data cycle is collated. This is to allow for richness in the data and for variances to be considered as part of the analysis.

2.5.3 Appendix one sets out the assessment criteria for the Shelford SNCT. The Trust holds a current, valid license to use this tool.

2.6 Care Hours per Patient Day (CHPPD)

2.6.1 CHPPD is a nationally recognised method of measure for available staffing capacity. Lord Carter (2016) indicated CHPPD is a key marker for patient safety, as part of the unwarranted variation review in English acute hospitals. It is a mandated monthly report and provides local and central information regarding the average amount of care delivery time each patient receives a day.

2.6.2 Model Hospital publishes data, submitted from NHS organisations on a monthly basis, allowing comparison with peer and other provider organisations. The data shows the actual care hours delivered and can be viewed in quartiles, with a median figure provided for guidance. It is important to note that the data, and particularly the median figure, does not reflect best practice or take account of patient acuity and dependency and should therefore be considered in line with other safe staffing recommendations.

2.6.3 Where other organisations CHPPD differ, it is important to remember that the data reflected is actual staffing numbers. This will include any staff shortfalls due to vacancy, sickness or leave and any additional staff utilised for one-to-one care, such as registered mental health nurses.

2.7 Whilst there are clear links between patient outcomes, staff well-being and nurse staffing levels, there are intentionally no prescribed minimum staffing levels. The delivery of safe nurse staffing is therefore entrusted to be delivered locally, through national guidance as detailed above.

3. Analysis and Discussion

3.1 Since the first annual establishment review for UHD in 2023 and following the National Quality Board (2014) expectations, UHD have now adopted a full review to be undertaken annually, reporting to Trust Board in December/January. A light touch review will be completed at 6 months reporting to Care Group boards, to ensure on-going quality and compliance with the safe staffing national recommendations.

3.2 Establishment Review Methodology

3.2.1 The Annual 2024 safe staffing review utilised the following methodologies:

- Calculation of the recommended staffing requirement, based on 30 days of data collection, using the Shelford SNCT and staffing calculation tool
- Staffing recommendations shared with Care Group Directors of Nursing (GDON) and Heads of Nursing & Professions (HONP) for local care group review and discussion with Matrons and Ward Leaders
- Professional judgement conversations with Deputy Chief Nursing Officer (DCNO), GDON, HONP, Matrons, Ward Leaders and Lead Nurse Workforce, covering aspects such as environment, patient acuity and dependency, quality and activity factors to triangulate information.
- CHPPD benchmarking exercise using the Model Hospital platform, reviewing proposed staffing levels against the system, ICS and peer acute trust partners
- Presentation of recommendations to the Chief Nursing Officer with DCNO, GDON, HONP and Workforce Lead, for professional review and approval

3.3 Overall, two audit cycles using the Shelford SNCT have been completed during 2024. However, it should be noted the Shelford SNCT was updated in October 2023 with two additional levels of care and associated nursing multipliers for patients requiring enhanced therapeutic levels of care (1c and 1d). As a result of this, professional judgment was applied when reviewing the recommended staffing levels for this review, in the absence of previous comparable data.

3.4 The Safer Nursing Care Tool (acuity/dependency model) has been used to model required staffing, based on the national recommended nurse to patient ratios, for

each category of patient in all the areas. This is integrated into the health roster system as part of the safe-care tool and provides information on acuity/dependency levels and corresponding staffing levels on a real-time basis converted into care hours per patient day

3.5 The CHPPD data (appendix two) has been compared and benchmarked against peer organisation data from Model Hospital, for July 2024.

3.6 Most wards at UHD are currently staffed with Registered Nurses and Healthcare Assistants providing direct patient care. There are a small number of wards that incorporate Registered Nursing Associates in their establishment numbers. Due to the complexity of benchmarking, these roles have not been benchmarked individually but are included in the total CHPPD numbers. This does means that occasionally the total CHPPD number will not equal that of the registered nurse and healthcare support worker numbers when added together.

3.7 A review of pressure damage, falls, medicines incidents and other metrics were included in the discussions with care groups, to ensure safe, quality care can be provided within the establishments.

3.8 Nurse to Patient Ratios and skill mix

3.9 The Royal College of Nursing published their Nursing Workforce Standards (2021), developed as part of their safe staffing campaigns. The standards summarise the expectations in other national guidance and reiterate the importance of the Chief Nurse being responsible for setting nurse staffing levels based on service demand and user needs and the requirement to report directly to the Trust board.

3.10 There is no national standard that sets out nurse staffing levels. NICE (2014) suggest there is no single nursing staff-to-patient ratio that can be applied across the whole range of inpatient wards to safely meet patients' nursing needs.

3.11 The Shelford SNCT recommend a ratio of 72/28 for registered nurse to unregistered nurse in inpatient wards but is acknowledged that for some clinical areas, for example older persons rehabilitation, a skill mix of less than 60:40 can be appropriate due to the nature of the nursing interventions required at registrant level and patient needs that can be met by unregistered nurses.

3.12 UHD ward areas were reviewed against the Shelford recommended best practice benchmark of 70:30 registered to unregistered ratios and 60:40 as the minimum wards should ideally not fall below unless planned as the model of care.

3.13 The support of the Registered Nurse Associate, a Band 4 role, continues to be designed in as part of a model of care in a number of areas. In many areas where the acuity and intensity of patients has increased, and treatment and medication regimes are complex, a further reduction in the overall skill-mix of registered to unregistered staff is not appropriate to maintain safe staffing levels and ensure adequate supervision.

3.14 The nursing ratios will be kept under close review against other metrics to ensure safe, quality care can be provided within the funded establishments; in acknowledgement of the research highlighting the impact on patient outcomes in areas with reduced registered nurse cover.

3.15 Allocated Time for Supervision of Students and Learners

3.16 As a University teaching hospital each areas establishment needs to accommodate for the provision of appropriate supervision of learners undertaking placement in the clinical areas.

3.17 Recommendations for the provision of supervision are set out in the Standards for Supervision (NMC 2019).

3.18 As part of the establishment review consideration has been given to the impact of the supervision of learners in the clinical areas.

3.19 UHD Standards

3.20 Band 7 management / clinical time. There are several models in place across the NHS that advocates non-clinical time for the Band 7 Clinical Leader to focus on their management responsibility.

3.21 At UHD the model of 15 hours a week management time complimented by 22.5 hours for clinical leadership was set in the 2023 review as the minimum standard.

3.22 It is recognised that in some clinical areas this model is not suitable; where there are more staff, a larger footprint or a need for specialist nurses. Where this is the case, professional judgement has been applied.

3.23 Headroom was reviewed post-merger in 2021 to align the legacy organisations. A further amendment was agreed at Trust Management Group in 2024. The new allowances were used to calculate staffing requirements for this review, using the Shelford SNCT calculator.

Clinical area	Headroom allowance %	Change since last review
ED	25	-2%
Critical Care	22.2	-2.8%
Admission Units	22.2	-2.8%
General wards	22.2	No change

3.24 Enhanced Therapeutic Observation of Care (ETOC) and Mental Health Support Worker Roles (MHSW)

3.25 In recent years, there has been a national increase in patients requiring enhanced levels of care, direct supervision or close monitoring to maintain safety, most commonly because of being held under the mental health act whilst waiting for on-going care elsewhere, challenging behaviour or awaiting social care placement or community support.

3.26 An approach was made in 2023 to our local Community Mental Health Trust requesting support to review mental health care delivery at UHD and make recommendations for any workforce adaptations that may be required.

3.27 The outcome of this work is the Enhanced Care Policy in inpatient settings that provides a clear process of assessment and review to determine the needs of all patients requiring enhanced levels of care are appropriately met. The Policy will be launched in December 2024.

3.28 UHD is represented by the DCNO at the newly formed NHSE ETOC collaborative; a national project working with NHS Trusts to develop best practice models for the delivery of ETOC.

4. Ward Staffing Review summary

4.1 The Establishment Review Complete Data (appendix two) - summarises the current and proposed staffing levels across in patient areas, including:

- Registered and unregistered staff on each shift by ward.
- Registered and unregistered skill mix ratio
- Registered nurse (RN) to patient ratio
- Total (registered and unregistered) nurse to patient ratio
- Shelford SNCT calculated CHPPD based on recommended staffing
- Model Hospital reported CHPPD for July 2024 (latest available data), for benchmarking and comparison of the registered, unregistered and combined staffing data for UHD, Peer (CQC Good) Median and Provider (Acute Trust) Median

4.2 This data identifies the ward establishments across UHD allow for registered nurse to patient ratios during the day to range from 1:2 (CCU and Child Health) to 1:9 (Brownsea, Lytchett and Lulworth ward) reflecting the specialty and overall staffing model.

4.3 The average RN to patient level is set to achieve 1:4 to 1:6 in 28 (71%) of wards during the day with 17 wards meeting a ratio of 1:7 to 1:9.

4.4 The wards on or above the 1:7 ratio, on one or more shift, are Ward 2, 3, 4, 5, 14, 16, 22, B1, B3, B4, A1, Kimmeridge, Brownsea, Lytchett, Lulworth, Portland and Derwent.

4.5 There are 22 wards with an RN to unregistered nurse ratio of at least 60:40 and 5 wards at 70:30.

4.6 The following sections provides further analysis of each of the care group's position:

4.7 Medical Care Group

4.8 Nurse to patient ratios by registered and total nursing

4.8.1 The ward establishments across the Medical Care Group at UHD allow for RN to patient ratios during the day to range from 1:2 (CCU) to 1:9 (late shifts on Lulworth, Lytchett and Brownsea wards) depending on the specialty and overall staffing model.

4.8.2 There are 12/25 wards with a ratio of 1:4 – 1:6 during the day and 8 wards at a ratio of 1:7. At night the RN: patient ratio is between 1:5 and 1:9 for all areas with the exception of 2 wards (Fayrewood and ward 24) that have a 1:10 – 1:13 ratio.

4.8.3 Wards with lower RN: patient ratios (as noted in some older people services) require on-going monitoring to ensure there is no further reduction in the RN ratio.

4.9 Registered to unregistered ratios

4.9.1 The medical care group ward areas were reviewed against the benchmark of 60:40 RN: unregistered nurse ratios as the level to which ward establishments should ideally not fall below, unless planned as the model of care.

4.9.2 There are 14/25 wards below the 60:40 ratios; of which 5 wards have a ratio at 53/47 – 59/41. One ward (Portland) has a ratio of 40:60 RN: patient over the 24 hour period, reflecting the model of care for this specialist area (Brain Injury Unit) and increased need for enhanced levels of care.

4.10 Care Hours per Patient Day

4.10.1 The planned total Care Hours per Patient Day (CHPPD) range from 5.5 rising to 12.01 (AMU RBH). This is comparable with the Model Hospital reference data for most areas, the exception being AMU and CCU.

4.11 Specific Care Group issues emerging for Medical Care Group

4.11.1 The staffing levels across the Medical Care Group were reviewed and following triangulation of quality metrics and professional judgement discussions, were agreed to be appropriate in most areas.

4.11.2 There were some common themes identified in addition to specific ward requirements, as detailed below.

4.11.3 A common theme from the review was variation in the Discharge Coordinator and Housekeeper resource due to vacancy and some funding shortfall. This was cited as a pressure on nursing staff that were required to fulfil the roles. A review of the Housekeeper and Discharge Coordinator funding will be undertaken and recommendations made for investment at Care Group level, as required.

4.11.4 The Acute Admission (AMU/OPAU) units, Stroke Unit and CCU reported that the Band 6 uplift had been removed, adding a budgetary risk into the establishment. These areas require a Band 6 Nurse-in-charge 24 hours a day with the associated budget uplift; uplift costs to cover annual leave, sickness and study leave have been applied at Band 5 not Band 6 level as required.

4.11.5 The SNCT audit data including the 1c/1d recommended staffing required an increase on 15 of the 25 wards. Safety of these patients is currently mitigated with on-going assessment of need and deployment of temporary staffing. The launch of the ETOC Policy in December will strengthen safe staffing across the wards caring for patients with enhanced care needs.

4.11.6 The medical care group are already in the process of reviewing enhanced care in the older person's directorate and are building a business case to create a more sustainable resource.

4.12 Areas for inclusion at budget setting post 2024/25 review

4.12.1 Ward 2 reported an increase in the acuity and dependency of patients requiring respiratory support or Level 2 care. The current template reduces by 1 RN at the weekend on day shifts and their unregistered numbers reduce to 1 every night. Following this establishment review it was agreed there is a need to increase the weekend RN Ratio on days from 4 to 5 and also increase the night RN: unregistered staffing from 3:1 to 3:2 and additional unregistered nurse on days. The funding for this uplift is available within existing budgets with the exception of the unregistered nurse early shift. This will be reviewed as part of budget setting by the care group.

4.12.2 A care group review of the Band 6 uplift in acute admission areas, CCU & Stroke Unit is required with a recommendation the uplift is re-instated to ensure consistent 24 hour cover at Band 6.

4.12.3 A5 ward reported a need to create a high acuity bay on the ward, to align with the gastroenterology care model on Ward 1 at RBH. To achieve this, an additional RN at night is required. This investment is being reviewed by the care group and is expected to be cost neutral.

4.12.4 RACE, the OPS admissions unit, employs Band 2 Patient Support Workers (PSW) to assist with patient escorts and improve patient flow. The ward recruited 1.0wte using unregistered nursing budget but require a further 1.0wte to run the service effectively.

This is a cost pressure to the ward and requires further discussion as part of budget setting within the care group. AMU also employs PSW but are using Housekeeper budget to fund the posts. This service element requires further review by the Care Group prior to a decision to further invest in this area.

4.12.5 Durlston ward wish to fund a Discharge Co-ordinator for three days a week, this was agreed as funding would come from within budget due to changing the HCSW role, it was noted that this would not impact on the quality of care provided but enhance the skill mix by releasing nursing staff.

4.12.6 Ward 23 sought additional investment to increase their HCSWs to a 2:2 model to provide an additional HCSW at night; this was highlighted due to an increase in dependency in this ward since the transfer of cardiology to the Royal Bournemouth site. This additional investment will be reviewed as part of budget setting by the care group.

4.13 Surgical Care Group

4.14 Nurse to patient ratios by registered and total nursing

4.14.1 The range in RN: Patient ratios across the Surgical Care Group is between 1:4 and 1:7 during the day and 1:4 and 1:12 at night, depending on specialty and overall staffing model.

4.14.2 There are 10/15 wards with a 1:4 - 1:5 ratio on days and 6 with this ratio at night. A further 5 wards have a ratio on days of 1:6 - 1:7 and 5 have this ratio at night. The remaining 4 wards have a night ratio of 1:8 - 1:12 (E3 ward but the recommended staffing increase will improve the ratio to 1:8 RN: patient). The BPC (Private Ward) has a ratio of 1:3 day and night.

4.15 Registered to unregistered ratios

4.15.1 Across surgery ward areas were reviewed against the benchmark of 60:40 registered to unregistered ratios as the level to which ward establishments should ideally not fall below unless planned as the model of care.

4.15.2 7 wards are rostered at between 60:40 and 70:30, with 2 wards between 50:50 and 57:43 and a further 6 at or below 50:50 on at least 1 shift (early or late). A review of areas at or below a 50:50 ratio will be kept under close review.

4.16 Care Hours Per Patient Day

4.16.1 Planned total Care Hours per Patient Day (CHPPD) range from 5.01 rising to 15.95 (Derwent ward) and average at 8.31. A comparison with the Model Hospital data suggests ward 15 CHPPD are lower at 5.67 compared with 8.0 and Derwent is significantly higher at 15.95 compared to the mean provider level of 7.05.

4.17 Specific Care Group issues emerging for Surgical Care Group

4.17.1 The staffing levels across the Surgical Care Group were reviewed and following triangulation of quality metrics and professional judgement discussions, were agreed to be appropriate in most areas.

4.17.2 The SNCT audit data including the 1c/1d recommended staffing required an increase on 4 of the 14 wards in Surgery. Safety of these patients is currently mitigated with on-going assessment of need and deployment of temporary staffing. The launch of the ETOC Policy in December will strengthen safe staffing across the wards caring for patients with enhanced care needs.

4.17.3 A further review of Ward 12 was required to confirm the funding for any additional requirements in increase of HCSW requirements.

4.18 Areas to put forward at budget setting post 2024/25 review:

4.18.1 Ward B2 review identified that there was skill mix gap therefore agreed that they would review two Band 4 posts to uplift to Band 5 posts, this is supported. This additional small investment will be reviewed as part of budget setting by the care group.

4.18.2 Ward B4 review identified a leadership gap and therefore agreed for an increase into the B6 line by uplifting a B5 to a B6 post, small uplift found within the establishment. The need for an additional HCSW on a long day, seven days a week was discussed, agreed that further review of this was required in terms of use of Enhanced Therapeutic Observations of Care (ETOC); any additional support required in this area is supported by a temporary workforce.

4.18.3 Ward B3 review identified that they want the nurse-in-charge to be supernumerary due to the complexities of the clinical environment; a 30 bedded ward that requires the nurse in charge to manage a caseload of patients and coordinate. This was agreed in principle but would need to be prioritised through the care group's budget setting meeting.

4.18.4 Ward E3 is a trauma admissions unit accepting patients with lower limb fragility fractures day and night, including direct admissions from ED. Following this establishment review there is an ask for an additional RN at night to maintain safe staffing, aligned with other admission units across the Trust.

4.18.5 C4SAU review identified a change in skill mix converting a 0.4 wte of HCSW role to a ward clerk, without compromising current CHPPD. This was approved as within budget and no additional headcount.

4.18.6 Ward 15 was given approval to convert an unregistered nurse 10am – 6pm shift to a late shift to meet the increased demand on the ward in the evening.

4.18.7 Ward 16 review identified an additional registered nurse on night duty to increase the RN to unregistered nurse ratio to 4:2 on night duty due to an increase in acuity and dependency. This was agreed in principle but would need to be prioritised through the care group's budget setting meeting. Further detailed review of the request for a HCSW seven days a week was requested and will be taken forward by the Care Group DON.

4.19 Women's, Cancer Care and Specialist Services (WCCSS) Care Group

4.20 Nurse to patient ratios by registered and total nursing

4.20.1 The 9 ward establishments across the WCCSS Care Group allow for registered nurse to patient ratios during the day to range from 1:2 (Child Health) to 1:8 (A1, B1) depending on specialty and overall staffing model.

4.20.2 The average RN: patient ratio on days is 1:3 to 1:4 (5 wards) with 2 wards at 1:5 – 1:6 (CAU & Sandbanks).

4.20.3 The RN: patient ratio at night ranges from 1:2 to 1:8 (Sandbanks, Ward 11 & Macmillan Unit)

4.21 Registered to unregistered ratios

4.21.1 The WCCSS ward areas were reviewed against the benchmark of 60:40 registered to unregistered ratios as the level to which ward establishments should ideally not fall below unless planned as the model of care.

4.21.2 Five wards are now rostered at between 60:40 and 70:30

4.21.3 There are 3 wards below the 60:40 ratios and 1 at 50:50.

4.21.4 The SNCT audit data including the 1c/1d recommended staffing required an increase on 4 of the 14 wards in WCCSS. Safety of these patients is currently mitigated with on-going assessment of need and deployment of temporary staffing. The launch of the ETOC Policy in December will strengthen safe staffing across the wards caring for patients with enhanced care needs.

4.22 Care Hours Per Patient Day

4.22.1 Planned total Care Hours per Patient Day (CHPPD) range from 4.42 – 14.07 and average at 11.60. In comparison with the Model Hospital data for Cancer services, UHD has a lower CHPPD. A further review of these areas by the GDON is recommended as part of the establishment review due to the increased complexity of the patients.

4.23 Specific Care Group issues emerging for WCCSS Care Group

4.23.1 The staffing levels across the WCCSS Care Group were reviewed and following triangulation of quality metrics and professional judgement discussions, were agreed to be appropriate in most areas.

4.23.2 Sandbanks ward has experienced a high staff turnover due to career progression and some anxiety of the future transformation changes. This has created some skill mix challenges as new, less experienced staff are appointed.

4.23.3 Ward 7R is a new ward in the WCCSS care group following ward moves from Poole to RBH as part of the transformation programme. A challenge for the ward is a loss of nursing hours due to an RN being required to collect blood for patient transfusions; estimated at 50+ hours per week.

4.23.4 An increase in the number of children with challenging mental health needs was evident in these discussions.

4.24 Areas to put forward at budget setting post 2024/25 review:

4.24.1 Ward 7R establishment review identified an increase in the unregistered nurse twilight shift to a full night shift. The ward is unable to seek cover from the neighbouring ward and therefore at risk during staff breaks. This change was agreed as the cost can be covered within the current budget and will not impact on headroom.

5. Establishment Review Outcome Recommendations

5.1 The focus of this establishment review has been on the nursing establishments to maintain safe staffing. However, it was apparent that some of the nursing budget has been used to support non-nursing services that impact on patient activity and flow. The following recommendations are made to ensure future establishments reviews give due consideration to this.

5.2 Continued training on the use of the Shelford SNCT and SafeCare Allocate to increase staff understanding and confidence when completing the acuity and dependency audits

5.3 A review of the model for Discharge Co-ordination to include parity in role description, banding, and whether a blended central / ward aligned model is right for the Trust post transformation

5.4 Outcomes from the ward housekeeper and ward hostess review to be shared and implemented, with one role and job title being agreed

5.5 Band 6 uplift to be reinstated in acute assessment and admission areas to fund the 24 hour Band 6 staffing requirement

5.6 Implementation and embedding of the Enhanced Therapeutic Observation of Care policy

5.7 Launch of the updated rostering policy and monitoring compliance through the Safer Staffing Group

5.8 Review night shift registered nurse staffing numbers across care groups and current impact to identify themes and trends

6. Conclusion

6.1 Following this detailed review of the nursing templates at UHD the authors and lead contributors believe that the proposed rosters will provide safe, high-quality, cost-effective care for our patients.

6.2 All rosters and templates have been vigorously reviewed using a consistent process and aligned with the corporate minimum standards and best practice guidance. The result of which sees the majority of templates remaining static with some requiring investment.

6.3 Although the review has identified areas for investment and budget alignment it is important to note that the senior nursing team did not find any areas where the current staffing position was deemed to be unsafe.

6.4 The proposed new rosters fit national safe staffing guidance and will enable our staff to deliver safe, high-quality care. It is, therefore, the recommendation of the senior nursing team that the proposed changes to the rosters are approved and implemented.

6.5 To note findings of this annual ward establishment review and the Trust position in relation to adherence to the monitored metrics on nurse staffing levels.

6.6 To note the introduction of acuity 1c and 1d in the Shelford Safer Nursing Care Tool this will form part of on-going evidence and monitoring for patients needing enhanced care.

6.7 To support the continued Trust wide commitment and momentum on actions to fill vacancies and further reduce the reliance on agency and bank against the backdrop of rising acuity, emergency and elective recovery.

6.8 Systematic ward staffing reviews to be reported to board annually, with a 6 monthly light touch reviews reported through the Care Group Board. Next full staffing review to be presented to Trust Board in January 2026.

7. Appendix One – Shelford Safer Nursing Care Tool Levels of Care

the SHELFORD GROUP

Safer Nursing Care Tool (SNCT)

Safer Nursing Care Tool

Care level	Descriptor *Care requirements may include the following:*
Level 0 Hospital Inpatient Needs met by provision of normal ward cares.	• Underlying medical condition requiring on-going treatment. • Post-operative / post-procedure care - observations recorded as per local policy. • National Early Warning Score (NEWS) is within normal threshold. • Patients requiring oxygen therapy. • Patients not requiring enhanced therapeutic observations (according to local policy). • Patients requiring assistance of one with some activities of daily living.
Level 1a Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.	• Step down from Level 2 care. • Requiring continual observation / invasive monitoring/physiological assessment. • NEWS local trigger point reached and requiring intervention/action/review. • Pre-operative optimisation/post-operative care for complex surgery. • Requiring additional monitoring/clinical interventions/clinical input including: - Patients at risk of a compromised airway - Oxygen therapy greater than 35%, + / - chest physiotherapy 2–6 hourly or intermittent arterial blood gas analysis - Post 24 hours following insertion of tracheostomy, central lines, epidural or multiple chest drains - Severe infection or sepsis - New spinal injury/cord compression
Level 1b Patients who are in a STABLE condition but are dependent on nursing care to meet most or all of their care needs.	• Complex wound management requiring more than one nurse or takes more than one hour to complete. • Patients with stable Spinal/Spinal Cord Injury. • Patients who consistently require the assistance of two or more people with mobility or repositioning. • Requires assistance with most or all care needs. • Complex Intravenous Drug Regimes – (including those requiring prolonged preparatory/administration/post-administration care). • Patient and/or carer's requiring enhanced psychological support owing to poor disease prognosis or clinical outcome. • Patients requiring intermittent or within eyesight observations according to local policy. • Facilitating a complex discharge where this is the responsibility of the ward-based nurse.
Level 1c Patients who are in a STABLE condition but are requiring additional intervention to mitigate risk and maintain safety	• Patients requiring arm's length or continuous observation as per local policy.

Care level	Descriptor *Care requirements may include the following:*
Level 1d Patients who are in a STABLE condition but are requiring additional intervention to mitigate risk and maintain safety	• Patients requiring arm's length or continuous observation by 2 or more members of staff (provided from within ward budget) as per local policy.
Level 2 Patients who may be managed within clearly identified, designated beds with the resources, expertise and staffing levels required OR may require transfer to or be cared for in a dedicated Level 2 facility/unit.	• Deteriorating / compromised single organ system. • Step down from Level 3 care or step up from Level 1a. • Post-operative optimisation/ extended post-op care. • Cardiovascular, renal or respiratory optimization requiring invasive monitoring. • Patients requiring non-invasive ventilation/respiratory support; CPAP/BiPAP in acute respiratory failure. • First 24-hours following tracheostomy insertion or patients post 24-hours requiring 2-hourly suction. • CNS depression of airway and protective reflexes. • Patients with burns where more than 30% body surface area is affected or requiring conscious sedation for dressing changes. • Requires a range of therapeutic interventions which may include: - Greater than 50% oxygen continuously - Requiring close observation due to acute deterioration and needing advanced organ support - Drug Infusions requiring more intensive monitoring e.g. vasoactive drugs (amiodarone, inotropes, gtn) or potassium, magnesium - CNS depression of airway and protective reflexes - Invasive neurological monitoring including ICP, external ventricular drains and lumbar drains
Level 3 Patients needing advanced respiratory support and/ or therapeutic support of multiple organs.	• Monitoring and supportive therapy for compromised/collapse of two or more organ/ systems. • Respiratory or CNS depression/compromise requires mechanical/invasive ventilation. • Invasive monitoring, vasoactive drugs, treatment of hypovolaemia/haemorrhage/ sepsis or neuro protection.

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8. Appendix Two – CHPPD Data Overview

Medical Care Group (1/2) – Specialist Medicine and Network Medicine

Key: **Green Text** = increase in staffing within budget
Red Text = reduction in staffing
Yellow highlight = review recommended increase at budget setting
** Change in skill mix resulting in RN:unregistered ratio below 60:40

						Finance Budgeted	Staffing Data														CHPPD		Model Hospital CHPPD Data (Latest July 2024)								
	Directorate	Clinical Area	Cost Centre	Funded Beds/ Unfunded beds	Shift	Budgeted Nursing (WTE)	Registered Numbers		Unregistered Numbers		Total Nurse Numbers		Skill Mix (RN/HCSW)		Comments	Patients RN Ratio (RN:Patient)		Patient Nurse Ratio (Nurse:Patient)				UHD			Peer (CQC Good) Median			Provider Median		
						Current	Current	Proposed	Current	Proposed	Current	Proposed	Current	Proposed		Current	Proposed	Current	Proposed	Current	SCNT Recommend	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total
Medical Care Group	Specialist Medicine	Ward 1	10377	22	Early	29.56	5	5*	3	3	8	8	63/37	63/37	*Historical RN reduction by 1 on E weekend shifts	1:4	1:4	1:3	1:3	7.1	6.54	4.09	3.94	8.03	3.38	3.73	6.74	3.63	3.94	7.5
					Late		4	4	2	2	6	6	67/33	67/33		1:5	1:5	1:4	1:4											
					Night		3	3	1	1	4	4	75/25	75/25		1:7	1:7	1:5	1:5											
		Ward 2	10369	27	Early	29.57	5	5*	3	4*	8	9	63/37	**56/44	*Increase in RN for E/L at wend plus HCSW Early	1:5	1:5	1:3	1:3	6.0	8.12	3.34	2.39	5.73	3.09	4.11	7.08	3.27	4.11	7.21
					Late		4	4	2	3*	6	7	67/33	**57/43	*Increase HCSW x1 on Late Shift	1:7	1:7	1:4	1:4											
					Night		3	3	1	2*	4	5	75/25	60/40	*Increase HCSW x1 on Night Shift	1:9	1:9	1:6	1:5											
		Ward 3	10598	28	Early	34.81	5	5	4	4	9	9	55/45	55/45		1:6	1:6	1:3	1:3	6.57	6.23	3.20	2.28	5.48	3.09	4.11	7.08	3.27	4.11	7.21
					Late		4	4	3	3	7	7	57/43	57/43		1:7	1:7	1:4	1:4											
					Night		3	3	2	2	5	5	60/40	60/40		1:9	1:9	1:6	1:6											
		Ward 14	10361	28	Early	34.81	5	5	4	4	9	9	55/45	55/45		1:6	1:6	1:3	1:3	6.82	7.39	3.28	3.23	6.51	3.63	3.03	7.08	3.70	3.17	7.32
					Late		4	4	3	3	8	7	57/43	57/43		1:7	1:7	1:3	1:4											
					Night		3	3	2	2	5	5	60/40	60/40		1:9	1:9	1:6	1:6											
		A5 (Avonbourne)	20325	27	Early	41.47	5	5	4	4	9	9	55/45	55/45		1:5	1:5	1:3	1:3	7.91	7.58	4.42	3.03	9.02	3.63	3.03	7.08	3.70	3.17	7.32
					Late		5	5	3	3	8	8	63/37	63/37		1:5	1:5	1:3	1:3											
					Night		3	4*	3	3	6	7	50/50	**57/43	*Increae RN x 1 on Night Shift	1:9	1:7	1:5	1:4											
		A4 (Arne)	20330	26	Early	44.57	7	7*	3	3	10	10	70/30	70/30	*To reduce RN x1 on E weekend shifts (support W2)	1:4	1:4	1:3	1:3	9.0	5.55	5.34	4.56	4.31	4.56	3.18	3.89	4.31	7.79	8.51
					Late		6	6	3	3	9	9	67/33	67/33		1:4	1:4	1:3	1:3											
					Night		4	4	3	3	7	7	57/43	57/43		1:6	1:6	1:4	1:4											
		AMU P	20317	30	Early	59.94	8	8	5	5	13	13	62/38	62/38	SDEC staffing included in numbers	1:4	1:4	1:3	1:3	8.15	7.60	6.34	3.05	9.39	3.63	3.03	7.08	3.70	3.17	7.32
					Late		8	8	5	5	13	13	62/38	62/38	SDEC staffing included in numbers	1:4	1:4	1:3	1:3											
					Night		6	6	2	2	8	8	75/25	75/25		1:5	1:5	1:4	1:4											
		AMU RBH	10380	46	Early	84.22	10	10	7	7	17	17	59/41	59/41	SDEC staffing included in numbers	1:4	1:4	1:3	1:3	12.01	7.06	5.86	3.54	9.41	3.63	3.03	7.08	3.70	3.17	7.32
					Late		10	10	7	7	17	17	59/41	59/41	SDEC staffing included in numbers	1:4	1:4	1:3	1:3											
					Night		9	9	5	5	14	14	64/36	64/36		1:6	1:6	1:3	1:3											
		Durlston		15	Early	22.4	3	3	3	2*	6	5	50/50	60/40	*Remove 10-6 shift & invest in Dicharge Co-ordinat	1:5	1:5	1:3	1:3	7.8	6.2	3.62	2.55	6.17	3.11	3.75	6.84	3.11	3.75	6.84
					Late		3	3	3	2	6	5	60/40	60/40		1:5	1:5	1:3	1:3											
					Night		3	3	1	1	4	4	75/25	75/25		1:5	1:5	1:4	1:4											
	Networked Medicine	CCU	10314	15	Early	35.05	7	7	2	2	9	9	78/22	78/22		1:2	1:2	1:2	1:2	10.97	8.19	12.12	1.65	13.77	4.46	3.54	7.97	4.92	2.91	8.02
					Late		7	7	2	2	9	9	78/22	78/22		1:2	1:2	1:2	1:2											
					Night		5	5	0	0	5	5	100/0	100/0		1:3	1:3	1:3	1:3											
		Ward 23	11530	19	Early	33.27	4	4	3	3	7	7	57/43	57/43		1:5	1:5	1:3	1:3	6.23	4.84	4.98	2.70	7.96	4.46	3.54	7.97	4.92	2.91	8.02
					Late		4	4	3	3	7	7	57/43	57/43		1:5	1:5	1:3	1:3											
					Night		2	2	1	2*	3	4	66/33	**50/50	*Increase HCSW x1 on Night Shift	1:10	1:10	1:5	1:5											
		Ward 24	10365	25	Early	32.58	5	5	3	3	8	8	63/37	63/37		1:5	1:5	1:3	1:3	7.16	5.29	3.11	2.71	5.81	4.47	3.55	7.98	4.93	2.92	8.03
					Late		5	5	3	3	8	8	63/37	63/37		1:6	1:6	1:4	1:4											
					Night		2	2	3	3	5	5	40/60	40/60		1:13	1:13	1:5	1:5											
		Portland(BI)	20403	14	Early	22.74	3	3	4	4	7	7	43/57	43/57		1:3	1:3	1:2	1:2	10.8	11.09	6.62	4.23	6.84	3.11	3.75	6.84	3.11	3.75	6.84
					Late		2	2	4	4	6	6	33/67	33/67		1:7	1:7	1:2	1:2											
					Night		2	2	3	3	5	5	40/60	40/60		1:7	1:7	1:3	1:3											
		Acute Stroke Unit	10368	43	Early	67.18	10	10	6	6	16	16	63/37	63/37		1:4	1:4	1:3	1:3	8.94	8.70	5.03	2.61	7.65	3.11	3.75	6.84	3.11	3.75	6.84
					Late		9	9	5	5	14	14	64/36	64/36		1:5	1:5	1:3	1:3											
					Night		7	7	4	4	11	11	67/33	64/36		1:5	1:5	1:4	1:4											

Appendix Two – Medical Care Group (2/2) – Older Persons Services and Acute Care

Key: Green Text = increase in staffing within budget
Red Text = reduction in staffing
Yellow highlight = review recommended increase at budget setting
** Change in skill mix resulting in RN:unregistered ratio below 60:40

	Directorate	Clinical Area	Cost Centre	Funded Beds/ Unfunded beds	Shift	Finance Budgeted	Staffing Data												CHPPD		Model Hospital CHPPD Data (Latest July 2024)								
						Budgeted Nursing (WTE)	Registered Numbers		Unregistered Numbers		Total Nurse Numbers		Skill Mix (RN/HCSW)		Comments	Patients RN Ratio (RN:Patient)		Patient Nurse Ratio (Nurse:Patient)				UHD			Peer (CQC Good) Median			Provider Median		
						Current	Current	Proposed	Current	Proposed	Current	Proposed	Current	Proposed		Current	Proposed	Current	Proposed	Current	SNCT recommended	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total
	Older Persons Services & Acute Care	Ward 4	10577	28	Early	39.98	5	5	4	4	9	9	56/44	56/44		1:6	1:6	1:3	1:3	6.1	6.97	2.71	3.41	6.12	3.11	3.75	6.84	3.11	3.75	6.84
					Late		4	4	4	4	8	8	50/50	50/50		1:7	1:7	1:4	1:3											
					Night		3	3	3	3	6	6	50/50	50/50		1:9	1:9	1:5	1:5											
		Ward 5	10378	28	Early	39.11	5	5	4	4	9	9	56/44	56/44		1:6	1:6	1:3	1:3	5.5	6.92	2.67	3.04	5.50	3.11	3.75	6.84	3.11	3.75	6.84
					Late		4	4	4	4	8	8	50/50	50/50		1:7	1:7	1:3	1:3											
					Night		3	3	3	3	6	6	40/60	50/50		1:9	1:9	1:5	1:5											
		Ward 22	10594	28	Early	39.63	5	5	4	4	9	9	55/45	55/45		1:6	1:6	1:3	1:3	5.9	7.36	2.81	3.04	5.85	3.11	3.75	6.84	3.11	3.75	6.84
					Late		4	4	4	4	8	8	50/50	50/50		1:7	1:7	1:4	1:4											
					Night		3	3	3	3	6	6	50/50	50/50		1:9	1:9	1:5	1:5											
		Kimmeridge	20315	34	Early	46.71	4	4	5	5	9	9	45/55	45/55		1:8	1:8	1:3	1:3	5.5	6.33	2.64	2.90	5.54	3.11	3.75	6.84	3.11	3.75	6.84
					Late		4	4	4	4	8	8	50/50	50/50		1:7	1:7	1:4	1:3											
					Night		3	3	3	3	6	6	50/50	50/50		1:10	1:9	1:5	1:4											
		Brownsea	20400	26	Early	35.76	4	4	4	4	8	8	50/50	50/50		1:6	1:6	1:3	1:3	8.61	7.66	3.67	2.87	6.54	3.11	3.75	6.84	3.11	3.75	6.84
					Late		3	3	4	4	7	7	43/57	43/57		1:9	1:9	1:4	1:4											
					Night		3	3	2	2	5	5	60/40	60/40		1:9	1:9	1:4	1:4											
		Lytchett	20395	28	Early	35.76	4	4	4	4	8	8	50/50	50/50		1:7	1:7	1:4	1:4	6.75	8.33	4.07	1.90	6.10	3.11	3.75	6.84	3.11	3.75	6.84
					Late		3	3	4	4	7	7	43/57	43/57		1:9	1:9	1:4	1:4											
					Night		3	3	2	2	5	5	60/40	60/40		1:9	1:9	1:6	1:6											
		Lulworth	20398	27	Early	35.64	4	4	4	4	8	8	50/50	50/50		1:7	1:7	1:3	1:3	6.73	8.02	2.81	2.17	4.98	3.11	3.75	6.84	3.11	3.75	6.84
					Late		3	3	4	4	7	7	43/57	43/57		1:9	1:9	1:4	1:4											
					Night		3	3	2	2	5	5	60/40	60/40		1:9	1:9	1:6	1:6											
		Fagrewood	10360	19	Early	29.25	4	4	3	3	7	7	57/43	57/43		1:5	1:5	1:3	1:3	9.5	8.26	6.82	3.34	4.92	3.11	3.75	6.85	3.11	3.75	6.85
					Late		3	3	3	3	6	6	50/50	50/50		1:6	1:6	1:3	1:3											
					Night		2	2	2	2	4	4	50/50	50/50		1:10	1:10	1:5	1:5											
		RACE	20386	20	Early	46.01	6	6	4	4	10	10	60/40	60/40		1:3	1:3	1:2	1:2	11.6	8.07	6.86	4.70	11.56	3.11	3.75	6.84	3.11	3.75	6.84
					Late		6	6	4	4	10	10	60/40	60/40		1:3	1:3	1:2	1:2											
					Night		4	4	3	3	7	7	57/43	57/43		1:5	1:5	1:3	1:3											
		OPAU	10285	50	Early	83.29	9	9	8	8	17	17	53/47	53/47		1:5	1:5	1:3	1:3	8.91	7.52	3.81	3.41	7.21	3.11	3.75	6.84	3.11	3.75	6.84
					Late		9	9	8	8	17	17	53/47	53/47		1:5	1:5	1:3	1:3											
					Night		8	8	6	6	15	14	53/47	53/47		1:6	1:6	1:3	1:3											
		Ward 8		26	Early	39.98	5	5	4	4	9	9	55/45	55/45		1:5	1:5	1:3	1:3	6.8	6.16	3.34	3.49	6.84	3.11	3.75	6.84	3.11	3.75	6.84
					Late		4	4	4	4	8	8	50/50	50/50		1:6	1:6	1:3	1:3											
					Night		3	3	3	3	6	6	50/50	50/50		1:10	1:10	1:5	1:5											

Appendix Two – Surgical Care Group

Key: **Green Text** = increase in staffing within budget
Red Text = reduction in staffing
Yellow highlight = review recommended increase at budget setting
** Change in skill mix resulting in RN:unregistered ratio below 60:40

						Finance Budgeted	Staffing Data												CHPPD		Model Hospital CHPPD Data (Latest July 2024)								
	Directorate	Clinical Area	Cost Centre	Funded Beds/ Unfunded beds	Shift	Budgeted Nursing (WTE)	Registered Numbers		Unregistered Numbers		Total Nurse Numbers		Skill Mix (RN/HCSW)		Comments	Patients RN Ratio (RN:Patient)		Patient Nurse Ratio (Nurse:Patient)				UHD			Peer (CQC Good) Median			Provider Median		
						Current	Current	Proposed	Current	Proposed	Current	Proposed	Current	Proposed		Current	Proposed	Current	Proposed	Current	SCNT Recommend	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total
Surgical Care Group	Trauma & Orthopaedics	BPC	10532	7 beds +1 trolley	Early	13.1	2	2	1	1	3	3	66/34	66/34		1:4	1:4	1:3	1:3	8.72	7.91	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
					Late		2	2	1	1	3	3	66/34	66/34		1:4	1:4	1:3	1:3											
					Night		2	2	1	1	3	3	66/34	66/34		1:4	1:4	1:3	1:3											
		7L	10590	9	Early	16.13	2	2	2	2	4	4	50/50	50/50		1:5	1:5	1:2	1:2	9.37	4.74	3.97	1.04	5.01	3.53	3.39	3.11	3.73	3.39	7.07
					Late		2	2	1	1	3	3	66/34	66/34		1:5	1:5	1:3	1:3											
					Night		2	2	0	0	2	2	100/0	100/0		1:5	1:5	1:5	1:5											
		Derwent	10586	27	Early	37.77	5	5	4	4	9	9	55/45	55/45		1:5	1:5	1:3	1:3	7.15	4.46	9.16	6.79	15.95	3.53	3.39	7.05	3.73	3.11	7.07
					Late		4	4	4	4	8	8	50/50	50/50		1:7	1:7	1:3	1:3											
					Night		3	3	2	2	5	5	60/40	60/40		1:9	1:9	1:5	1:5											
		C3	20413	19	Early	34.84	3	3	2	2	5	5	42/58	42/58		1:6	1:6	1:3	1:3	9.7	7.48	3.55	5.19	8.74	3.53	3.39	7.05	3.73	3.11	7.07
					Late		3	3	4	4	7	7	42/58	42/58		1:6	1:6	1:3	1:3											
					Night		3	3	3	3	6	6	50/50	50/50		1:6	1:6	1:3	1:3											
		B3	20451	30	Early	42.72	4	4	5	5	9	9	44/56	44/56	Nurse in Charge - increase supervisory full time	1:7	1:7	1:3	1:3	7.54	6.32	3.63	2.54	6.23	3.53	3.39	7.05	3.73	3.11	7.07
					Late		4	4	5	5	9	9	44/56	44/56		1:7	1:7	1:3	1:3											
					Night		4	4	3	3	7	7	50/50	57/43		1:7	1:7	1:4	1:4											
		B4	20324	30	Early	40.09	4	4	5	6*	9	10	44/56	**40/60	*Increase HCSW x1 on Early Shift	1:7	1:7	1:3	1:3	7.07	6.39	3.08	2.8	5.88	3.53	3.39	7.05	3.73	3.11	7.07
					Late		4	4	5	6*	9	10	44/56	**40/60	*Increase HCSW x1 on Late Shift	1:7	1:7	1:3	1:3											
					Night		3	3	3	3	6	6	50/50	50/50		1:10	1:10	1:5	1:5											
		E3	20415	24	Early	40.09	4	4	5	5	9	9	44/56	44/56		1:6	1:6	1:3	1:3	8.86	7.85	3.46	3.08	6.57	3.53	3.39	7.05	3.73	3.11	7.07
					Late		4	4	5	5	9	9	44/56	44/56		1:6	1:6	1:3	1:3											
					Night		2	3*	4	4	6	7	40/60	**43/57	*Increase x1 RN at night	1:12	1:8	1:4	1:3											
	Surgery	SAU PH	20332	15	Early	24.9	3	3	2	2	5	5	60/40	60/40	Convert HCSW 0.4 to Ward Clerk	1:5	1:5	1:3	1:3	9.38	5.36	6.24	2.83	9.08	4.45	3.85	8.02	4.65	3.51	7.90
					Late		3	3	2	2	5	5	60/40	60/40		1:5	1:5	1:3	1:3											
					Night		3	3	1	1	4	4	75/25	75/25		1:5	1:5	1:4	1:4											
		B2	20450	24	Early	40.1	5	5	3	3	8	8	63/37	63/37		1:4	1:4	1:3	1:3	9.23	6.15	4.74	2.92	7.68	4.45	3.85	8.02	4.65	3.51	7.90
					Late		5	5	3	3	8	8	63/37	63/37		1:4	1:4	1:3	1:3											
					Night		4	4	3	3	7	7	67/33	67/33		1:5	1:5	1:3	1:3											
		12		20 (escalate to 26	Early	29.4	4	4	3	3	7	7	60/40	60/40	Weekend staffing reduced to E 3/2, L 3/1, N 3/1	1:5	1:5	1:3	1:3	9.52	7.01	4.65	2.92	7.68	4.45	3.85	8.02	4.65	3.51	7.90
					Late		4	4	3	3	7	7	50/50	60/40		1:5	1:5	1:3	1:3											
					Night		3	3	2	2	5	5	67/33	67/33		1:7	1:7	1:4	1:4											
		Ward 15	10426	26	Early	37.46	5	5	3*	3	8	8	63/37	63/37	*HCSW x1 works 10-6 to convert to late shift	1:5	1:5	1:3	1:3	7.08	5.33	3.1	2.57	5.67	4.45	3.85	8.02	4.65	3.51	7.90
					Late		5	5	3	3	8	8	63/37	63/37		1:5	1:5	1:3	1:3											
					Night		4	4	3	3	7	7	57/43	57/43		1:7	1:7	1:4	1:4											
		Ward 16	10427	24 funded 4 unfunded	Early	34.09	5	5	3	3	8	8	63/37	63/37		1:5	1:5	1:3	1:3	8.26	5.91	3.65	2.71	6.36	4.45	3.85	8.02	4.65	3.51	7.90
					Late		5	5	3	3	8	8	63/37	63/37		1:5	1:5	1:3	1:3											
					Night		3	4*	2	2	5	6	60/40	80/20	*Increase x1 RN at night (due to acuity/dependanc	1:8	1:6	1:5	1:4											
		Ward 17	10428	21	Early	34.84	4	4	3	3	7	7	57/43	57/43		1:5	1:5	1:3	1:3	8.77	5.93	3.51	2.66	6.17	4.45	3.85	8.02	4.65	3.51	7.90
					Late		4	4	3	3	7	7	57/43	57/43		1:5	1:5	1:3	1:3											
					Night		3	3	2	2	5	5	60/40	60/40		1:7	1:7	1:4	1:4											
		SAU BH	10535	20	Early	24.9	5	5	2	2	7	7	71/29	71/29		1:4	1:4	1:3	1:3	9.10	6.7	5.99	2.66	8.30	4.45	3.85	8.02	4.65	3.51	7.90
					Late		5	5	2	2	7	7	71/29	71/29		1:4	1:4	1:3	1:3											
					Night		4	4	2	2	6	6	67/33	67/33		1:5	1:5	1:4	1:4											
	Head & Neck	C4E	20414	14	Early	32.75	3	3	2	2	5	5	60/40	60/40		1:5	1:5	1:3	1:3	11.07	5.3	6.45	2.81	9.57	N/A	N/A	N/A	6.48	3.36	9.92
					Late		3	3	2	2	5	5	60/40	60/40		1:5	1:5	1:3	1:3											
					Night		3	3	1	1	4	4	75/25	75/25		1:5	1:5	1:4	1:4											

Appendix Two– Women's, Cancer Care and Specialist Services (WCCSS) Care Group

Key: **Green Text** = increase in staffing within budget
Red Text = reduction in staffing
Yellow highlight = review recommended increase at budget setting
** Change in skill mix resulting in RN:unregistered ratio below 60:40

	Directorate	Clinical Area	Cost Centre	Funded Beds/ Unfunded beds	Shift	Finance Budgeted	Staffing Data												CHPPD		Model Hospital CHPPD Data (Latest July 2024)								
						Budgeted Nursing (WTE)	Registered Numbers		Unregistered Numbers		Total Nurse Numbers		Skill Mix (RN/HCSW)		Comments	Patients RN Ratio (RN:Patient)		Patient Nurse Ratio (Nurse:Patient)				UHD			Peer (CQC Good) Median			Provider Median		
						Current	Current	Proposed	Current	Proposed	Current	Proposed	Current	Proposed		Current	Proposed	Current	Proposed	Current	SCNT Recommend	RN	HCSW	Total	RN	HCSW	Total	RN	HCSW	Total
Women, Children, Cancer & Specialist Services Care Group	Oncology & Haematology	Macmillan	10565	16	Early	31.75	4	4	3	3	7	7	57/43	57/43		1:4	1:4	1:2	1:2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
					Late		4	4	3	3	7	7	57/43	57/43		1:4	1:4	1:2	1:2											
					Night		2	2	2	2	4	4	50/50	50/50		1:8	1:8	1:4	1:4											
		Forest Holme	21925	11	Early	20.93	3	3	2	2	5	5	60/40	60/40		1:4	1:4	1:2	1:2	10.39	11.23	6.42	3.81	11.57	7.46	3.81	11.57	7.26	3.77	11.51
					Late		3	3	2	2	5	5	60/40	60/40		1:4	1:4	1:2	1:2											
					Night		2	2	1	1	3	3	66/34	66/34		1:6	1:6	1:4	1:4											
		Ward 7 R		10	Early	16.47	3	3	1	1	4	4	75:25	75:25		1:3	1:3	1:2	1:2	8.10	8.10	4.70	2.28	6.99	7.46	3.81	11.57	7.26	3.77	11.51
					Late		3	3	1	1	4	4	75:25	75:25		1:3	1:3	1:2	1:2											
					Night		2	2	1	1*	3	3	66/34	66/34	*Increase HCSW twighlight to full night shift	1:5	1:5	1:3	1:3											
		Sandbanks	20335	23	Early	34.39	4	4	4	4	8	8	50/50	50/50		1:6	1:6	1:3	1:3	7.9	7.47	3.88	3.47	7.43	7.46	3.81	11.57	7.26	3.77	11.51
					Late		4	4	3	3	7	7	57/43	57/43		1:6	1:6	1:3	1:3											
					Night		3	3	2	2	5	5	60/40	60/40		1:8	1:8	1:5	1:5											
		Ward 11	10340	16	Early	28.1	5	5	2	2	7	7	70/30	70/30		1:3	1:3	1:2	1:2	9.35	6.75	5.83	2.64	8.47	7.46	3.81	11.57	7.26	3.77	11.51
					Late		5	5	2	2	7	7	70/30	70/30		1:3	1:3	1:2	1:2											
					Night		2	2	1	1	3	3	66/34	66/34		1:8	1:8	1:3	1:3											
	Child Health	A1 (HDU)	20370	11	Early	55.51	2	2	1	1	3	3	66/34	66/34		1:2	1:2	1:2	1:2	14.07	6.1	7.36	4.74	12.10	11.32	2.41	14.96	12.16	2.88	14.79
					Late		2	2	1	1	3	3	66/34	66/34		1:2	1:2	1:2	1:2											
					Night		2	2	1	1	3	3	66/34	66/34		1:2	1:2	1:2	1:2											
		A1 Stepdown	20370		Early		2	2	0	0	2	2	100/0	100/0		1:8	1:4	1:9	1:2	7.02	7.97									
					Late		2	2	0	0	2	2	100/0	100/0		1:8	1:4	1:9	1:2											
					Night		2	2	0	0	2	2	100/0	100/0		1:8	1:4	1:9	1:2											
		B1	20370	15	Early		2	2	2	2	4	4	50/50	50/50		1:8	1:8	1:4	1:4	7.48	7.48									
					Late		2	2	2	2	4	4	50/50	50/50		1:8	1:8	1:4	1:4											
					Night		2	2	2	2	4	4	50/50	50/50		1:8	1:8	1:4	1:4											
		CAU	20370	9	Early		2	2	1	1	3	3	66/34	66/34		1:5	1:5	1:3	1:3	4.42	11.06	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
					Late		2	2	1	1	3	3	66/34	66/34		1:5	1:5	1:3	1:3											
					Night		2	2	1	1	3	3	66/34	66/34		1:5	1:5	1:3	1:3											

9. Appendix Three RAG review of Care Group Asks & Financial cost.

RAG rating:

- **Red** – priority for investment 2025/26
- **Amber** - further scrutiny/review at Care group level
- **Green** - identified from within Care group current funded establishments.

Medicine:

Ward	Ask	Rationale	RAG rating
RACE	Introduce a Patient Support Worker (PSW) 7 days a week (long day) - Band 2	PSW role assist with patient escorts and improve patient flow in acute admission areas	
AMU PGH			
AMU PGH	Re-instatement of the Band 6 headroom/uplift	The acute assessment and admission areas require consistent 24 hour cover at Band 6. The headroom was removed as part of the review in 2023 but Band 6 cover has been maintained resulting in a cost pressure to the Care group.	
AMU RBH			
RACE			
OPAU			
Stroke Unit			
CCU			
Total investment required in Medicine			

Surgery:

Ward	Ask	Rationale	RAG rating
E3	1 additional Band 5 RN at night	To maintain safe staffing, aligned with other admission units across the Trust (the ward is a trauma admissions unit accepting patients 24/7).	
C4 SAU	Re-instatement of Band 6 headroom/uplift	The acute assessment and admission areas require consistent 24-hour cover at Band 6. The headroom was removed as part of the review in 2023 but Band 6 cover has been maintained resulting in a cost pressure to the Care group.	
SAU RBH			
E3			
Total investment required (for areas with red rag rating) in Surgery			

Total investment required to fund Red RAG areas	**£313,031**

Green and Amber RAG

Medicine

Ward	Ask	Rationale	RAG rating
A5	1 RN at night - Band 5	Need for high acuity bay, to align with the gastroenterology care model on Ward 1 at RBH.	
Ward 2	1 RN on weekend day shifts -Band 5	Increase in the acuity and dependency of patients requiring respiratory support or Level 2 care and currently a reduction in staffing at night and weekends.	
	1 HCSW every night – Band 3		
	1 HCSW every day (long day) - Band 3		
Durlston	Discharge Co-ordinator to work three days per week - Band 2	Discharge coordinator role being covered by unregistered nursing staff	
AMU RBH	Patient Support Workers every day (long day) - Band 2	PSW role assist with patient escorts and improve patient flow in acute admission areas	
Ward 23	1 HCSW every night - Band 3	There has been an increase in patient dependency since the transfer of cardiology to the Royal Bournemouth site	

Women's, Cancer Care and Specialist Services (WCCSS)

Ward	Ask	Rationale	RAG rating
7R	Twilight shift increase to full night shift - Band 3	The ward is unable to seek cover from the neighbouring ward when RN on break - ward at risk during staff breaks.	

Surgery

Ward	Ask	Rationale	RAG rating
C4 SAU	Skill mix change HCSW to Ward Clerk - Band 3	The Ward has no Ward Clerk.	
B2	Uplift two RNA to RN – Band 4 to Band 5	A skill mix gap with RNA role will be mitigated with RN.	
Ward 16	1 RN at night - Band 5 1 HCSW every day (long day) - Band 3	Increase in patient acuity and dependency requiring additional staffing.	
B4	Uplift RN – Band 5 to Band 6 & Increase HCSW on early shift 7 days week	There is a leadership gap in the Band 6 line Alignment with HCSW required due to safe care data showing a potential shortfall – further review by care group.	

B3	Supervisory Band 7 full time - Band 7	The complexities of the clinical environment; a 30 bedded ward currently requires the nurse in charge to manage a caseload of patients and coordinate.	

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 08 January 2025

Agenda item: 8.1

Subject:	People & Culture Strategy 2024 to 2027
Prepared by:	Tina Ricketts, Chief People Officer
Presented by:	Tina Ricketts, Chief People 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)	BAF risks relating to culture and workforce
Purpose of paper:	Decision/Approval
Executive Summary:	The new People & Culture Strategy for 2024 to 2027 is set out in the attachment documents for approval. There are two documents – an executive summary for publication on the Trust's website and a detailed working document containing the strategic framework and plans on a page for each of the 19 programmes of work. The strategy has been widely socialised across the Trust with an earlier version being shared with the Board in September. A new governance structure will be introduced this month to support the delivery of the strategy and to provide reference groups for the programmes of work. The proposed governance structure is set out in the working document.
Background:	The following engagement has been undertaken to support the development of the strategy: • Workshops held with all members of the People & Culture Directorate • With staffside colleagues through the Social Partnership Forum • With Care Groups and Corporate Directorates through Strategic Deployment Review meetings • With Trust senior leadership through Trust Management Group • With People & Culture Committee members • With Integrated Care System Chief People Officers and Deputies

	Further engagement planned: • With staff diversity networks • With patient experience networks
Key Recommendations:	The Board is asked to approve the new people and culture strategy for 2024 to 2027
Implications associated with this item:	Council of Governors ☐ Equality, Equity, Diversity & Inclusion ☒ Financial ☐ Health Inequalities ☐ Operational Performance ☐ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☐ Regulatory ☐ Strategy/Transformation ☒ System ☐
CQC Reference:	Safe ☐ Effective ☐ Caring ☐ Responsive ☐ Well Led ☒ Use of Resources ☒

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Trust Management Group	19/11/2024	Reviewed and approved for submission to People & Culture Committee
People & Culture Committee	11/12/2024	Approved

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

University Hospitals Dorset
NHS Foundation Trust

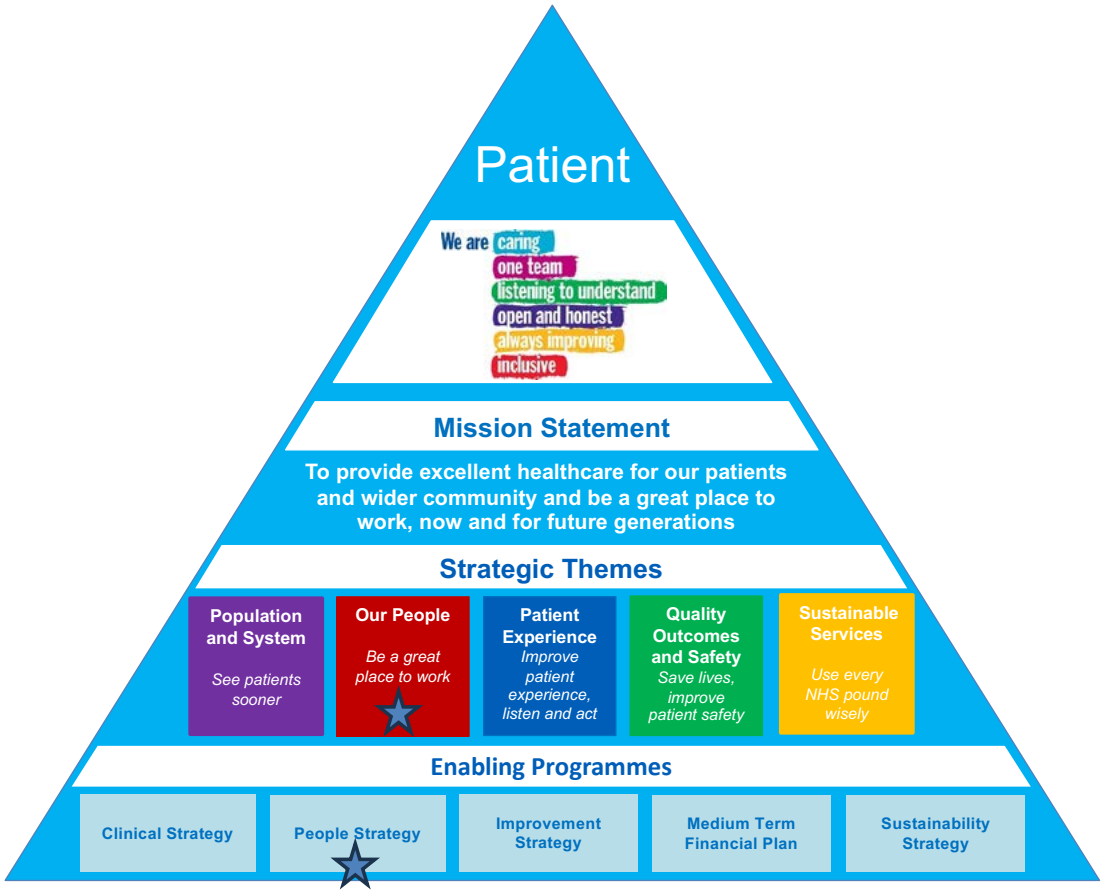
People and Culture Strategy 2024 to 2027

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

1.0 Message to UHD colleagues

Thank you for taking the time to respond to the NHS staff survey and for participating in our recent listening events. Your commitment to putting patients first and making UHD a great place to work shines through in your honest feedback and ideas.

Our True North (see diagram below) sets out the values that we hold dear to our heart and confirms that you “our people” are at the centre of ensuring excellent healthcare for our patients and wider communities.



From your feedback we have identified that:

- We are on the right path in creating an inclusive culture true to our values, where everyone is able to speak up and be themselves at work. However, we have further work to do to stop colleagues from being subject to poor behaviours, discrimination and micro-aggressions from patients, the public and each other
- Personal development is important to you and we could be better at succession planning and talent management
- Your health and wellbeing is at the centre of how you perform at work and how you function outside of work. You have told us that we could do better at prevention with more timely access to support
- The culture around flexible working could be improved to better support service demands and your worklife balance
- The support that you get from managers is variable impacting on your experience at work

- The glass ceiling at band 6 is preventing a representative workforce at all levels of the Trust and there is further work to do to unleash the talent that colleagues bring
- Reducing our reliance on the temporary workforce and improving our time to hire will improve the resilience of the team and service that you work in

The People and Culture Strategy has been developed to respond to this feedback with 5 strands of work as set out in the following diagram.

People and Culture Strategic Framework

NHS PEOPLE PROMISE

STRATEGIC THEME

Be a great place to work

BAF RISKS

- **Culture** - If we fail to sustain an inclusive organisational culture true to our values, where everyone is able to speak up and bring their whole self to work, then we may fail to have the best people which will impede the delivery of safe, effective high quality compassionate treatment and care.
- **Talent Management** - if we do not have a representative workforce, a supply of talent and a focus on succession planning then we will not have a workforce with the right skills and experience to deliver our services.
- **Leadership** - If we do not have a comprehensive leadership plan in place then we will not have the right leadership behaviours, capability and capacity to deliver our strategic objectives and priorities.
- **Workforce** - If we do not have a healthy, sustainable workforce that is organised for success, we will not be able to provide high quality, safe and effective services resulting in poor patient and staff experience and increased premium staffing costs.

BAF RISKS

Staff Experience	Leadership and Talent Management	Staff Offer	Workforce	People Function
A values based inclusive culture where colleagues feel respected, valued and included at work	A, empowered, well lrepresentativeed workforce that delivers better outcomes and performance for our patients	A staff offer that attracts and retains the best people	A right sized, sustainable workforce that is organised to provide the optimum patient and staff experience	A people function that is organised around the optimum employee journey supporting the Care Groups and Corporate Directorates to deliver their priorities

As we implement the strategy, we will ask you to tell us how it's going. But don't wait if there is something that would make a difference. Small changes at local team level can make a huge difference to how work feels so talk to your colleagues, your line manager and sign up to our Patient First journey.

2.0 Introduction

We are committed to creating a positive staff experience to help everyone thrive at work. We know from speaking to colleagues that there are many things we get right to create a great place to work, we also know that we do not always get everything right for everyone and this must change.

The strategy will create a positive staff experience where the communities we serve will see us as an employer of choice, attracting and retaining the best people.

Our commitment:

1. Our culture will be values based where colleagues feel they belong, they have a voice and feel valued and respected
2. Our workforce will be representative at all levels. Colleagues will be well led and empowered to deliver better outcomes and performance for our patients
3. Our staff offer will attract and retain the best people
4. Our workforce will be sustainable and organised to provide the optimum patient and staff experience
5. Our People and Culture function will be organised around the employee journey and will support teams across the Trust to deliver their priorities

Everyone at UHD plays a part in creating a great place to work. This is our strategy, and we are all responsible for creating a positive working environment. As we move forward with our plans, we will continue to invite colleagues to tell us how we are doing and how it feels working for UHD so that we can adapt and respond. On going communications and engagement with colleagues is vital and we value the contributions and perspectives our staff bring.

3.0 Who we are

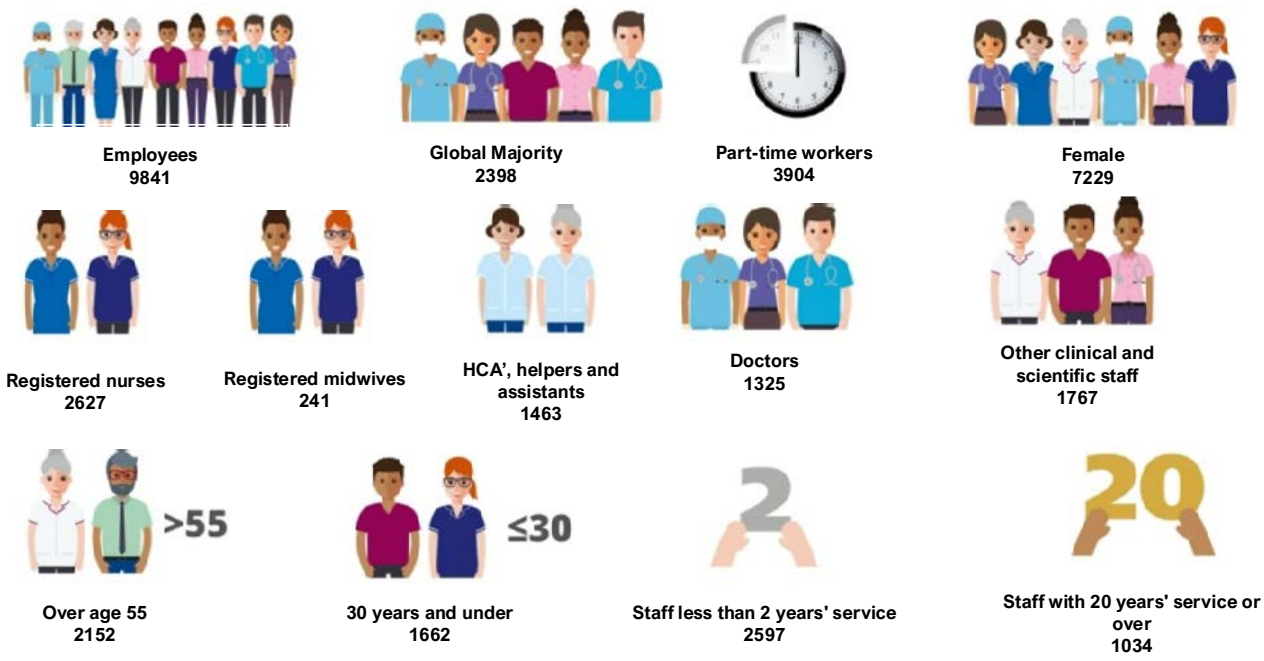
Our trust is comprised of three hospitals; the Royal Bournemouth Hospital, Poole Hospital and Christchurch Hospital, which merged on 1 October 2020, creating a new organisation.

Within UHD we pride ourselves on the delivery of safe and high quality care. Every single person working within this organisation makes a difference to the quality of care provided.

We have a number of exciting developments due to take place over the next few years, coupled with an ambitious transformation agenda. The Royal Bournemouth Hospital will become the major emergency hospital and Poole Hospital will become the major planned hospital, alongside other services provided for east Dorset. Christchurch Hospital incorporates the Day Hospital which provides rehabilitation for our older population, the Macmillan Unit which provides specialist palliative care, rheumatology, and dermatology.

Our workforce composition in numbers is set out in the infographic below.

WORKFORCE COMPOSITION IN NUMBERS



4.0 Context

Our strategy is underpinned by the NHS People Promise (NHS England » Our NHS People Promise).

We were pleased to see how we performed against the NHS People Promise in our 2023 staff survey results. When benchmarked with our peer organisations we performed about average in each of the seven elements.

Our strategy will also support the delivery of the NHS long-term workforce plan (NHS England » NHS Long Term Workforce Plan)

Our strategy is aligned to the One Dorset People Plan.

5.0 Our Strategy

Our 3 year strategy sets out our ambition to be a great place to work. We have identified 5 strategic priorities with 19 areas for improvement (programmes of work) which will help us to realise this ambition.

People and Culture Strategy on a page linked to Trust Strategic Themes

Strategic Theme	**Be a great place to work**				
Strategic Enabler	**People Strategy**				
Priority	**1 Staff Experience**	**2 Leadership and Talent Management**	**3 Staff Offer (Retention)**	**4 Workforce**	**5 People Function**
Strategic Priorities	A values based inclusive culture where colleagues feel respected, valued and included at work	A representative, empowered, well led workforce that delivers better outcomes and performance for our patients	A staff offer that attracts and retains the best people	A right sized and sustainable workforce that is organised to provide the optimum patient and staff experience	A people function that is organised around the optimum employee journey supporting the Care Groups and Corporate Directorates to deliver their priorities
Programmes of Work	**Team UHD (EDI) Plan**	**Leadership and Management Development Plan**	**Flexible and Agile Working Plan**	**Workforce Transformation Plan**	**Workforce Systems Corporate Project**
	Behaviour Charter		**Education, Learning and Development Plan (including widening participation and work experience)**	**Recruitment Plan**	**Temporary Staffing Model**
	Culture Champions and Advocate Network Development	**Talent Plan**		**Temporary Workforce Plan**	**HR Business Partner Model**
	Care Group and Corporate Directorate Staff Experience Plans		**Staff Welfare Plan**		**On Call Review**
	Freedom to Speak Up Plan		**Staff Health and Wellbeing Plan**		
			Transforming Care Together People Ready Plan		
Cross Cutting work	**Patient First**				
	Values and Behaviour Framework				

The tables below set out the goals for the period 1 October 2024 to 31 December 2027 for each of our five priorities:

Priority 1: Staff Experience

Aim	Goals	Delivered Through
A values based inclusive culture where colleagues feel respected, valued and included at work	To have a representative workforce at all levels of the Trust	Team UHD Plan
	A behaviour charter which reflects our values, providing clear standards of behaviour that we expect from our staff, patients and visitors	Behaviour Charter
	To further embed our values and behaviours across all Trust sites	Culture Champions and Advocate Network
	To improve staff experience	Culture Plans
	To develop a culture of safety where all staff are encouraged to speak up, are listened to and the issues are followed up	Freedom to Speak Up Plan

Priority 2: Leadership and Talent Management

Aim	Goals	Delivery Workstream
An empowered, well led workforce that delivers better outcomes and performance for our patients	To improve the quality and consistency of leadership at all levels of the Trust	Leadership and Management Development Plan
	To recognise and unleash the previous knowledge and experience of all staff	Talent Management Plan

Priority 3: Staff Offer

Aim	Goals	Delivery Workstream
A staff offer that attracts and retains the best people	To be recognised as an employer of choice due to our approach to flexible and agile working	Flexible Working Plan
	Personal development is seen as a core part of our staff offer	Education, Learning and Development Plan
	The welfare needs of our staff are met (rest areas, changing facilities, catering facilities/ food outlets)	Staff Welfare Plan
	Staff health and wellbeing is seen as a top priority	Staff Health and Wellbeing Plan
	Managers have the knowledge, confidence and skills to support staff through change	Transforming Care Together People Ready Plan

Priority 4: Workforce

Aim	Goals	Delivery Workstream
A right sized and sustainable workforce that is organised to provide the optimum patient and staff experience	A right sized, sustainable workforce	Workforce Transformation Plan
	A recruitment plan that meets the future needs of the Trust	Recruitment Plan
	To reduce our reliance on the temporary workforce	Temporary Workforce Plan

Priority 5: People Function

Aim	Goals	Delivery Workstream
A people function that is organised around the optimum employee journey supporting the Care Groups and Corporate Directorates to deliver their priorities	Workforce IT systems that support the effective deployment of human resources	Workforce Systems Corporate Project
	A cost-effective temporary staffing model that meets the needs of the Trust	Temporary Staffing Model
	A strategic HR Business Partner model that pro-actively supports the Care Groups and Corporate directorates to develop and deliver their people and culture plans and priorities	HR Business Partner Model
	A trust wide On-Call Policy that is equitable and meets the needs of the Trust.	On Call Review

This is an ambitious strategy and will require the alignment of resources within the people and culture directorate to deliver all 19 goals. To help with this we have split the delivery of the strategy into 2 stages.

The first stage of the strategy will be focused on the following 10 outcomes by 31 December 2025

	Priority	Outcome	Key Performance Indicator	Baseline	Target by 31/12/2025
1	**Staff Experience**	To have a representative workforce	Increase in global majority representation at band 8a and above	6%	9%
2	**Staff Experience**	To be in the top quartile for the NHS survey results for: We are compassionate and inclusive, civility and respect	Measured through NHS Staff Survey	7.07	7.20
3	**Leadership and Talent Management**	To Improve the quality and compliance of appraisals	Appraisal compliance rate	72%	90%
4	**Leadership and Talent Management**	To improve the capability of middle managers (Band 6 and 7)	Percentage of middle managers who have attended leadership development	tbc	50%
5	**Staff Offer**	Improvement in NHS Staff Survey question “My organisation takes positive action on health and well-being”	Measured through NHS Staff Survey	56%	60%
6	**Staff Offer**	To have a stable staff turnover rate throughout the Transforming Care Together programme	Staff turnover rate	10.6%	10.6%
7	**People Function**	The new Bank and Agency model to be in place and operational by 30June 2025	n/a	n/a	n/a
8	**People Function**	The new HR Business Partner model to be in place and operational by 1 April 2025	n/a	n/a	n/a
9	**People Function**	To be better than our peer group average for our time to hire	Average time to hire	68 days	60 days
10	**People Function**	A harmonised On-call Policy and availability rates are in place by 31 March 2025	n/a	n/a	n/a

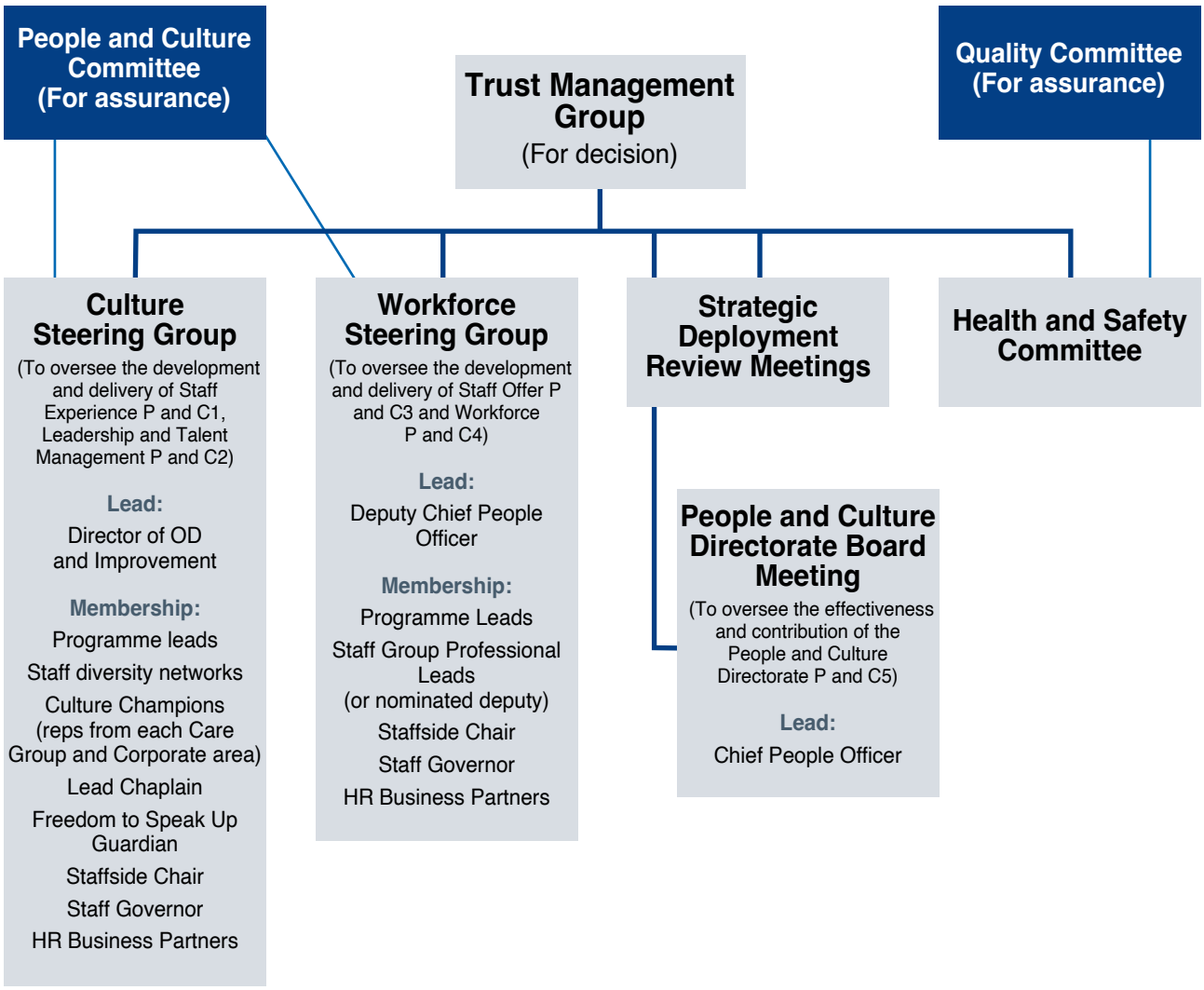
The second stage of the strategy will be focused on the following 9 outcomes by 31 December 2027

	Priority	Outcome	Key Performance Indicator	Baseline	Target by 31/12/2025
1	**Staff Experience**	To have culture plans in place at specialty and corporate directorate level which are regularly reviewed through Care Group/ Corporate Service Board meetings	Number of culture plans	tbc	100%
2	**Staff Experience**	To be in the top quartile for the NHS staff survey question “if I spoke up about something that concerned me, I am confident my organisation would address my concern	Measured through staff survey	50.6%	56%
3	**Staff Experience**	To recruit at least 50% of our workforce as culture advocates	Number of culture advocates (as percentage of total workforce)	<10%	>50%
4	**Staff Offer**	To achieve Timewise accreditation for our culture and approach to flexible working		n/a	n/a
5	**Staff Offer**	Staff welfare is seen as a top priority for the Trust	Measured through staff survey	n/a	n/a
6	**Staff Offer**	Every member of staff has a personal development offer (including mandatory training, essential to role training, continued professional development and personal development)	Percentage of staff with a personal development offer	tbc	100%
7	**People Function**	To reduce our vacancy rate	Staff vacancy rate	8.6%	<5%
8	**People Function**	To reduce our reliance on the temporary workforce	Bank and agency WTE as percentage of total WTE	11%	5%
9	**People Function**	3 year workforce plans are in place for all service and corporate areas	Number of approved workforce plans in place	tbc	100%

6.0 Governance structure

The delivery of our strategy will be overseen through the following governance structure.

Proposed Governance Structure



Regular progress reports will be provided to the Trust Management Group and People and Culture Committee.

7.0 Summary

This is an ambitious strategy that puts our people at the centre of ensuring excellent healthcare for our patients and wider community. UHD is already making strides in being a great place to work and this strategy will ensure we are an employer of choice into the future.

People & Culture Strategy 2024 to 2027

v2 10th October 2024

University Hospitals Dorset NHS Foundation Trust

“A great place to work”

CONTENT

CONTEXT

National Context

National Context

The NHS will take action to address workforce gaps and meet the challenges of a growing and ageing population across three priority areas:

Train - Grow the workforce, including:

- Double the number of medical school training places, taking the total number of places up to 15,000 a year by 2031/32,
- Increase the number of GP training places by 50% to 6,000 by 2031/32
- Increase apprenticeships and alternative routes – with 22% of all Training for clinical staff to be delivered through apprenticeship routes by 2031/32
- Introduce medical degree apprenticeships, with pilots running in 2024/25, so that by 2031/32, 2,000 medical students will train via this route
- Attract and recruit staff, building on the national work done so far and supporting systems to improve local recruitment processes

Retain - Embed the right culture and improve retention, including:

- Reduce the number of staff leaving the NHS by up to 130,000 people by 2036/37
- Ensure staff are valued, respected, recognised and fairly rewarded
- Increase flexible working and total staff numbers to improve work-life balance - including via systems such as e-rostering
- Support career progression and continuous development
- Foster a culture of wellbeing, inclusion and belonging which aligns with the recently published EDI Improvement Plan

Reform - Working and training differently, including:

- Expand enhanced, advanced and associate roles – increasing the proportion of staff in these roles from 1% to 5% by 2036/37
- Grow staff working in mental health, primary & community care by 73%
- Ensure roles are appropriately regulated to use their full scope of practice
- Embrace technological innovations, such as Artificial Intelligence and robotic assisted surgery
- Ensure that all foundation doctors have a placement in GP by 2030/31
- Support medical schools to move to 4 year degree programmes, and pilot a medical internship programme which will shorten training time

Dorset Integrated Care System

People Plan 2023-2028

Priority 1

Planning for the future

We act as an anchor system, attracting a talented and diverse workforce and plan effectively to address workforce supply issues now and in the future, responding to the shift to prevention and new models of healthcare and thriving communities

Priority 2

Retaining our people

We look after our people, investing in and supporting lifelong, flexible careers where everyone feels valued, included and encouraged to reach their full potential.

Priority 3

Developing our people

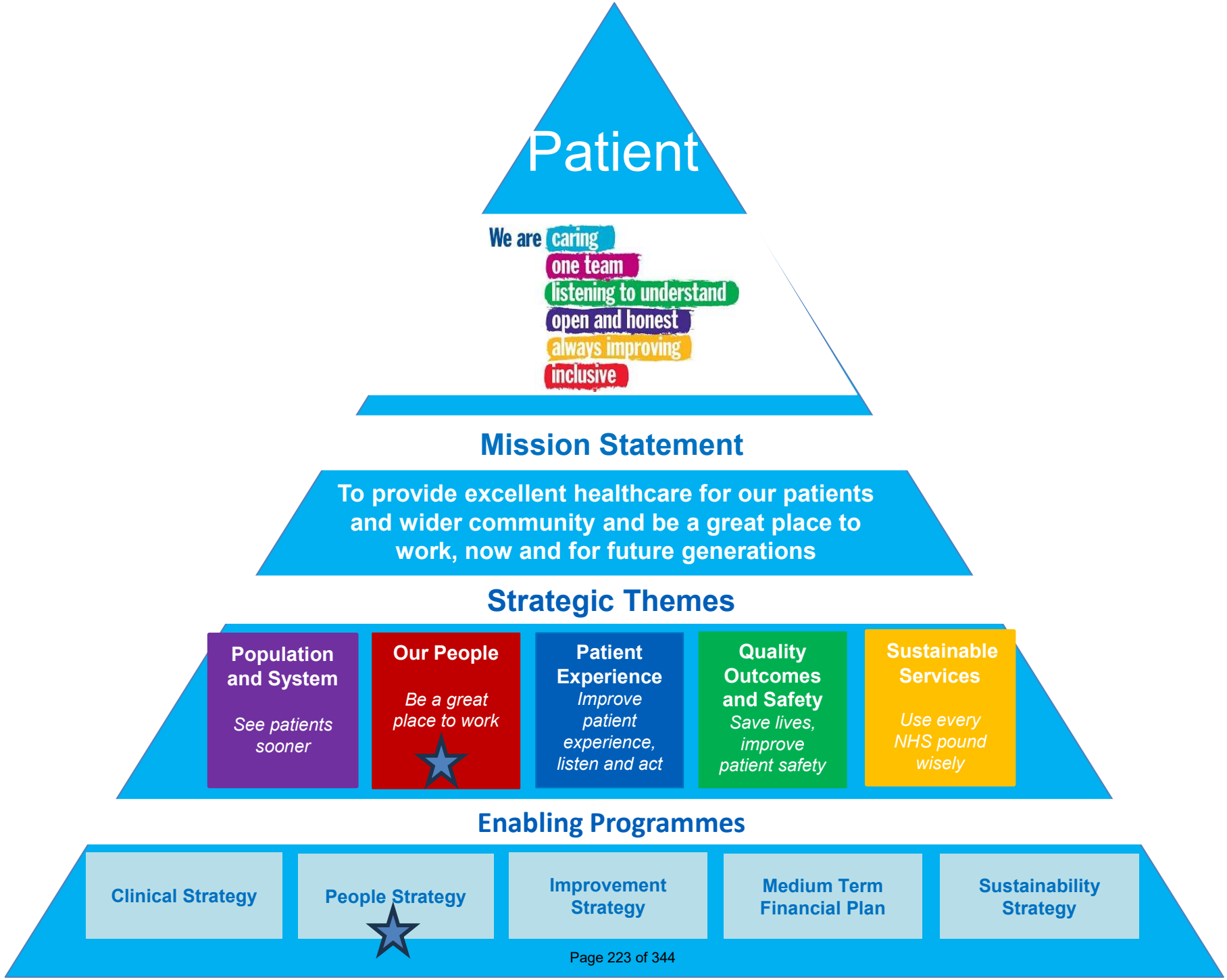
Our people are our most valuable asset, and we offer everyone the opportunity to develop, learn and grow in response to the changes in how we deliver health and care for our population and for professional development.

Priority 4

Transforming people services for productivity and efficiency

Dorset has high quality people services and highly skilled people professionals, meeting the future needs of one Dorset workforce and realising the ambitions of this people plan.

University Hospitals Dorset NHS Foundation Trust – Our True North



Making sense of this for every member of staff...via a meaningful, values-based appraisal.

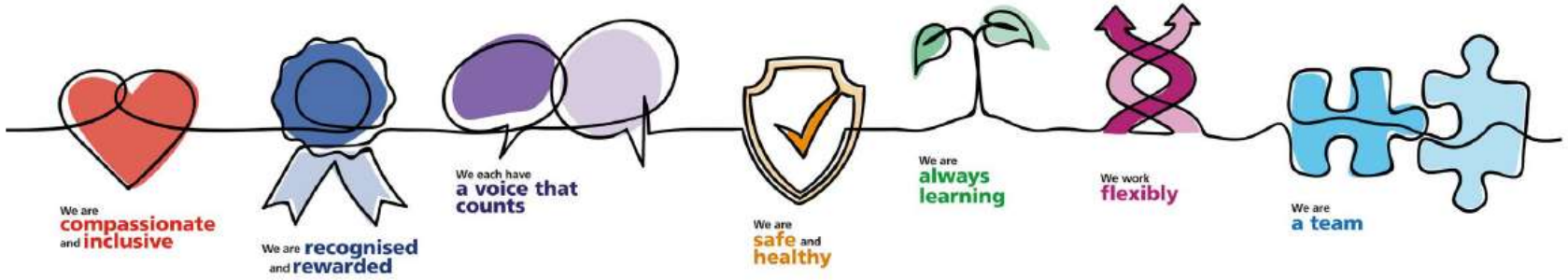
University Hospitals Dorset NHS Foundation Trust - Our Values and Behaviours

Strategic Theme	Strapline	Vision LONG TERM	Strategic Goal MEDIUM TERM: 3 -5 YEARS	Breakthrough Objective SHORT TERM: 12 – 18 MONTHS
POPULATION AND SYSTEM *Mark Mould*	 "See patients sooner"	Consistently delivering timely, appropriate, accessible care as part of a wider integrated care system for our patients.	• Meeting the patient national constitutional standards for Planned and Emergency care, reducing inequalities in outcome and access and improving productivity and value	• Planned Care - to achieve 109% weighted value elective activity against a 2019/20 baseline, including specialist advice and guidance • Emergency/Urgent Care: >78% of patients treated within 4 hours through the emergency care pathway
OUR PEOPLE *Tina Ricketts*	 "Be a great place to work"	**To be a great place to work, attracting and retaining the best talent.**	• **Significantly improved staff experience, engagement and retention** • **NHS Staff Survey results in top 20% of comparator Trusts**	**To deliver improvements in the NHS Staff Survey Results for:** • **"I would recommend my organisation as a place to work" > 65%** • **Staff Engagement Score > 7.1 / 10**
PATIENT EXPERIENCE *Sarah Herbert*	 "Improve patient experience listen and act"	All patients at UHD receive quality care which results in a positive experience for them, their families and carers. Every team is empowered to make continuous improvement by engaging with patients in a meaningful way, using their feedback to make change.	• Rated as Outstanding by CQC as Caring • Over 80% of our employees see patient care as a top priority for UHD • In the top 20% of NHS Acute Hospital Trusts on the 'overall experience' section in all CQC national surveys	• A 5% improvement in employees who see patient care as a top priority for UHD • To increase the Friends & Family Test (FFT) and Have Your Say (HYS) feedback rates by 30%
QUALITY OUTCOMES AND SAFETY *Peter Wilson*	 "Save lives, improve patient safety"	To be rated the safest Trust in the country and be seen by our staff, as an outstanding organisation for effectiveness (Hospitalised Standardised Mortality Ratios – HSMR) and patient safety (Patient Safety Incidents - PSIs).	• In the top 20% of trusts in country for Hospitalised Standard Mortality Ratios (HSMR) • Rated as Outstanding by CQC for Safety • Decrease severe/moderate harm Patient Safety Incidents (as a ratio of all incidents) by 30% • Over 80% of employees believe the Trust promotes a safety culture	• HSMR <100 • Improve Staff Survey safety culture questions by 5% • Implement UHD PSaF
SUSTAINABLE SERVICES *Pete Papworth*	 "Use every NHS pound wisely"	To maximise value for money enabling further investment and sustainability in our services to improve the timeliness and quality of care for our patients, and the working lives of our staff.	• Return to recurrent financial surplus from 2026/27 • Rated as Outstanding by the CQC for our Use of Resources • Achieve our Green UHD goals of sustainability for people and planet, and 80% carbon reduction by 2030	• To fully deliver the budgeted Efficiency Improvement Programme target with at least 80% achieved recurrently

PEOPLE & CULTURE STRATEGY OVERVIEW

People & Culture Strategic Framework

NHS PEOPLE PROMISE



STRATEGIC THEME

Be a great place to work

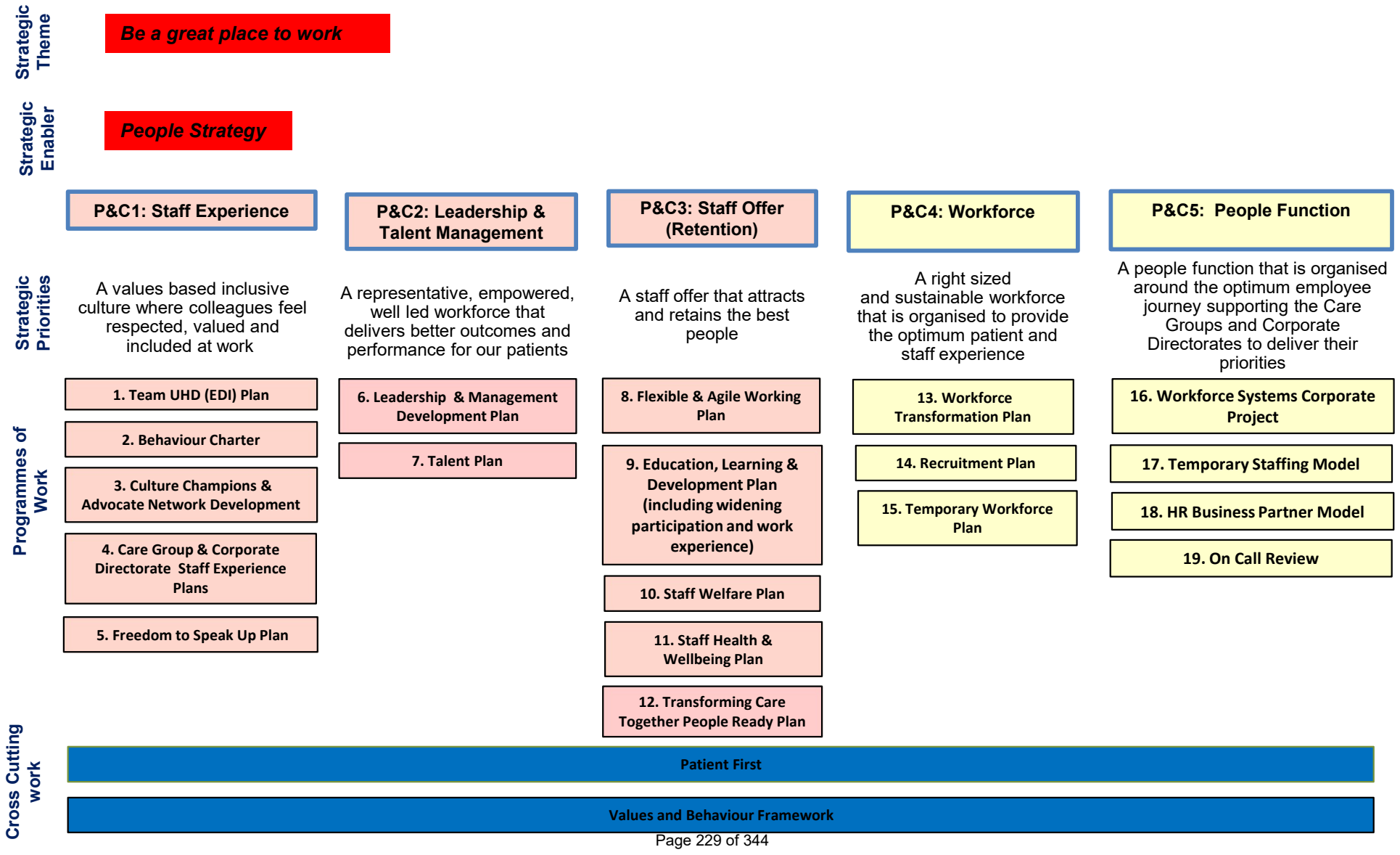
BAF RISKS

- **Culture –** If we fail to sustain an inclusive organisational culture true to our values, where everyone is able to speak up and bring their whole self to work, then we may fail to have the best people which will impede the delivery of safe, effective high quality compassionate treatment and care.
- **Talent Management** – if we do not have a representative workforce, a supply of talent and a focus on succession planning then we will not have a workforce with the right skills and experience to deliver our services.
- **Leadership –** If we do not have a comprehensive leadership plan in place then we will not have the right leadership behaviours, capability and capacity to deliver our strategic objectives and priorities.
- **Workforce –** If we do not have a healthy, sustainable workforce that is organised for success, we will not be able to provide high quality, safe and effective services resulting in poor patient and staff experience and increased premium staffing costs.

STRATEGIC PRIORITIES

P&C1: Staff Experience	P&C 2: Leadership & Talent Management	P&C3: Staff Offer	P&C4: Workforce	P&C5: People Function
A values based inclusive culture where colleagues feel respected, valued and included at work	A representative, empowered, well led workforce that delivers better outcomes and performance for our patients.	A staff offer that attracts and retains the best people	A right sized, sustainable workforce that is organised to provide the optimum patient and staff experience	A people function that is organised around the optimum employee journey supporting the Care Groups and Corporate Directorates to deliver their priorities

People & Culture Strategy on a page linked to Trust Strategic Themes



GOALS AND OBJECTIVES

P&C1: Staff Experience – Goals and Objectives

Strategic Priority	Goals	Delivery Workstream	Short Term Objectives [12 – 18 months]	Medium Term Objectives [18 - 36 months] Additional Watch / Driver Metrics
Staff Experience [P&C1] **Aim:** A values based inclusive culture where colleagues feel respected, valued and included at work	To have a representative workforce at all levels of the Trust	**Team UHD EDI Plan**	Improvement in the % of global majority staff at band 8a level and above Baseline: 6% (to be validated) Target: > 9% (31 December 2025) **[DRIVER METRIC]**	Improvement in % of global majority staff at band 6 level and above Baseline: variable at each band level Target: 3% increase from 31st March 2024 baseline **[WATCH METRIC]**
	To develop a behaviour charter which reflects our values, providing clear standards of behaviour that we expect from our staff, patients and visitors.	**Behaviour Charter**	To be in the top quartile for the NHS survey results for: We are compassionate and inclusive, civility and respect Baseline: 7.07 Target : 7.2 (2025 survey) **[DRIVER METRIC]** Improvement in the staff survey question "the last time I experienced harassment, bullying or abuse at work, myself or a colleague reported it" Baseline 46.6% Target 50% (2025 survey) **[WATCH METRIC]** Improvement in NHS Staff Survey question 'In the last 12 months 'I have personally been the target of unwanted behaviour of a sexual nature in the workplace from patients / service users or members of the public'. Baseline: 10% Target: 7% (2025 Survey) **[WATCH METRIC]**	To be one in the top 10% for the NHS survey results for: We are compassionate and inclusive, civility and respect Baseline: 7.07 Target : 7.4 (2026 survey) **[WATCH METRIC]** Improvement in the staff survey question "the last time I experienced harassment, bullying or abuse at work, myself or a colleague reported it" Baseline 46.6% Target 55% (2026 survey) **[WATCH METRIC]** Improvement in NHS Staff Survey question 'In the last 12 months 'I have personally been the target of unwanted behaviour of a sexual nature in the workplace from patients / service users or members of the public'. Baseline: 10% Target: 5% (2026 Survey) **[WATCH METRIC]**
	To further embed our values and behaviours across all Trust sites	**Culture Champions and Advocate Network Development**	We have recruited a selection of our workforce as culture advocates Target: 1 representative from each specialty and corporate area **[WATCH METRIC]**	We have recruited our workforce as culture advocates Target: >50% [31 March 2027] **[DRIVER METRIC]**
	To improve Care Group and Corporate Directorate staff survey results from a 2023 baseline	**Culture Plans:** Care Group and Corporate Directorate	Culture plans are in place at specialty and corporate directorate level **[WATCH METRIC]**	Culture plans are in place at specialty and corporate directorate level, and these are regularly reviewed through Care Group and Corporate Service Board meetings with oversight via Strategic Deployment Review [SDR] meetings. Target: 31 March 2026 **[DRIVER METRIC]**
	To develop a culture of safety where all staff are encouraged to speak up, are listened to and the issues are followed up.	**Freedom to Speak Up Plan**	Improvement in NHS staff survey question "if I spoke up about something that concerned me, I am confident my organisation would address my concern Baseline: 50.6% Target: 53% (2025 survey) **[WATCH METRIC]**	To be in the top quartile in the NHS staff survey question "if I spoke up about something that concerned me, I am confident my organisation would address my concern Baseline: 50.6% Target: 56% (2026 survey) **[DRIVER METRIC]** Number of FTSU referrals Baseline: 600 projected 2024/5 Target: >600 (2025/6) [WATCH METRIC]

P&C2: Leadership & Talent Management – Goals and Objectives

Strategic Priority	Goals	Delivery Workstream	Short Term Objectives [12 – 18 months]	Medium Term Objectives [18 - 36 months] Additional Watch / Driver Metrics
Leadership & Talent Management [P&C2] **Aim:** An empowered, well led workforce that delivers better outcomes and performance for our patients	To improve the quality and consistency of leadership at all levels of the Trust	**Leadership and Management Development Plan**	50% of middle managers (Band 6 &7) have attended leadership development/ training Target: 31 December 2025 **[DRIVER METRIC]**	Staff have attended leadership development / training Target: 50% by 31 December 2027 **[WATCH METRIC]**
	To recognise and unleash the previous knowledge and experience of all staff	**Talent Management Plan**	Improvement in appraisal compliance Baseline: 55% Target: 90% by 31 December 2024 **[DRIVER METRIC]**	% of global majority colleagues with personal development plans [monitored through appraisal rates) Baseline: tbc Target: 100% **[WATCH METRIC]**

P&C3: Staff Offer – Goals and Objectives

Strategic Priority	Goals	Delivery Workstream	Short Term Objectives [12 – 18 months]	Medium Term Objectives [18 - 36 months] Additional Watch / Driver Metrics
Staff Offer [P&C3] **Aim:** A staff offer that attracts and retains the best people	To be recognised as an employer of choice due to our approach to flexible and agile working	**Flexible & Agile Working Plan**	Improvement in NHS staff survey "We work flexibly" **Baseline: 6.30** **Target 6.50 (2025 Survey)** **[WATCH METRIC]**	We have achieved Timewise accreditation for our culture and approach to flexible and agile working Target: by 31st March 2027 **[DRIVER METRIC]** An increase in flexible working applications resulting in a 10% increase in approved outcomes Baseline: 977 applications (12 months) / 34% agreed Target: 44% agreed by 31st March 2026 **[WATCH METRIC]**
	Personal development is seen as a core part of our staff offer	**Education, Learning & Development Plan (including widening participation and work experience)**	Faculties are in place for all staff groups, which hold responsibility for developing the education, learning and development offer for their members **[WATCH METRIC]** 10% increase in number of apprenticeships from March 2024 baseline Baseline: tbc Target: tbc (31st December 2025) **[WATCH METRIC]**	A personal development offer (mandatory training, essential to role training, continued professional development and personal development) is in place for every member of staff Baseline: tbc Target: 100% of staff have a personal development offer (31st December 2027) **[DRIVER METRIC]**
	The welfare needs of our staff are met (rest areas, changing facilities, catering facilities/ food outlets)	**Staff Welfare Plan**	The location and function of all our staff welfare facilities are mapped and known by staff. Target: By 31st March 2025 **[WATCH METRIC]**	Staff welfare is seen as a top priority for the Trust Target: By 31st March 2025 **[DRIVER METRIC]**
	Staff health and wellbeing is seen as a top priority	**Staff Health & Wellbeing Plan**	Improvement in NHS Staff Survey question "My organisation takes positive action on health and well-being" Baseline: 56% Target: >60% (2025 Survey) **[DRIVER METRIC]**	Improvement in NHS Staff Survey question "My organisation takes positive action on health and well-being" Baseline: 60% Target: >65% (2026 Survey) **[DRIVER METRIC]** Improvement in absence relating to mental health (S10) Baseline: 1.1% Target: 0.8% **[WATCH METRIC]** Improvement in absence relating to muscoskeletal (S11, 12 & 28) Baseline: 0.8% Target: 0.6% **[WATCH METRIC]**
	Managers have the knowledge, confidence and skills to support staff through change	**Transforming Care Together People Ready Plan**	Staff turnover rate remains stable throughout the Transforming Care Together programme Baseline: 10.6% Target: 10.6% (31st December 2025) **[DRIVER METRIC]**	Staff turnover rate remains stable throughout the Transforming Care Together programme Baseline: 10.6% Target: 10.6% (31st December 2027) **[WATCH METRIC]**

P&C4: Workforce – Goals and Objectives

Strategic Priority	Goals	Delivery Workstream	Short Term Objectives [12 – 18 months]	Medium Term Objectives [18 - 36 months] Additional Watch / Driver Metrics
Workforce [P&C4] **Aim:** A right sized and sustainable workforce that is organised to provide the optimum patient and staff experience	To have the right sized, sustainable workforce	**Workforce Transformation Plan**	Workforce plans are in place for all service areas impacted by the Transforming Care Together Programnme Target: by agreed gateway date **[WATCH METRIC]** The Workforce Transformation Plan informs the Trust's Efficiency and Improvement Plan for 25/26 Target: 31st March 2025 **[WATCH METRIC]**	3 year workforce plans are in place for all service and corporate areas Target: 31st March 2026 **[DRIVER METRIC]**
	A recruitment plan that meets the future needs of the Trust	**Recruitment Plan**	Improvement in our vacancy rate Baseline: 8.8% Target: 7.5% (31st December 2025) **[WATCH METRIC]**	Improvement in our vacancy rate Baseline: 7.5% (31st December 2025) Target: 5% (31st December 2027) **[DRIVER METRIC]**
	To reduce our reliance on the temporary workforce	**Temporary Workforce Plan**	Average agency costs as a percentage of total pay costs remain below the national target Baseline: 3.4% Target: 3.2% (31st March 2025) **[WATCH METRIC]** Our reliance on the temporary workforce has reduced Baseline: 11.5% (of current workforce) Target: 8.5% (31st December 2025) **[WATCH METRIC]**	Average agency costs as a percentage of total pay costs meet the local target Baseline: 3.2% (31st March 2025) Target: <3% (31st March 2027) **[WATCH METRIC]** Our reliance on the temporary workforce has reduced Baseline: 8.5% (31st December 2025) Target: 5.5% (31st December 2027) **[DRIVER METRIC]**

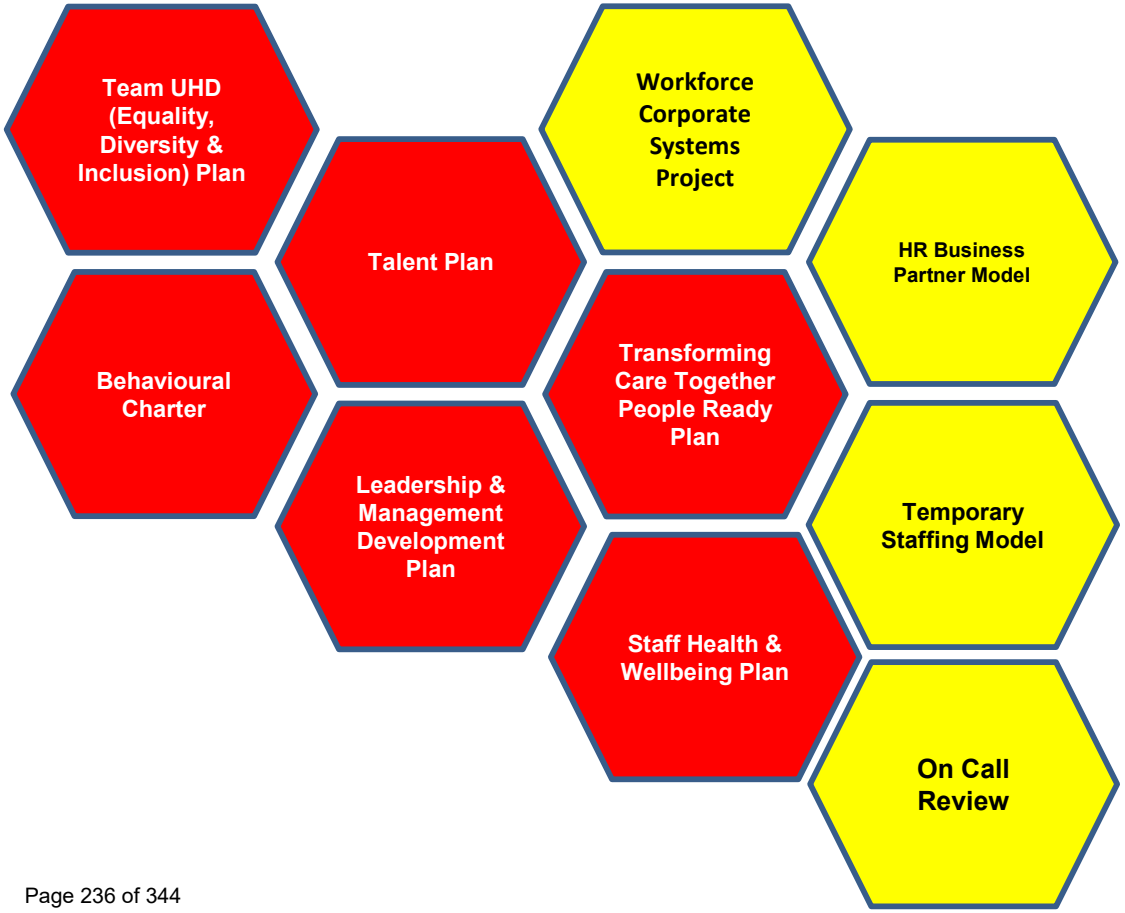
P&C5: People Function – Goals and Objectives

Strategic Priority	Goals	Delivery Workstream	Short Term Objectives [12 – 18 months]	Medium Term Objectives [18 - 36 months] Additional Watch / Driver Metrics
People Function [P&C5] **Aim:** A people function that is organised around the optimum employee journey supporting the Care Groups and Corporate Directorates to deliver their priorities	Workforce IT systems that support the effective deployment of human resources	**Workforce Systems Corporate Project**	Improvement in the management of annual leave Baseline: Up to 18% of staff off on annual leave Target: <16% of staff on annual leave during July & August and <14% of staff on annual leave the rest of the year (31st March 2025) **[WATCH METRIC]** Improvement in the management of fixed term contracts Review of all fixed term contracts by 31st December 2024 **[WATCH METRIC]** Improvement in our time to hire **Baseline: Average 68 days** **Target: Average <60 days (31st December 2025)** **[DRIVER METRIC]**	All medical staff on e-rostering system to support demand/ capacity modelling Baseline: tbc Target: 100% (31st March 2026) **[WATCH METRIC]** Improvement in our time to hire **Baseline: Average 60 days (31st December 2025)** **Target: Average <50 days (31st December 2027)** **[WATCH METRIC]**
	A cost-effective temporary staffing model that meets the needs of the Trust	**Temporary Staffing Model**	New Bank and Agency model in place and operational by 30th June 2025 **[DRIVER METRIC]**	Bank and Agency model fully integrated into the Trust's operating model by 31st March 2026 **[WATCH METRIC]**
	A strategic HR Business Partner model that pro-actively supports the Care Groups and Corporate directorates to develop and deliver their people and culture plans and priorities	**HR Business Partner Model**	New HR Business Partner model in place and operational by 1st April 2025 **[DRIVER METRIC]**	HR Business Partner model fully integrated into the operating model of Care Groups and Corporate Directorates by 1st April 2026 **[WATCH METRIC]**
	A trust wide On-Call Policy that is equitable and meets the needs of the Trust.	**On Call Review**	UHD on call policy and harmonised availability rates in place by 1st April 2025 **[DRIVER METRIC]**	

People & Culture Strategy – Summary of Short-term Objectives 2024/5

Strategic Priority	Strapline	Key short-term objectives 12 to 18 month period
Staff Experience	Be a great place to work	• To have a representative workforce at band 8a and above • To be in the top quartile for the NHS survey results for: We are compassionate and inclusive, civility and respect
Leadership & Talent Management	Be a great place to work	• To Improve the quality and compliance of appraisals • To improve the capability of middle managers (Band 6 &7)
Staff Offer	Be a great place to work	• Improvement in NHS Staff Survey question "My organisation takes positive action on health and well-being" • To have a stable staff turnover rate throughout the Transforming Care Together programme
People Function	Use every NHS £ wisely	• The new Bank and Agency model to be in place and operational by 30th June 2025 • The new HR Business Partner model to be in place and operational by 1st April 2025 • To be better than our peer group average for our time to hire • A harmonised On Call Policy and availability rates are in place by 31st March 2025

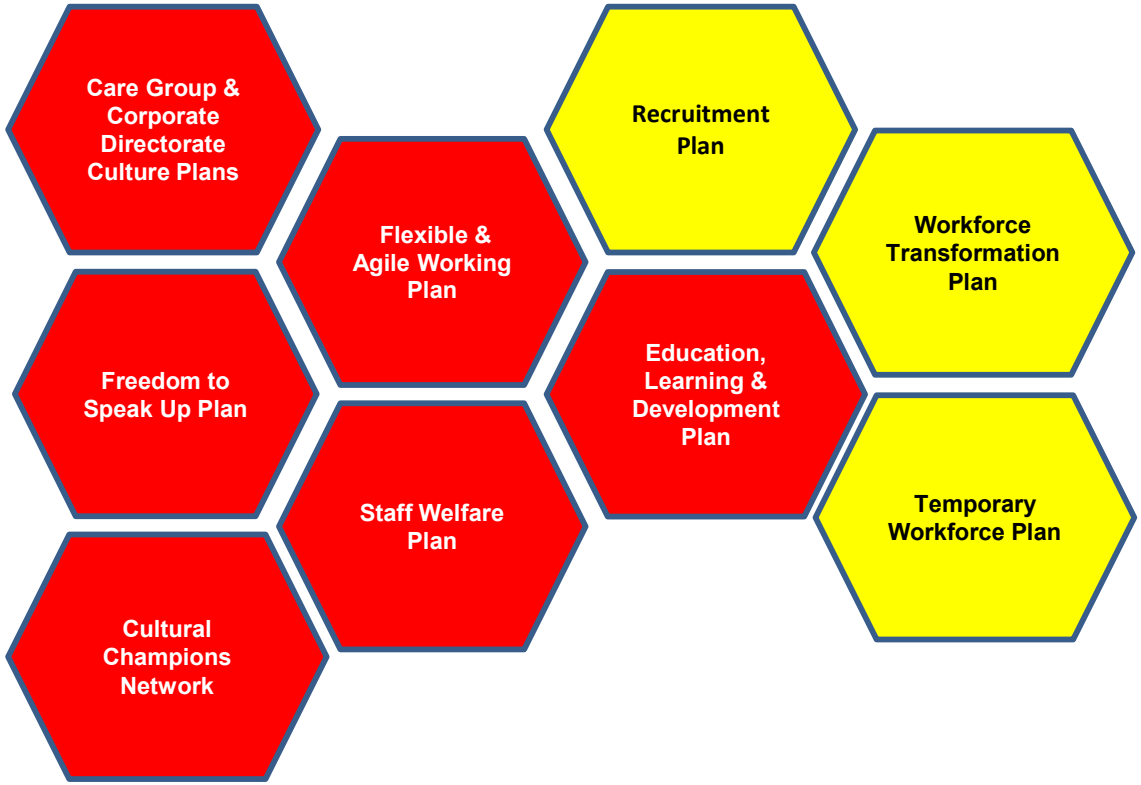
10 Priority Programmes of work 2024/5



People & Culture Strategy – Summary of Medium-Term Objectives 2026/7

Strategic Priority	Strapline	Key medium-term objectives 18 to 36 month period
Staff Experience	Be a great place to work	• To have culture plans in place at specialty and corporate directorate level which are regularly reviewed through Care Group/ Corporate Service Board meetings • To be in the top quartile for the NHS staff survey question "if I spoke up about something that concerned me, I am confident my organisation would address my concern • To recruit at least 50% of our workforce as culture advocates
Staff Offer	Be a great place to work	• To achieve Timewise accreditation for our culture and approach to flexible working • Staff welfare is seen as a top priority for the Trust • Every member of staff has a personal development offer (including mandatory training, essential to role training, continued professional development and personal development)
Workforce	Use every NHS £ wisely	• To reduce our vacancy rate to below 5% • To reduce our reliance on the temporary workforce to below 5% • 3 year workforce plans are in place for all service and corporate areas

9 Priority Programmes of work 2026/7



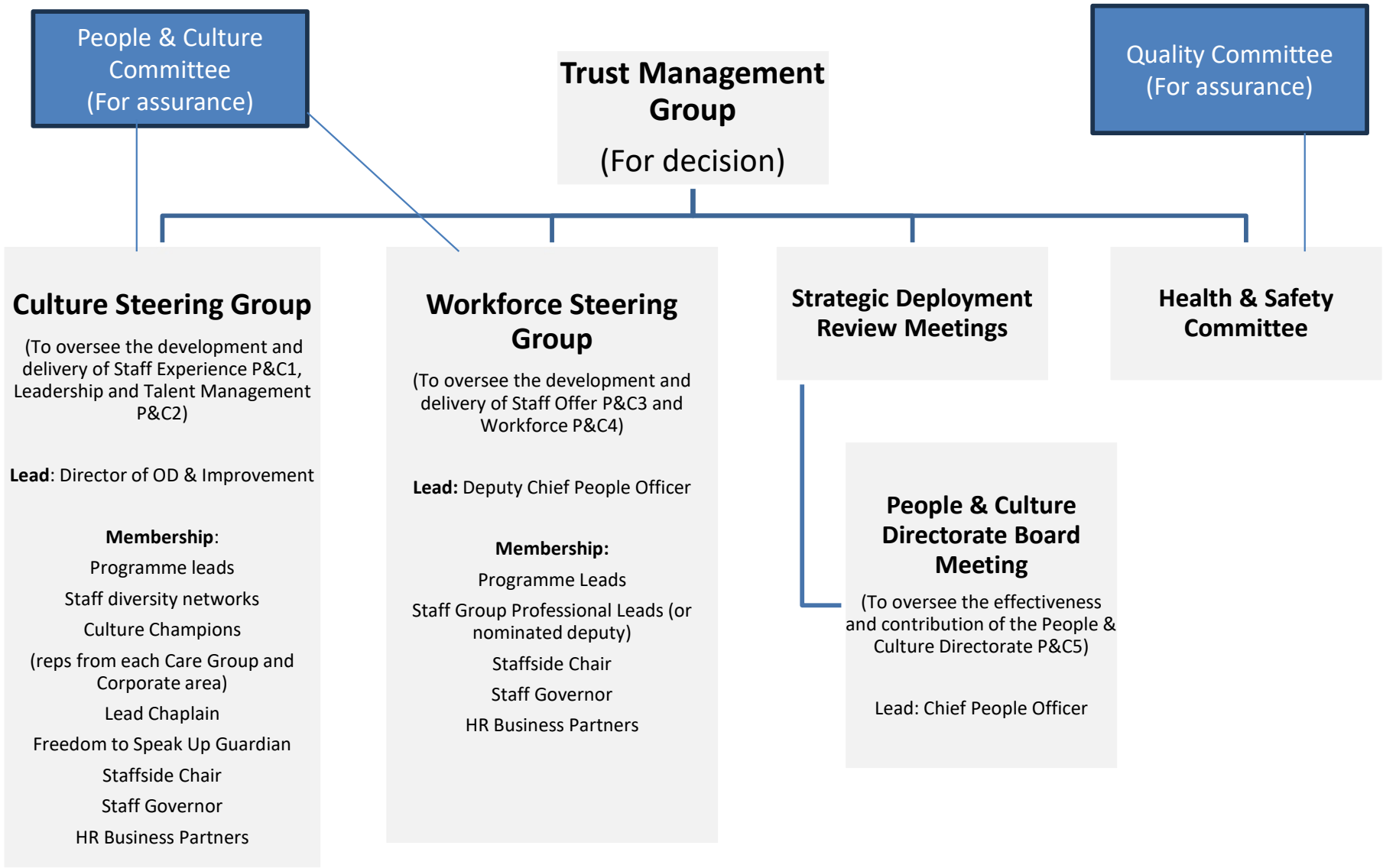
PROGRAMMES OF WORK - LEADS

Strand & Programmes of Work - Leads

	Strand 1	Strand 2	Strand 3	Strand 4	Strand 5
Priority **Strand Lead**	**Staff Experience** Director of OD & Improvement	**Leadership & Talent Management** Director of OD & Improvement	**Staff Offer** Deputy Chief People Officer	**Workforce** Deputy Chief People Officer	**People Function** Deputy Chief People Officer
Programmmes of Work	**1. Team UHD (Equality, Diversity & Inclusion Plan)** Head of OD - JH	**6. Leadership & Management Development Plan** Head of OD - BM	**8. Flexible & Agile Working Plan** Associate Director of HR Operations	**13. Workforce Transformation Plan** HR Business Partner Transformation	**16. Workforce Systems Corporate Project** Associate Director Workforce Systems
	2. Behaviour Charter Freedom to Speak up Guardian	**7. Talent Management Plan** Head of OD - BM	**9.Education, Learning & Development Plan** Associate Director of Education	**14. Recruitment Plan** Head of Recruitment	**17. Temporary Staffing Model** Deputy Chief People Officer
	3. Culture Champions/ advocate network Head of OD - BM		**10. Staff Wefare Plan** Head of OD- JH	**15. Temporary Staffing Plan** Head of Temporary Staffing	**18. HR Business Partner Model** Associate Director HR Operations
	4. Care Group & Corporate Directorate Staff Experience Plans Head of OD - JH		**11. Staff Health & Wellbeing Plan** Head of Occupational health/ Head of Psychological Support and Counselling Service		**19. On Call Review** Associate Director HR Operations
	5. Freedom to Speak Up Plan Freedom to Speak up Guardian		**12. Transforming Care Together People Ready Plan** Deputy Chief People Officer		

GOVERNANCE STRUCTURE

People & Culture Strategy – Proposed Governance Structure



PROGRAMMES OF WORK – PLANS ON A PAGE

1. Team UHD EDI Plan

Date Agreed: October 2024
Programme Lead: Jon Harding / Deepa Pappu

1. Problem Statement

Background: Creating an inclusive and psychologically safe environment enables staff to feel supported, engaged, and empowered, maximising the benefits of diversity and ensuring safe, high-quality patient care.

Problem: Despite efforts to promote inclusion and equity, staff still report prejudice and discrimination in organisational and individual behaviours, as reflected in lived experiences and workforce reports.

Impact: There is a risk that staff engagement, health, and wellbeing will suffer, negatively impacting the employee lifecycle, patient care quality and financial outcomes.

2. Scope

In Scope:	Out of Scope:

3. Programme Goal(s)

To have a representative workforce at all levels of the Trust

4. Key Exit Criteria (what will success look like)

UHD has a values based inclusive culture where colleagues feel respected, valued and included at work. UHD will be in the top quartile for the NHS survey results for: We are compassionate and inclusive, civility and respect

5. Short term objectives 2024/25

Improvement in the % of global majority staff at Band 8a level and above

Baseline: 6% (to be validated)
Target: > 9% (31 December 2025)
[DRIVER METRIC]

6. Medium term objectives 2026/7

Improvement in % of global majority staff at Band 6 level and above

Baseline: variable at each band level
Target: 3% increase from 31st March 2024 baseline
[DRIVER METRIC]

7. Key Programme Milestones

Milestones	Lead	By When	Status
Support our staff networks to work more closely with UHD strategic needs and provide project support for engagement activity	JH	Dec 24	In progress
Introduce inclusive recruitment alongside the Dorset ICS and our internal process	DP/TGP	Mar 25	Project initiation
Develop a one-stop approach to reasonable adjustments	DP/GL	Mar 25	In progress
Roll out of conscious inclusion workshops	DP/JH	ongoing	In progress

8. Key Risks

1. Patient First, BAU and new business may have competing priorities [statutory obligations]

2. Resource constraints to deliver Conscious Inclusion Workshops at scale over the project life cycle

3. Staff Network leads released by departments

9. Driver metrics

% of Global Majority	Baseline target	Timeline
% band 8a and above	> 9%	Dec-25
% band 6 and above	by 3%	Mar-27

10. Impact: planned benefits relating to True North strategic priorities

Population and System:

Patient Experience: An inclusive culture that has a positive effect on our patient care

Quality Outcomes and Safety:

Sustainable Services:

Our People: To be a 'great place to work,' attracting, developing and retaining the best talent.

Staff Experience [P&C 1] Team UHD EDI Plan

Our work so far ….

- Conscious Inclusion Workshop developed
- Data collection via WRES
  WDES
  Gender Pay
  EDI Audit
  EDS
- Modern Slavery statement updated
- Staff Network Audit commissioned with recommendations
- Maturity Audit follow-up
- Staff Engagement Events supported throughout 2024
- Ad-hoc individual support for staff
- Draft EIA to be shared
- Cohort 3 Reverse Mentoring underway

Quarter 3 24/25			Quarter 4 24/25			Quarter 1 25/26			Quarter 3 25/26			Quarter 3 25/26		
Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec

Cultural Awareness
Continue to develop and deliver Conscious Inclusion workshops. Other delivery methods to be considered. **Project will be ongoing**

Inclusive Recruitment
Initiated conversation with Dorset ICS and UHD Recruitment Team. Agree further scope and timelines.

Reasonable Adjustments
Working Group with Occupational health, ProAbility staff Network and HR in progress

Staff Network
Strategic Alignment: review recommendations and implement

These four workstreams will be included in the UHD 6 HIA improvement plan.

% of global majority staff at Band 8a level and above >9%

2. Behaviour Charter

Date Agreed: October 2024
Programme Lead: Helen Martin / Tara Vachell

1. Problem Statement

How we act directly impacts on the experience of our staff and patient.
Despite this, we are told poor behaviours from staff, patients and visitors exist at UHD. This behaviour can range across a spectrum from incivility to physical violence. UHD has a plethora of messages about how we should act yet there remains a lack of clarity on the standards we expect.
This results in inconsistency of reporting and addressing poor behaviours. A behaviour charter (BC) will provide an explicit message 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.

2. Scope

In Scope:
Patients, visitors and staff

Out of Scope:
Stages 2 and 3

3. Programme Goal(s)

To develop a behaviour charter which reflects our values, providing clear standards of behaviours that we expect from our staff, patients and visitors.

4. Key Exit Criteria (what will success look like)

To develop a behaviour charter which reflects our values, providing clear standards of behaviour that we expect from our staff, patients and visitors.

5. Short term objectives 2024/25

DRIVER METRIC:

- To be in the top quartile for NHS survey results for People Promise: We are compassionate and inclusive; Civility and respect (Subscore 4; Q8b/8c) by increasing our score to 7.2 (2025)

WATCH METRICS:

- Improvement of staff survey question "the last time I experienced harassment, bullying or abuse at work myself or a colleague reported it" Baseline 46.6%. Target 50% (2025)
- Improvement in NHS Staff Survey question 'In the last 12 months 'I have personally been the target of unwanted behaviour of a sexual nature in the workplace from patients / service users or members of the public'.

Baseline: 10% Target: 7% (2025 Survey)

6. Medium term objectives 2026/7

WATCH METRICS:

- To be in the top 10% NHS survey results for People Promise; We are compassionate and inclusive; Civility and respect (Subscore 4; Q8b/8c) by increasing our score to 7.4 (2026)
- Improvement of staff survey question "the last time I experienced harassment, bullying or abuse at work myself or a colleague reported it" Baseline 46.6%. Target 55% (2026)
- Improvement in NHS Staff Survey question 'In the last 12 months 'I have personally been the target of unwanted behaviour of a sexual nature in the workplace from patients / service users or members of the public'. Baseline: 10% Target: 5% (2026 Survey)

7. Key Programme Milestones

Milestones	Lead	By When	Status
Stage 1 – Identify key stakeholders	HM/TV	15.8.24	
Arrange stakeholder meetings to draft BC	HM/TV	31.10.24	Completed main stakeholder events, ongoing conversations
Sense check with Culture Champions and patient focussed groups	HM/TV	30.11.24	In progress
Seek Board approval	HM/TV	Feb - May 2025	
Write Communication Plan	HM/TV	April – Aug 2025	

8. Key Risks

- Lack of ownership by all areas risks effective implementation
- HR capacity to deal with increased cases / referrals
- Management skill to embed and develop into a cultural shift
- Resource constraints around embedding, implementing and maturing

9. Driver metrics

Driver Metric	Year	Target	Score	Average	Best
Q8b/8c	2021/2		6.95	6.78	7.28
	2022/3		6.99	6.83	7.3
	2023/4		7.07	6.86	7.27
	2024/5	7.2			
	2025/6	7.4			

10. Impact: planned benefits relating to True North strategic priorities

Population and System: will provide a clear message on the standards we expect at UHD from patients, staff and visitors which will allow focus on providing excellent care

Patient Experience: Having a clear message on the standards we expect will help improve visitors and patient experience

Quality Outcomes and Safety: Having a clear message will contribute to reducing incivility and improve patient safety and staff wellbeing

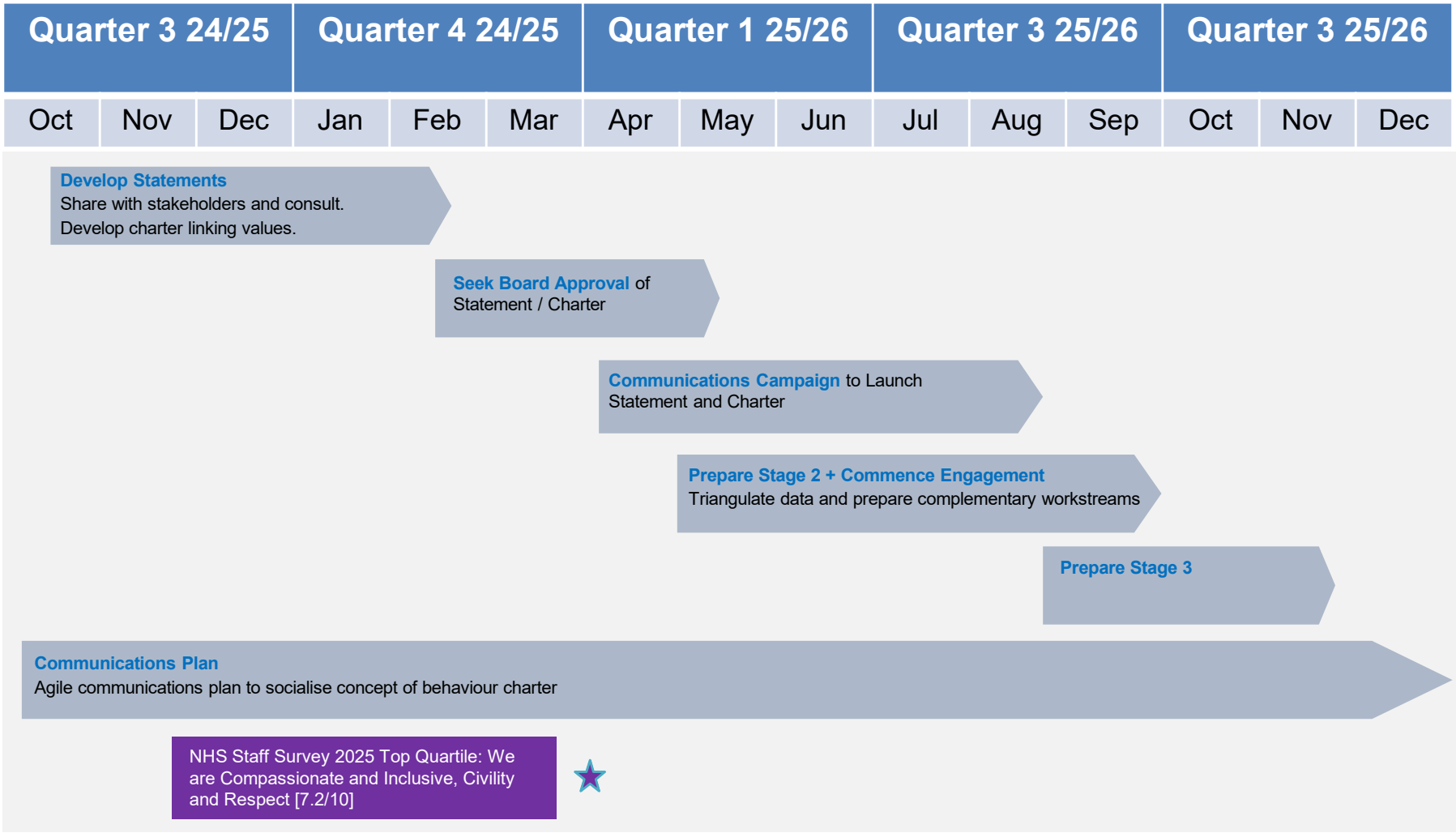
Sustainable Services: Having a clear message will outline the behaviours we expect and allow focus on healthcare.

Our People: provide an explicit message 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.

Staff Experience [P&C 1] Behaviour Charter

Our work so far ….

- Literature search / horizon scanning
- Identify key stakeholders
- Stakeholder events to inform development of statements



3. Culture Champions / Advocate Network Development

Date Agreed: October 2024
Programme Lead: Becky Neville

1. Problem Statement

Background:
There is an evidential link between building a compassionate, inclusive culture at work and improved employee engagement. Trusts that have higher staff engagement have better patient mortality rates and better patient experience. Where an employee feels valued and engaged, they will be more productive and more creative.

Problem:
Prior to the UHD merger, both legacy trusts had embarked on various successful culture programmes to engage their staff in growing a positive and inclusive culture. Since merger, UHD has become a large, complex organisation and despite two successful culture programmes, many staff report not feeling informed about the integration and service changes, wellbeing offers, development opportunities or other aspects that would make them feel valued at UHD. It is increasingly difficult to reach all of our staff, particularly those working in busy clinical areas and those undertaking large-scale change in line with our transformation programme.

Impact:
In a culture where staff do not feel valued, it is more likely that staff will not feel safe to bring their full self to work or be fully effective. The impact of a reduction in our engagement scores could be a reduction in the quality of care our patients experience and on the effectiveness of the team and individual members of staff. This will also have a financial impact if staff are less effective or have increased sickness absence and / or leave the trust.

2. Scope

In Scope: Review and redesign of culture advocates framework

Out of Scope:

3. Programme Goal(s)

Creating a values based inclusive culture where colleagues feel respected, valued and included at work

4. Key Exit Criteria (what will success look like)

- Meeting the key driver target will be an indication of success with high levels of engagement within the trust
- Improved engagement metrics through People Pulse Staff Survey
- Note: as an ongoing programme of work different iterations will be developed as the priority areas are agreed

5. Short term objectives 2024/25

WATCH METRIC
We have recruited a selection of our workforce as culture advocates.
Target: 1 representative from each specialty and corporate area.

6. Medium term objectives 2026/7

[DRIVER METRIC]
We have recruited our workforce as culture advocates
Target: >50% [31 March 2027].

7. Key Programme Milestones

Milestones	Lead	By When	Status
Phase 1: scoping available workforce data. Compare national initiatives to inform options appraisal	BN	Oct – Nov 24	**N**
Phase 2: Design and develop UHD framework	BN	Nov – Dec 24	**N**
Phase 3: Implement framework. Engage with relevant stakeholders	BN / HRBPs / SLs	Jan – Mar 25	**N**
Phase 4: Review and evaluation of progress	OD / HRBPs	Q2 – Q4	**N**

8. Key Risks

- Leadership Engagement: potentially impacted by capacity
- Resource constraints releasing staff to support programme
- Team leaders not being held accountable for improving staff experience in their service
- HRBP modelling maturity and interdependencies across workstreams

9. Driver metrics

Measurable Target	Current	Short term [12-18 months]	Medium term [18-36 months]
Staff Survey Engagement Score	6.96	>7.1	>7.2
Would recommend the trust as a place to work	63.42%	65%	67%
% of culture advocates	0	20%	50%

10. Impact: planned benefits relating to True North strategic priorities

Population and System:

Patient Experience: Organisations with high levels of staff engagement tend to have lower levels of patient mortality and provide higher quality patient care.

Quality Outcomes and Safety:

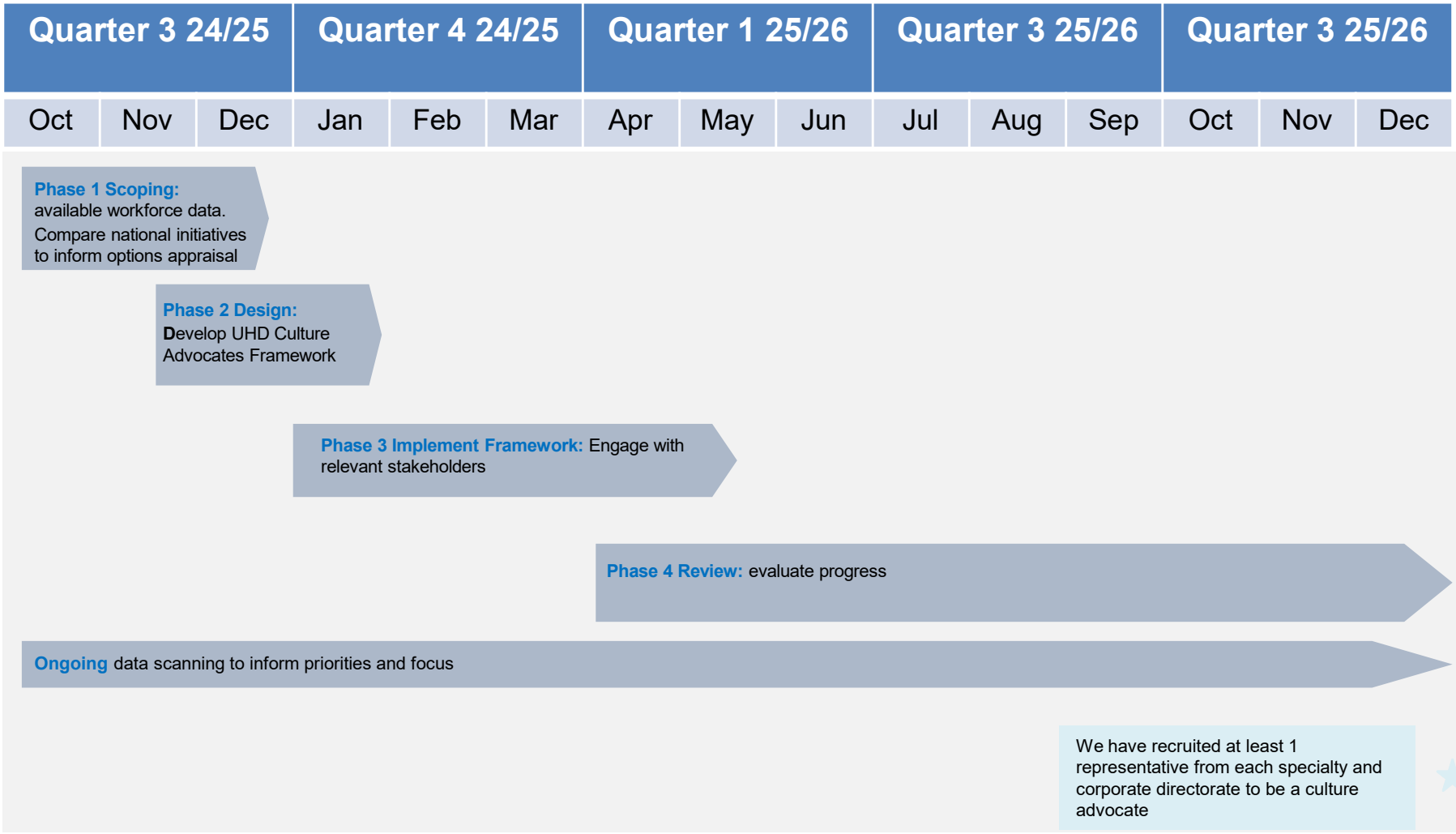
Sustainable Services:

Our People:

Staff Experience [P&C 1] Culture Champions / Advocate Network Development

Our work so far ….

- Data sharing to inform planning {NSS People Pulse]
- Increased completion rate in engagement surveys
- Staff Survey Managers Module
- Care Group SDRs in place



4. Care Group and Corporate Staff Experience / Culture Plans

Date Agreed: October 2024
Programme Lead: Jon Harding / Aimee Smith

1. Problem Statement

Extensive research shows that employee engagement is a crucial driver of staff morale and performance within the NHS. It has been proven that providers with high levels of staff engagement tend to have lower levels of patient mortality and provide higher quality patient care.
At UHD, there is a variation in how staff are experiencing their time at work across our care groups and directorates.
This impacts staff morale, sickness and retention rates and, in turn, negatively impacts on patient experience and finances. If we fail to sustain an inclusive and positive organisational culture, where our staff thrive and recommend our organisation as a place to work, then we may fail to have the best people which will impede the delivery of safe, effective high quality compassionate treatment and care.

2. Scope

In Scope:
Design of UHD Cultural Framework

Out of Scope:
Data input into framework and ongoing ownership

3. Programme Goal(s)

To improve care group and corporate NSS results from a 2023 baseline which will contribute to a values based, inclusive culture, where colleagues feel respected, valued and included at work

4. Key Exit Criteria (what will success look like)

Culture plans are in place at a specialty and corporate directorate level, and these are regularly reviewed through Care Group and Corporate Service Board meetings with oversight via SDR meetings.

5. Short term objectives 2024/25

WATCH METRIC:

- Culture plans are in place at specialty and corporate directorate level
- NSS Staff Engagement Score to increase >7.1
- NSS 'Would recommend trust as a place to work' to be 65%

6. Medium term objectives 2026/7

DRIVER METRIC:

Culture plans are in place at specialty and corporate directorate level, and these are regularly reviewed through Care Group and Corporate Service Board meetings with oversight via Strategic Deployment Review [SDR] meetings by 31st March 2026.

WATCH METRIC:

- NSS Staff Engagement Score to increase >7.2
- NSS 'Would recommend trust as a place to work' to be 67%

7. Key Programme Milestones

Milestones	Lead	By When	Status
Scope relevant cultural data and measures to create cultural baseline	AS	Dec 24	Not Started
Design and develop a cultural framework	AS	March 25	Not Started
Engage with relevant stakeholders to embed framework	OD / HRBPs	May 25	Not Started
Develop clear sign posting to appropriate support and / or interventions	AS	Sept 25	Not Started
Update OD intervention scoping form to incorporate data drivers	AS	March 25	Not Started
Identify areas of focus through NSS 2024 heatmaps for support	OD / HRBPs	Apr 25	Not Started

8. Key Risks

- Leadership Engagement: potentially impacted by capacity
- Resource constraints releasing staff to support programme
- Team leaders not being held accountable for improving staff experience in their service
- HRBP modelling maturity and interdependencies across workstreams

9. Driver metrics

Measurable Target	Current	Short term [12-18 months]	Medium term [18-36 months]
Staff Survey Engagement Score	6.96	>7.1	>7.2
Would recommend the trust as a place to work	63.42%	65%	67%

10. Impact: planned benefits relating to True North strategic priorities

Population and System:

Patient Experience: Organisations with high levels of staff engagement tend to have lower levels of patient mortality and provide higher quality patient care.

Quality Outcomes and Safety:

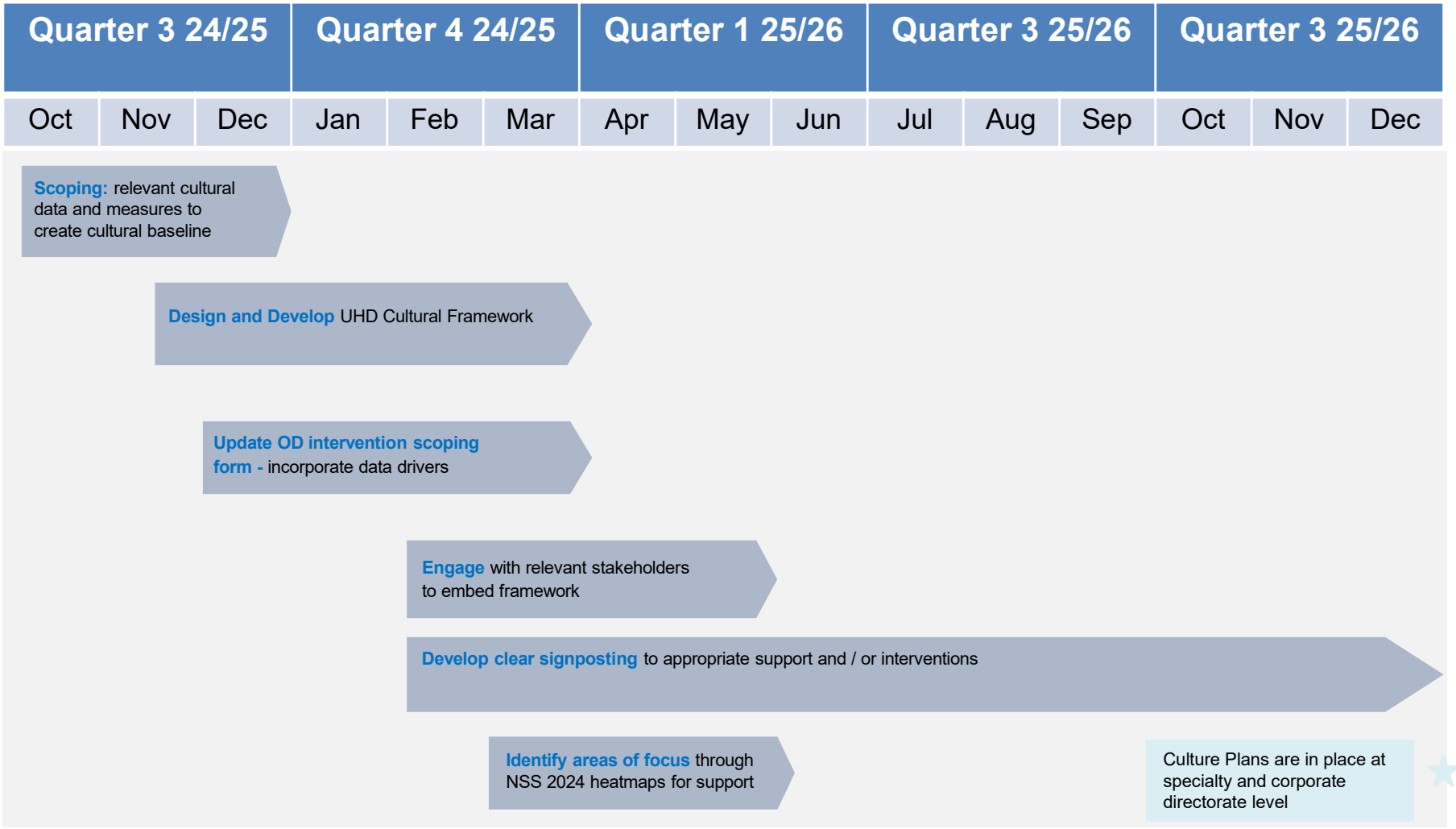
Sustainable Services:

Our People:

Staff Experience [P&C 1] Care Group & Corporate Staff Experience / Culture Plans

Our work so far ….

- Data available at directorate and team level from the NSS
- People Pulse survey now reports at directorate level
- Increased completion rates in both staff engagement surveys
- Staff Survey managers module in existence
- Care Group SDRs already in place
- Since becoming UHD, supported teams to take ownership of their team culture through building effective teams;
  Care Group – 3
  Directorate - 14
  Team - 29



5. Freedom to Speak Up Plan

Date Agreed: October 2024
Programme Lead: Helen Martin / Tara Vachell

1. Problem Statement

Background: Speaking up benefits everyone by improving staff experience and safer patient care. At UHD, speaking up is an essential component of our cultural and improvement journey. It is entrenched within our objectives, strategy and vision. At UHD, we have many routes that our people can speak up including our line managers, occupational health, staff governors, using our LERN forms, chaplains, education team and our HR team.

Problem: Our staff tell us that they are not confident in speaking up. Indeed, fear and futility remain the main barriers at UHD to speaking up. Fear of what might happen or a belief that nothing will be done. Despite this however, we are starting to make some positive progress. This work is however more than the FTSU team. The role of the FTSU team is to highlight the challenges and act as an early warning system of where failings might occur. Our leaders, need to play a significant role in setting the tone for fostering a healthy speak up, listen up and follow up culture at UHD. The **IMPACT** of not creating a speaking up culture, led by our senior leaders and collectively across UHD, will be that we will not create a working environment based on psychological safety eroding staff experience and ultimately deliver poorer patient care.

2. Scope

In Scope:	Out of Scope:
Speaking up through the FTSU channel	Speaking up outside of FTSU channel

3. Programme Goal(s)

To develop a culture of safety at UHD where all staff are encouraged to speak up, staff are listened to, and the issues are followed up.

4. Key Exit Criteria (what will success look like)

Deliver 5 MUSTs identified by NHSE reflection and planning tool (see step 7).

5. Short term objectives 2024/25

DRIVER METRIC:
Improvement in NHS Staff survey (NHSSS) question "If I spoke up about something that concerned me, I am confident my organisation would address my concern". Baseline 50.6% Target 53% (2025 Survey)

6. Medium term objectives 2026/7

DRIVER METRIC:
To be in the top quartile for NHS Staff survey (NHSSS) question "if I spoke up about something that concerned me, I am confident that my organisation would address my concern". Baseline 50.6% Target 56% (2026 staff survey)

WATCH METRIC:
Number of FTSU referrals projected baseline 2024/25 600. Target 600 by 2026.

7. Key Programme Milestones

Milestones	Lead	By When	Status
Update, improve and increase awareness of FTSU policy	HM	May 2025	On target
Increase completion of NGO Speak Up Module eLearning	HM	Mandatory Launch Oct 2024 Review uptake April 2025	On target
Develop and implement robust process for identify and address detriment	HM	May 2025	On target
Substantive B7 FTSUDG post approved	HM	1st August 2024	Completed
Commence Speaking Up Audit by internal auditors	HM	May 2025	On target

8. Key Risks

- Listening to concerns and seeing themes being raised without actionable outcomes or behaviour changes
- Increase in cases year on year without understanding what drives this and whether we have reached a tipping point where speaking up is NOT a good thing
- Reliance on FTSU as being the only channel that enables our workforce to speak up

9. Driver metrics

Driver and Watch Metrics	Target
Delivery of 5 strategic goals from NHSE reflection and planning tool	March 2025
Improvement in NHSSS "speaking up" question from Baseline of 50.6%	2025: 53% 2026: 56%
Number of FTSU referrals from projected baseline of 600 2024/25	2025/26: 600 referrals

10. Impact: planned benefits relating to True North strategic priorities

Population and System: Will improve speaking up through FTSU channel and support psychologically safe working environments, supporting staff to see patients sooner

Patient Experience: We will improve staff experience to then be able to improve patient experience, listen and act.

Quality Outcomes and Safety: Will ensure that staff have another channel to raise concerns and save lives and improve patient safety

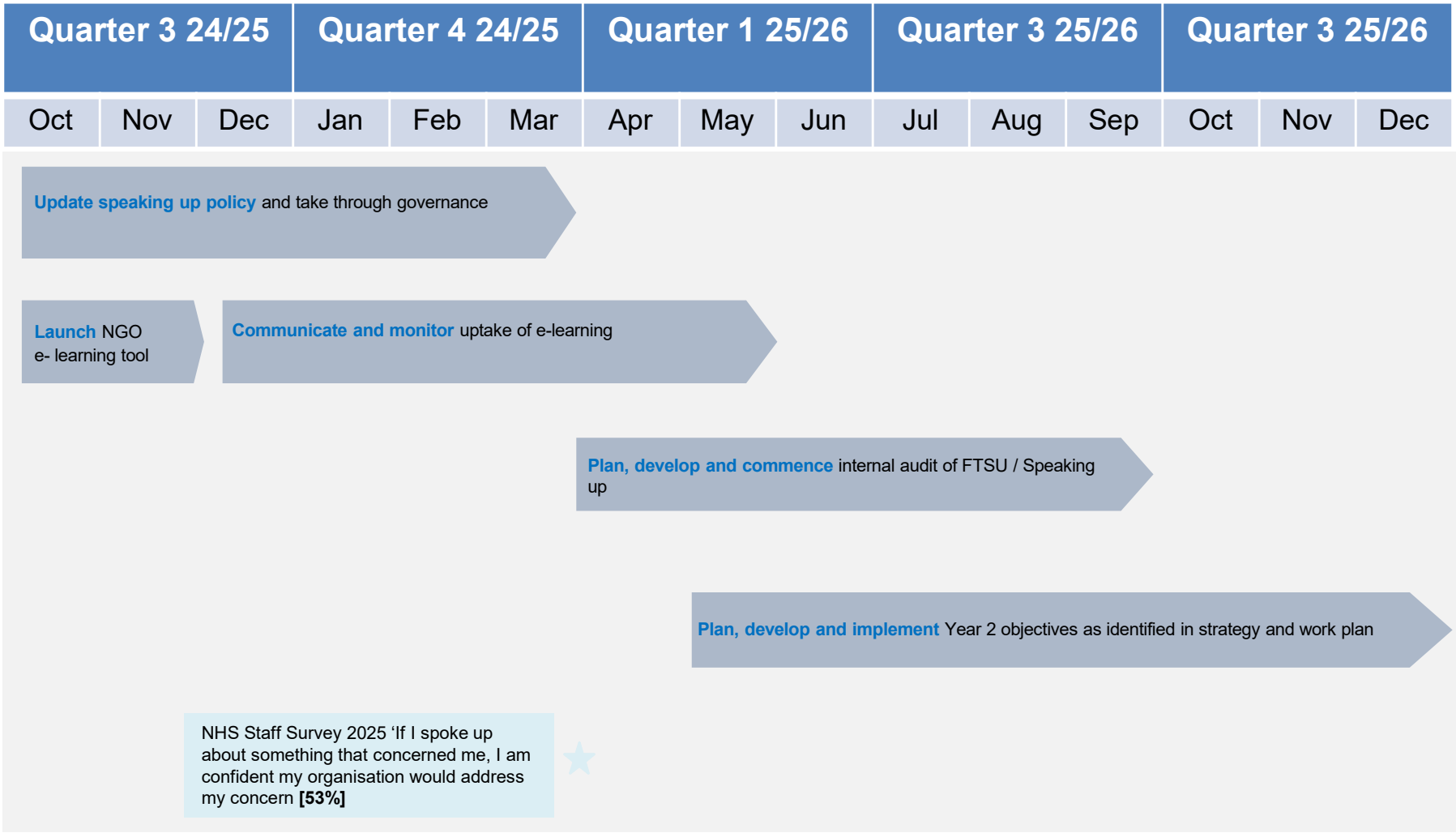
Sustainable Services: Will allow staff to raise concerns about improving services/working environments and making them sustainable and value for money

Our People: Will allow staff to have a confidential and impartial speaking up channel, improving staff experience and making it a great place to work

Staff Experience [P&C 1] Freedom to Speak Up Plan

Our work so far ….

- FTSU strategy 2023-6
- NHSI Self-assessment tool (Jan 2024)



6. Leadership and Management

Date Agreed: October 2024
Programme Lead: Gaynor Hurst

1. Problem Statement

Research shows compassionate leadership leads to more engaged, motivated staff with higher wellbeing, resulting in better care quality.

At UHD there is variation in leadership and management capabilities. The merger of two organisations with different values, background and cultures; the pandemic resulting in a period of reduced training activity together with our on-going transformation and integration has had an adverse impact on our leaders and potentially our ability to deliver effective outcomes. Some teams report dissatisfaction with management and feel unable to deliver the quality of care and service standards they aspire to, resulting in poor job satisfaction, engagement, and morale.

If we do not have a comprehensive leadership plan in place then we may not have the right leadership behaviours, capability and capacity to deliver our strategic objectives and priorities.

2. Scope

In Scope:	Out of Scope:

3. Programme Goal(s)

To improve the quality and consistency of leadership at all levels of the Trust, leading to an empowered, well-led workforce that delivers better outcomes and performance for our patients.

4. Key Exit Criteria (what will success look like)

A clear definition of a UHD leader with supporting behaviour framework and description expectations. Self-assessment tools and an accessible, structured way to access the appropriate leadership development / training. Numbers of staff accessing leadership development / training >50%.

5. Short term objectives 2024/25

DRIVER METRIC:
50% of middle managers (B6 & B7) have attended leadership development / training.

WATCH METRICS:

- Improvement in the National Staff Survey 'Compassionate Leadership' theme (Q9f, Q9g, Q9h, Q9i).
  Baseline score: 7.07. Target >7.1 (2025 Survey)
- Improvement of NHS Staff Survey 'Line Management 'theme (Q9a, Q9b, Q9c, Q9c)
  Baseline score: 6.88 Target: 6.9 (2025 Survey)

6. Medium term objectives 2026/7

DRIVER METRIC:
Staff have attended leadership development / training (target 50%)

WATCH METRICS:

- Improvement of the National Staff Survey 'Compassionate Leadership' theme (Q9f, Q9g, Q9h, Q9i).
  Target >7.15 (2026 Survey)
- Improvement of NHS Staff Survey 'Line Management' theme (Q9a, Q9b, Q9c, Q9c)
  Target: 6.95 (2026 Survey

7. Key Programme Milestones

Milestones	Lead	By When	Status
Define a UHD Leader and expectations of leaders / line managers	GH	29/11/24	In progress
Roll out leadership behaviour framework	GH	06/12/24	In progress
Finalise UHD leadership and management pathway	GH	06/12/24	In progress
Develop and launch development self-assessment tools	GH	31/03/25	**N**
Identify areas of focus through NSS heat maps for targeted leadership development	KH	Mar 25	N
Deliver programme of leadership development where there is the highest impact (initially B6 & B7)	AS/KH	Commence Feb 25	**N**
Engage leaders by launching UHD Leadership Community of Practice	GH	Commence May 25	N

8. Key Risks

- The ability to confidently measure the % of leadership development / training of staff
- Ensuring there is a link between training and development activity and the wider impact on staff experience
- Resource constraints around providing adequate training and development to achieve target.

9. Driver metrics

Driver Metric	Target
50% of middle managers (B6 & B7) have attended leadership development / training.	31 Dec 2025
Staff have attended leadership development / training (target 50%).	31 Dec 2027

10. Impact: planned benefits relating to True North strategic priorities

Population and System:

Patient Experience: Improved leadership leads to improved patient outcomes.

Quality Outcomes and Safety:

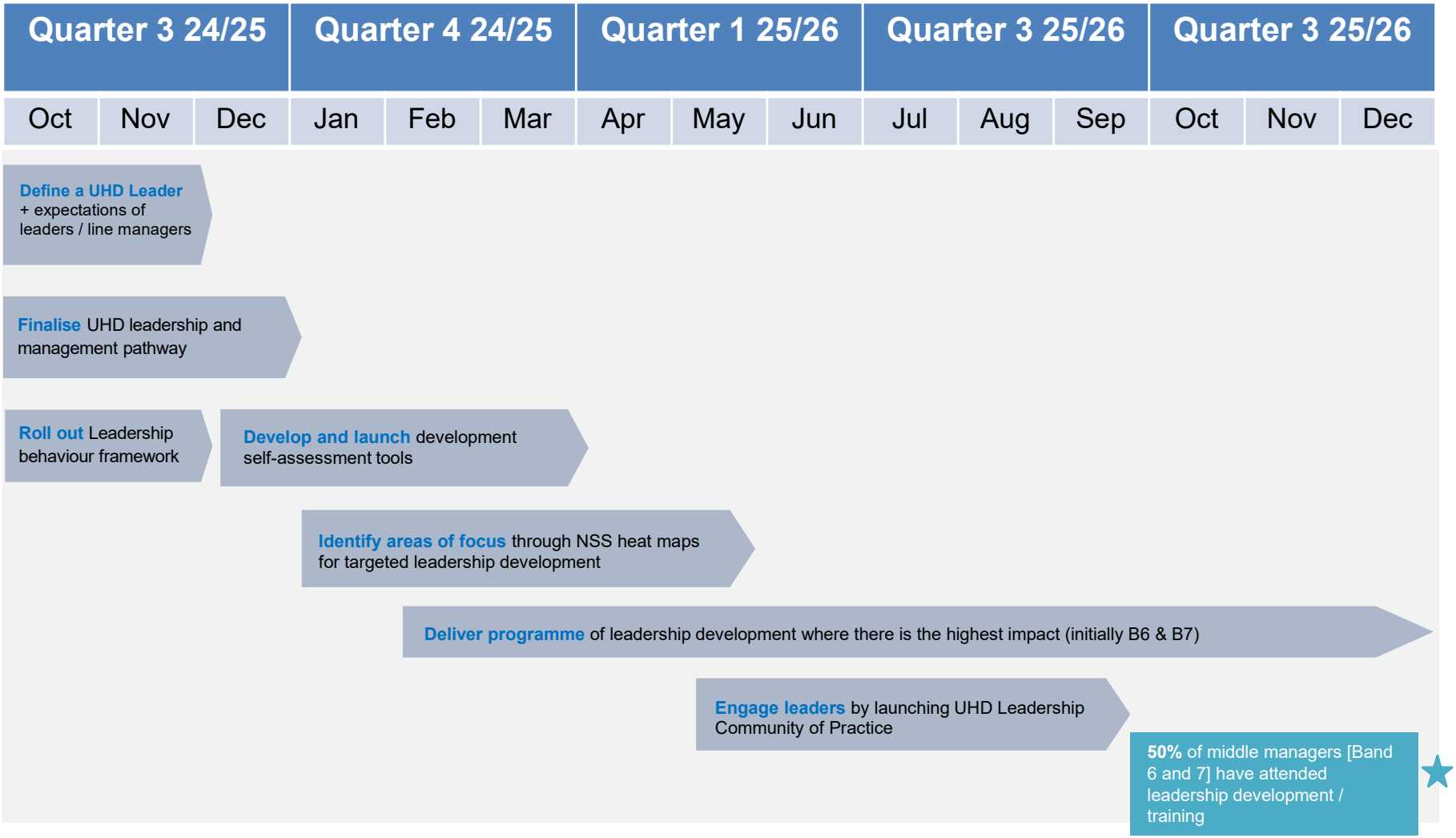
Sustainable Services:

Our People:

L&TM [P&C 2] Leadership and Management Development

Our work so far ….

- Leadership and Management Development Pathway
- UHD Leadership Behaviour Framework
- Expectations of Line Managers Framework
- Patient First for Leaders Training (circa 350 participants)
- Leadership in Action Programme (47 delegates since 2023)
- Leadership Fundamentals (113 delegates since 2023)
- Leadership Skills Workshops (1904 delegates)
-
- Level 7 (Cohorts 1 & 2 12 delegates)
-
- Coaching (41 coaches)



7. Developing Potential [Talent Management]

Date Agreed: October 2024
Programme Lead: Gaynor Hurst / Katherine Heredge

1. Problem Statement

Background: It is essential that we have a workforce with the right skills to deliver our services, meaning that we have an appropriate talent pipeline, supply of talent and organisational succession planning. Through developing the potential of our staff and harnessing their talent, we will ensure that they are able to deliver the quality of care and service standards that they aspire to, while also improving job satisfaction, engagement, and morale within the organisation. This will improve employee experience resulting in a significant, positive impact on staff turnover, sickness levels and financial sustainability.
Problem: Everyone has a role in unlocking and developing potential in our staff. At UHD, we do not have an inclusive talent management strategy that encompasses the entire employee lifecycle, and our staff do not have an equitable experience regarding their development and career progression.
Impact: There is no definition of what talent management means at UHD and limited understanding of what it encompasses, meaning that we do not have an agreed, established approach to developing the potential of our workforce. We cannot access development data on appraisal and PDPs, meaning that leaders are unable to plan and tailor development pathways for staff. There are also no clear pathways across all roles and faculties to provide equal access development and career progression.

2. Scope

In Scope: All non-medical staff

Out of Scope: Medical/ Dental staff

3. Programme Goal(s)

To recognise and unleash the previous knowledge and experience of all staff, which will contribute to an empowered, well-led workforce that delivers better outcomes and performance for our patients.

4. Key Exit Criteria (what will success look like)

Every eligible member of staff has an in-date, meaningful values-based appraisal and a personal development plan. Any member of staff who wishes to develop their career within the organisation is able to and we have access to the talent data of our workforce.

5. Short term objectives 2024/25

DRIVER METRIC:

- Increase values-based appraisal compliance to 90% by 31st December 2024
- Review and update all appraisal resources and training

6. Medium term objectives 2026/7

WATCH METRIC:

- 100% of global majority colleagues have personal development plans (monitored through appraisal rates)

DRIVER METRICS

- Develop / embed inclusive talent management strategy where everyone has equal access to development
- Map career pathways within every faculty
- Develop and pilot a career conversation framework
- Further utilise our internal coaching network to support staff with their continued professional development

7. Key Programme Milestones

Milestones	Lead	By When	Status
Review appraisal exclusions	KH	Oct 24	Complete
Review and update appraisal intranet and resources	KH	Nov 24	In progress
Appraisal compliance reaches 90%	TR	Dec 24	In progress
Develop talent management working group with key stakeholders	KH	May 25	In progress
Launch a career conversation framework	KH	Jan 26	Not started
Talent management plan embedded	KH	Apr 26	Not started

8. Key Risks

- Current systems and processes prevent significant improvement in appraisal compliance and data collection
- Support to enable data collection from PDPs
- Engagement from all key stakeholders

9. Driver metrics

Driver Metric	Target
Increase values-based appraisal compliance to 90% by 31st December 2024	Dec 2024

10. Impact: planned benefits relating to True North strategic priorities

Population and System:

Patient Experience:.

Quality Outcomes and Safety:

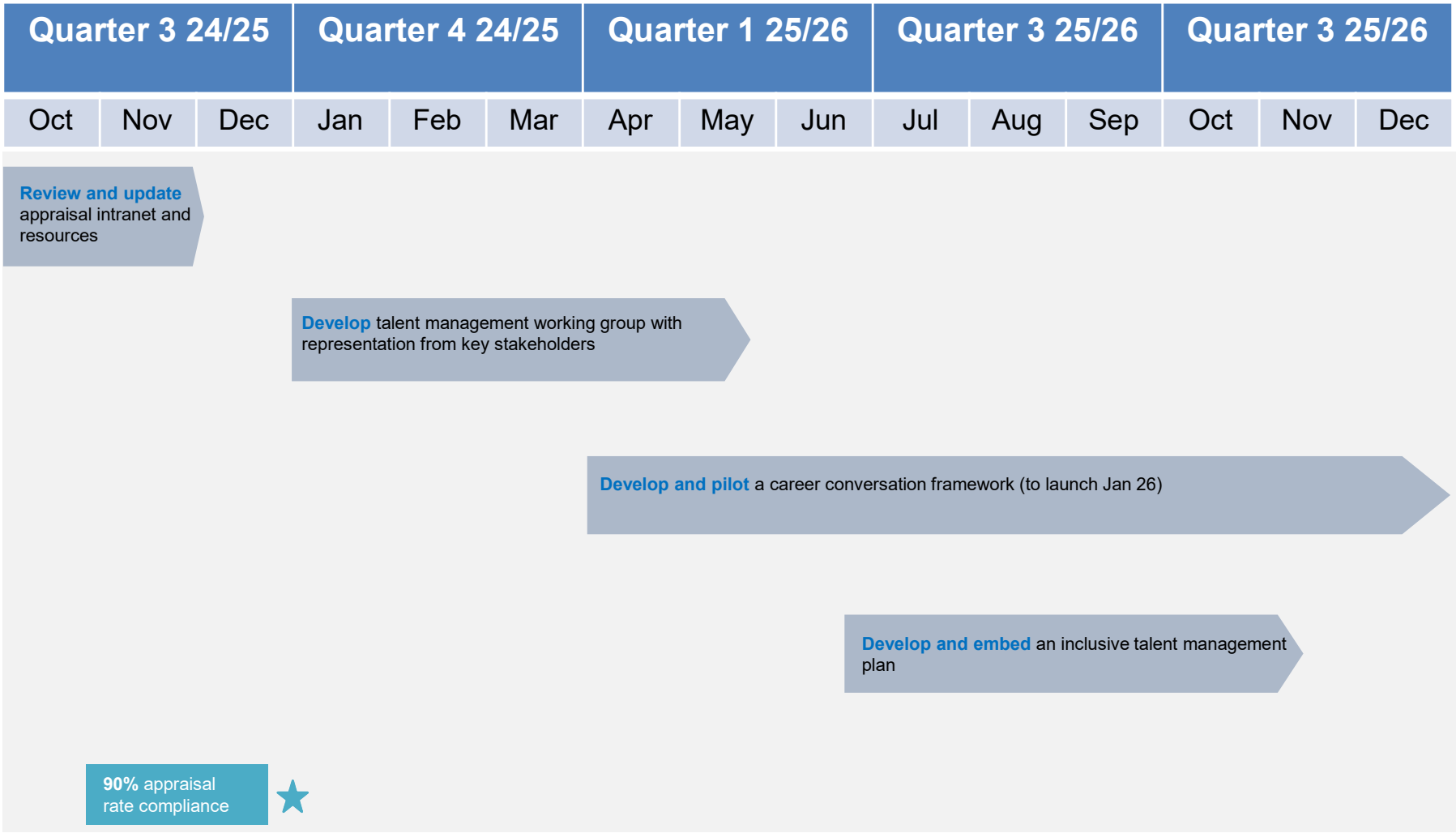
Sustainable Services:

Our People:

L&TM [P&C 2] Developing Potential [Talent Management]

Our work so far ….

- Extensive appraisal resources and training
- Reviewed exclusions to appraisal
- On-going pilot of national career conversation framework (Scope for Growth)
- Accelerated Development Programme for IENs
- Development of in-house coaching offer to provide tailored support for staff personal and professional development



8. Flexible and Agile Working Plan

Date Agreed: xx/xx/2024
Programme lead: Lisa White, Associate Director of HR Operations

1. Problem Statement

Background:
NHSE/I have a clear commitment to flexible working (NHS People Plan and The People Promise). A responsive, flexible and agile organisational culture enables UHD to be a great place to work. Having sustainable, safe and effective flexible and agile working practices has direct correlation to talent attraction, retention and motivation, inclusion and diversity, performance and business costs (NHS Employers 2024).

Problem:
We have no assurance of a flexible and agile working culture, or a robust and responsive staff offer, applied consistently across the organisation.

Impact:
Lack of Trust wide drive and role modelling of flexible and agile working as a positive approach to productivity has established a culture that flexible working is seen as counterproductive to service delivery. Consequently, manager confidence and competence in implementing flexible working is low, directly impacting the number of requests and subsequently agreed formal requests. This negatively impacts staff experience and retention.

2. Scope

In Scope: Accreditation and Improvement in levels of staff being able to work in a more flexible and agile way.

Out of Scope: Strategy and Transformation Space Utilisation / IT Infrastructure plans.

3. Programme Goal(s)

1. To have robust data demonstrating an increase of flexible working applications which follow governance processes and result in a measurable increase in approved outcomes.
2. Improvement in the NHS Staff Survey "We work flexibly" from 6.30 baseline to 6.50 following 2025 survey data collection
3. A reduction of leavers citing flexible working as their reason to leave UHD
4. An index of organisational roles aligned to agile working options
5. To make the flexible working application process easy and efficient and accessible to all staff

4. Key Exit Criteria (what will success look like)

Staff will choose UHD as an employer of choice for its flexible and agile culture, and through excellent leadership and role modelling of flexible working, be motivated to be their best at work.

5. Short term objectives 2024/25

Improvement in NHS staff survey "We work flexibly"
Baseline: 6.30
Target 6.50 (2025 Survey)

6. Medium term objectives 2026/7

We have achieved Timewise accreditation for our culture and approach to flexible and agile working. By 31.3.27.

An increase in flexible working applications resulting in a 10% increase in approved outcomes
Baseline: 977 applications (12 months) / 34% agreed
Target: 44% agreed by 31st March 2026.

7. Key Programme Milestones

Milestones	Lead	By When	Status
Engagement with Timewise and key stakeholders to map the programme of work	LW	Jan 2025	In Progress
Task and Finish Group in place	LW	March 2025	Not Started
Creation of an index of roles aligned to agile working	LW	July 2025	Not Started
An increase in agreed flexible working applications	LW	March 2026	Not Started
Timeline accreditation achieved	LW	March 2027	Not Started

8. Key Risks

Risks
1. Lack of leadership engagement to make cultural change required.
2. Interdependences to agile working i.e. IT infrastructure, space utilisation and booking systems.

9. Driver metrics

Driver Metrics (max of 3)	Target
Timewise accreditation.	31.3.27

10. Impact: planned benefits relating to True North strategic priorities

Population and System:

Patient Experience:

Quality Outcomes and Safety:

Sustainable Services: An agile offer that reduces the carbon footprint and space utilisation is maximised for clinical need.

Our People: A staff offer that attracts and retains the best people.

9. Education, Learning and Development

Date Agreed: xx/xx/2024

1. Problem Statement

Background:
The aim of delivering a staffing workforce, safe at the point of care to meet the healthcare needs of the current and future population across East Dorset requires intensive, multi-year education and training activities to underpin local and national strategic objectives.

Problem:
Overlapping national and local programmes of work have created an unmanageable training burden on our current workforce in terms of widening participation, statutory compliance, governance and workforce development.

Impact:
Risk of failing to meet statutory and mandatory training compliance targets, and severely impacting our ability to deliver meaningful and sustainable educations services to all. High risk of static workforce growth and retention with reputational, staff experience and patient safety quality metrics impacted.

2. Scope

In Scope:	Out of Scope
All UHD employees and learners on placement	Future workforce not yet employed or enrolled on a programme of education within UHD

3. Project Goal

Deliver meaningful, sustainable and accessible education, learning and development to all staff and UHD learners – one that facilitates workforce growth, staff retention and measurably improves quality, safety and experience within a culture of education and knowledge mobilisation by 2029.

4. Exit Criteria

Self-sustaining, embedded education service that supports the local and national programmes of work with an achievable strategic plan to meet the NHS Long-Term Workforce Plan by 2032, where UHD is viewed as a centre of excellence.

5. Sponsor and Project Team

Executive Sponsor:

Project Team:

A) **Reduction of Apprenticeship Levy attrition**
B) **Ready to Start Academy**
C) **Learning Needs Analysis Reform**
D) **Deliver outcomes from the Essential Core Skills Training Framework reform**

6.Governance Structure

Responsible: *Person or Role to directly manage and deliver the project*	LMc, AS
Accountable: *Person or Role to oversee the project and ensure delivery of the stated objectives and outcomes*	LMc, AS
Consulted: *Person or Role to be engaged in the development and delivery of the project. To ensure engagement with the wider organisation*	BEAT Senior Leads
Informed: *Person or Role to be assured about progress towards the delivery of the project*	TR, IM

7. High Level Project Milestones – 2024/25

Milestone	Lead	By When	Status
Number of enrolled UHD apprentices increased by 10%	AD, CM, AS	September 2025	In progress
All RNDAs to have guaranteed newly qualified B5 Nurse job offers at the point of registration	LMc, AD	September 2025	In progress
Embed work experience offerings within the Education Service organisational Structure	LMc, AS, AD	January 2025	In progress
Quality assurance process for assigning training requirements based on staff role	LMc, EG, TJ	April 2025	In progress
Establish quarterly education services quality and data review	AS	December 2024	In progress

8. Critical Success Factors and Key Risks

1. **Workforce templates** recognise and incorporate the clinical apprentice as a sustainable, core supply stream
2. **National Core Skill Training Framework** reform outcomes agreed across Dorset ICS
3. **Education quality standards** agreed and benchmarked against local and national frameworks.

Key risk: Unknown situation beyond April 2025 regarding the **vacancy control mechanisms**. High risk of impact on achieving milestones

9. Project Targets and KPIs

- 30% reduction of expired **Apprenticeship Levy** funds
- 100% **RNDAs have conditional job offer** prior to end point assessment
- **Ready to Start Academy** launched with Widening Participation programme sustainably delivered
- **90% statutory and mandatory training compliance** consistently achieved month on month
- Sustainable and achievable newly qualified NMC and HCPC **workforce supply strategy** in place and agreed across Dorset ICS

10. Impact: planned benefits relating to True North strategic priorities

Population and System: Ensuring the workforce have the right skills at the right time for their role and scope of practice.

Patient Experience: Deliver a culture of education across the organisation that empowers staff to seek and engage with continuing professional development and upskilling.

Quality Outcomes and Safety: Safe and competent staff delivering high-quality, evidence-based care, meeting national frameworks and statutory, Health & Safety legislation.

Sustainable Services: Use of NHSE and Apprenticeship Levy funding efficiently and sustainably to maximise value for money is service provision.

Our People: Improved staff experience and retention through visible, accessible and meaningful training opportunities.

10. Staff Welfare (Improving rest areas)

Date Agreed: xx/xx/2024
Programme lead:

1. Problem Statement

Background:

The hospital building infrastructure continues to change at pace and staff require access to adequate rest areas so that they can take breaks away from the immediate workplace. Problem). Staff find themselves taking breaks in the workplace where interruptions are common, many staff cannot use the rest areas close to them. Impact). Overly tired staff can affect the quality of patient care and staff can feel devalued potentially affecting their attendance and increasing sickness and turnover. For UHD to flourish, staff need to be engaged in their work and environment, and they need to have access to easily identifiable rest areas.

2. Scope

In Scope:
The welfare needs of our staff are met relating to rest areas.

Out of Scope:
Transport/Parking catering facilities/ food outlets and changing areas.

3. Programme Goal(s)

- The welfare needs of our staff are met (rest areas, changing facilities, catering facilities/ food outlets)
- Map staff rest and welfare areas and develop communication approaches to support staff navigation

4. Key Exit Criteria (what will success look like)

- Staff welfare is a seen as a top priority for the trust 31st March 2025
- Improved staff metrics in the Staff Survey and People Pulse connected to wellbeing
- The short and medium metrics have been reached

5. Short term objectives 2024/25

[WATCH METRIC)

The location and function of all our staff welfare facilities are mapped and known by staff. 31st March 2025.

6. Medium term objectives 2026/7

Staff welfare is a seen as a top priority for the trust 31st March 2025

[WATCH METRIC)

Fewer staff will feel worn out at the end of the working day. NSS Q12e will be monitored over 3 years reducing response rate annually to ≤30%

7. Key Programme Milestones

Milestones	Lead	By When	Status
***Phase 1: Scoping**: Identifying available workforce data and key stakeholders*	BN	Dec 25	In Progress
***Phase 2 : Design & Develop** Mapping approaches and methods aligning to connected Trust Programmes*	BN SAG	Jan 25	In Progress
***Phase 3: Implement** mapping process with relevant stakeholders*	BN SAG	Feb – Mar 2	In progress
*Phase 4: **Review and Evaluation** of progress and agree future ownership*	BN	Throughout programme, Q2, Q3 & 4	In progress

8. Key Risks

Risks

- Leadership Engagement: progress Impacted by departments not sharing their staff rest area locations
- Resource Constraints releasing staff to support this workstream caused by competing demands
- Lack of available space

9. Driver metrics

- The location and function of all our staff welfare facilities are mapped and known by staff.

10. Impact: planned benefits relating to True North strategic priorities

Population and System:

Patient Experience: Organisations with high levels of staff engagement tend to have lower levels of patient mortality and provide higher quality patient care.

Quality Outcomes and Safety:

Sustainable Services:

Our People: A great place to work

Staff Offer: Staff Welfare Plan (Improving Rest Areas)

Our work so far ….

NHSCT COVID money and local donations were used to improve staff areas, courtyards and gardens

Outdoor furniture for Bournemouth, Poole, Christchurch and Yeomans

Teams bidding for rest and staff areas improvements, 'bids phase 1 and 2'

Bids phase 3 to be considered with additional. funding applications

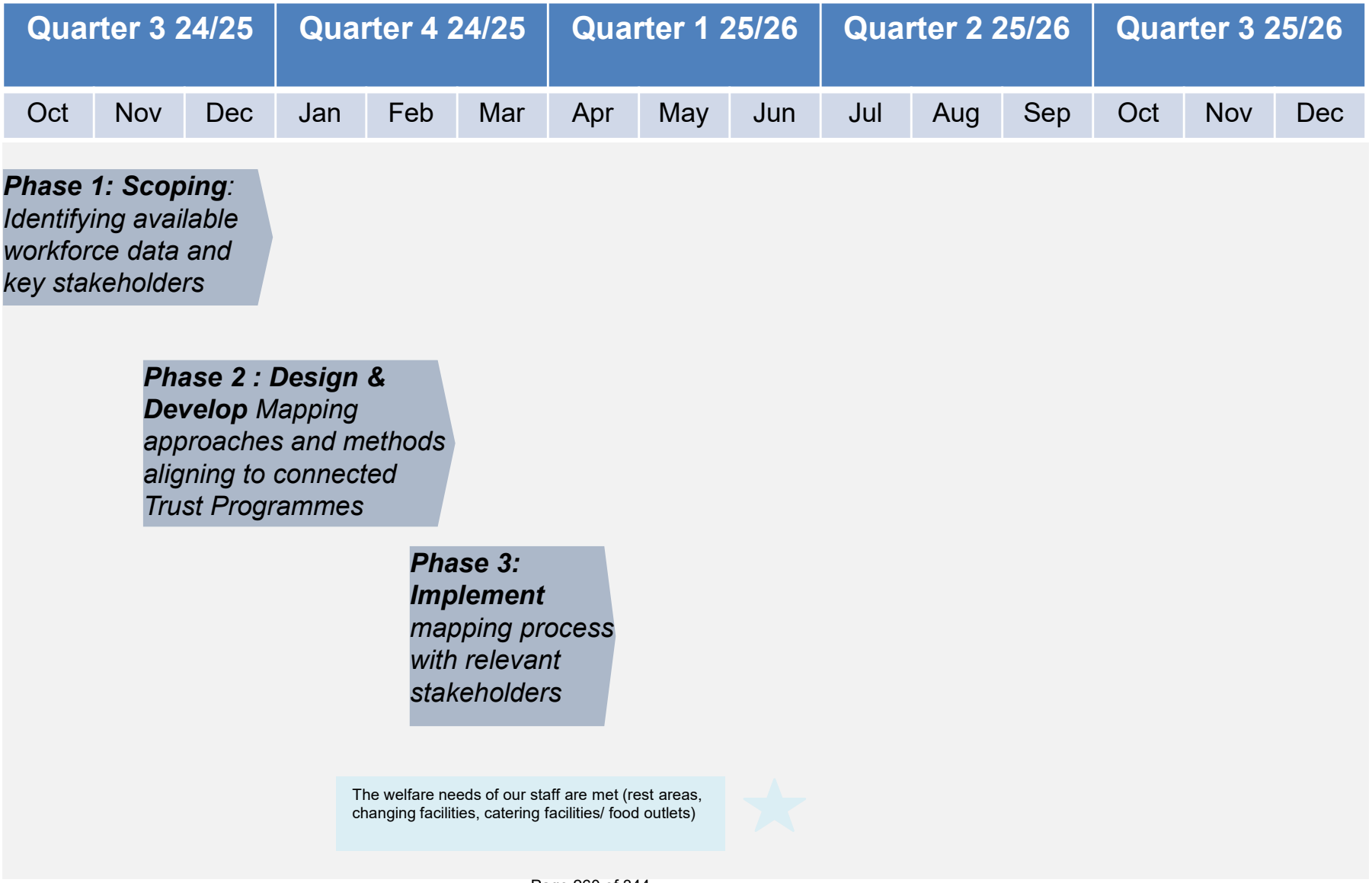
Thrive live week.

Reverse mentoring

PSC posts

Long covid rehab

Team vouchers



11. Staff Health and Wellbeing Plan

Date Agreed: xx/xx/2024
Programme leads: Gemma Lynn & Lorin Taranis

1. Problem Statement

Background:
As a healthcare provider we want our staff to be physically and mentally healthy, so we have been developing a range of supportive provision for staff. However, staff are generally not aware of what is available at UHD to help their physical and mental health (or what they are entitled to access independently of their manager). Our provision is poorly co-ordinated, reactive, and many of the interventions need further refinement.

Problem:
Because our provision is poorly defined and not yet fully integrated, this means that when people do attempt to access it they often find it impossible to find the right thing, or they attempt to access the "wrong" provision, for example managers refer to OH with the aim of accessing either Musculoskeletal (MSK) or Psychological (PSC) support, when these are in fact both self-referral services.

Impact:
The main issues for our staff are stress/MH and MSK, which together contribute to around 40% of all sickness absence, which affects staffing levels and has self-evident but largely unmeasurable effects on morale. Our current provision is not supporting staff with these issues as much as we need to.

2. Scope

In Scope:	Out of Scope
All H&W provisions, services and pathways already in place/development within UHD	Provisions not supported by existing services such as: urgent or emergency support for Mental Health crises and MSK injuries; listening services available elsewhere; and new provisions

3. Programme Goal(s)

12-18 Months: To significantly increase staff awareness of H&W provisions/services available to them within UHD and improve staff access to all provisions through a single point of access.

18-38 Months: To further develop our offer to improve scope and efficacy of support available, and improve coordination across all provisions ensuring staff feel support is 'joined-up'

4. Key Exit Criteria (what will success look like)

Success is defined as increased awareness and uptake of H&W offers, as well as a reduction in sickness absence due to stress/mental health and MSK. However, it is important to note sickness absence must be considered against a landscape of ever evolving, developing and ongoing factors that impact staff health and wellbeing.

5. Short term objectives 2024/25

1. Develop brand
2. Develop Single Point of Access (SPA) for all H&W provisions in UHD
3. Comms strategy to include: inclusion in induction for all new starters; manager training module; non-IT visual promotion (i.e. posters); presentations to teams; promotion via H&W Champions; Thrive Live H&W Conference
4. Survey subset of recent SA due S10 and MSK to find out knowledge of available support and blocks on accessing
5. More in depth information on pattern and periods of SA for MSK and S10

6. Medium term objectives 2026/7

1. Support to Managers and Teams in distress
2. Trust-wide approach to supporting staff following distressing incidents
3. Improved workplace support for staff with Mental Health and MSK
4. Link with Manager support pathways in relation to S10 and MSK
5. Closer working with other services within Directorate
6. Increased provision - H&W Champions and TRiM
7. Proactive sickness-absence outreach support and supported return-to-work programme for both S10 and MSK
8. Improve communication and integration across all wellbeing provisions

7. Key Programme Milestones

Milestones	Lead	By When	Status
Branding	Lorin Gemma	February 2025	
SPA	Lorin Gemma	April 2025	
Build one overall service	Lorin Gemma	April 2027	
Build proactivity into the service	Lorin Gemma	Aril 2027	
Expand provision	Lorin Gemma	April 2027	
Standard response to incidents	Lorin Gemma	April 2027	

8. Key Risks

Risks
1. External (i.e. non-work related) factors impacting sickness absence due to stress/mental health and MSK that are outside of the scope or control of this plan and the provision it covers.
2. An inability to identify and access the required space (i.e. rooms) required to develop/increase H&W provisions will significantly undermine the potential for success
3. X

Driver Metrics (max of 3)	Target
12-18 Months: NHS Staff survey question "My organisation takes positive action on health and well-being"	>=65%
18-36 Months: Sickness absence due to stress/mental health (S10)	<=0.9%
18-36 Months: Sickness absence due to MSK (S11/S12/S28)	<=0.6%

10. Impact: planned benefits relating to True North strategic priorities

Population and System: A physically and mentally healthier workforce will result in less sickness absence and less disruption to productivity

Patient Experience: A physically and mentally healthier workforce will significantly impact patient experience through multiple factors such as improved staff morale and reduced staffing pressures due to sickness absence

Quality Outcomes and Safety: A physically and mentally healthier workforce will result in less errors and contribute to a culture of improved welfare and wellbeing for staff and pateints

Sustainable Services: A physically and mentally healthier workforce will contribute to significant cost savings through a reduction in days lost to sickness absence and associated costs (e.g. agency cover)

Our People: An effective and accessible staff health and wellbeing offer will contribute to attracting new staff as well as retaining the staff we already have

12. Transforming Care Together (TCT) – People Ready Plan

Date Agreed: October 2024
Programme lead: Irene Mardon Deputy Chief People Officer

1. Problem Statement

Background: The Transforming Care Together plan requires a People Ready Plan to provide oversight & monitoring to ensure staff feel supported through the transfer of the services to new operating model ensuring staff turnover remains stable

Problem:

Workforce planning has not existed previously in a mature setting to support change programmes, deployment of staff and provide current and future requirement and needs for staffing. Support aligned to triangulation of Activity, Finance and Workforce requirements have not previously taken place in a full collaborative style. Consequently, the ability to map workforce systems and recruitment requirements along with ensuring all organisational change staff consultations have not been completed to agreed timelines, adhering to policies and best practice have been highlighted as trust risks. Capturing attrition rates aligned to organisational changes have not existed outside of the designated ESR reasons

Impact:

Limited support, knowledge, data and achievements of plans will deter transformation activities which may block and impede activities aligned to moving the Royal Bournemouth Hospital into being the Urgent Care Centre and Poole the Planned Care Centre

2. Scope

In Scope:.	Out of Scope:
All teams aligned with Phase 2 and Phase 3 moves. Attrition aligned to organisational moves	All teams not aligned to Phase 2 or Phase 3 moves. Attritions to all other reasons

3. Programme Goal(s)

1. To secure data that can measure attrition due to organisational change to inform future changes or to maintain stability of staff within the organisation
2. To set up systems, training, and tools enabling managers to have the knowledge, confidence and skills to support staff through change
3. People Ready activities enables flow and transition into Move Ready ahead of all Phase 2 and Phase 3 moves

4. Key Exit Criteria (what will success look like)

Attrition is stabilised aligned to organisational moves
People Ready activities enables flow and transition into Move Ready ahead of all Phase 2 and Phase 3 moves

5. Short term objectives 2024/25

Staff turnover rate remains stable throughout the Transforming Care Together programme
Baseline: 10.6%
Target: 10.6% (31st December 2025)

6. Medium term objectives 2026/7

Staff turnover rate remains stable throughout the Transforming Care Together programme
Baseline: 10.6%
Target: 10.6% (31st December 2027)

7. Key Programme Milestones

Milestones	Lead	By When	Status
Phase 1: Scoping: Benchmark with other trusts Capture reason for leaving on internal termination forms	LC and IT	December 2024	
Phase 2 : Design & Develop Develop reporting tools	LC, IT and BI	January 2024	
Phase 3: Implement Implement Workforce transformation, recruitment and Temporary staffing plan	JMR & LW TGP, ZM&MD	Dates as per strategy document	
Phase 4: Review and Evaluation Regular reviews of Care Group watch metrics at SDR's. Deep Dives to be completed as approp.	Care Group and senior Corporate Leads	Monthly	

8. Key Risks

1. Workforce transformation, Recruitment and Temporary Staffing Plans do not achieve objectives
2. Limited engagement and commitment from Care Group leads and teams which impact activity plans and move timescales
3. Financial – additional costs may deter progress

9. Driver metrics

Driver Metrics (max of 3)	Target
Achieve Driver metrics aligned to Workforce transformation, Recruitment and Temporary Staffing Plans	
Turnover remains stable at or under 10.6% during transformation programmes	

10. Impact: planned benefits relating to True North strategic priorities

Population and System: Transforming Care Together impacts the wider care provisions across Dorset and localised services to our patients

Patient Experience: A good flow of services into moving the Royal Bournemouth Hospital into being the Urgent Care Centre and Poole the Planned Care Centre will continue to provide enhanced care and good patient engagement

Quality Outcomes and Safety:

Sustainable Services: Triangulated plans aligned to the TCT programme will balance workforce with activity with finance

Our People: The People Ready plan will promote our staffs offer that attracts and retains the best people

13. Workforce Transformation Plan

Date Agreed: xx/xx/2024
Programme lead:

1. Problem Statement

Problem: Background: Workforce planning has historically, not been embedded as a core business process at UHD.

Problem: The skills, knowledge and understanding of the value to develop high quality, robust workforce plans that inform the staffing models to transform care together are not sufficiently mature across all services.

Impact: If we do not have robust workforce plans that are agreed by the organisation, we will not be able to progress to a people ready position and deliver a right sized, sustainable workforce with the skills and right support to provide care to meet the needs of the local population.

2. Scope

In Scope:	Out of Scope
Workforce plans impacted by transforming care together in the short term (12-18 months).	Workforce plans for services who are not impacted by transforming Care Together. Workforce plans in the medium-term (18-36 months).

3. Programme Goal(s)

To standardise the UHD approach to a defined workforce planning process and delivery of a training programme which will lead to high quality, robust workforce plans that will inform the right sized, sustainable workforce with the skills and support to provide care to meet the needs of the population.

4. Key Exit Criteria (what will success look like)

All required workforce plans will have been completed and agreed by the organisation for the short term and handed onto the HR business partners to develop the medium-term workforce plans.
A workforce planning training programme will have been developed and delivered to UHD senior leaders to support development of medium-term workforce plans.

5. Short term objectives 2024/25

WATCH METRIC
For workforce plans to be triangulated to meet gateway deadline.
And to
Inform the Trusts 2025/26, Efficiency and Improvement plan by 31st March 2025

6. Medium term objectives 2026/7

WATCH METRIC
3-year workforce plans in place for all service and corporate areas by 31st March 2026.

Driver metrics	Target
100% of service and corporate workforce plans impacted by transforming care together (phase 2 and 3) have been completed and have organisational sign off.	31st March 2025
75% of UHD middle managers/leads have attended workforce planning training.	30th June 2025

7. Key Programme Milestones

Milestones	Lead	By When	Status
All workforce service and corporate plans impacted by phase 2 BEACH moves have been completed and have organisational sign off.	IM/JMR	31st October 2024	In progress
All workforce service and corporate plans impacted by transforming care together phase 3 have been completed and have organisational sign off.	IM/JMR	31st March 2025	In progress
Workforce planning training programme has been designed.	JMR/HRBP's	30th April 2025	Not yet started
Workforce planning training programme has been delivered to 75% of UHD middle managers/leads.	JMR/HRBP's	31st July 2025	Not yet started
Handover of medium-term workforce plans to HRBP's	JMR/LW	1st September 2025	Not yet started

8. Key Risks

Risks
1. Workforce plans are not completed in a timely manner to be able to progress to a people ready position.
2. Future service models have not been agreed (includes space allocation).

10. Impact: planned benefits relating to True North strategic priorities

Population and System:
Patient Experience:
Quality Outcomes and Safety:
Sustainable Services:
Our People:

14. Recruitment Plan

Date Agreed: xx/xx/2024
Programme lead:

1. Problem Statement

Background:
This document supports the Recruitment Plan A3 – the Plan is devised to better support services within the trust with meeting the resource requirements of transformation and annual workforce plans.

Problem:
the Recruitment Team is currently divided into 3 small teams, one manages Surgery and Medical Care Group, another Specialties, and the other Corporates and Project Recruitment- NQN's, International, Trust wide HCSW, RNDA's. There is a lack of continuity and knowledge within those teams during annual leave or sickness absence, which affects Time to Hire and Vacancy rates. There is also a lack of expert knowledge of TRAC across the team, which is needed to identify areas for process improvement s that increase candidate and recruiting manager satisfaction with the service provided. Changes are required to create capacity of the Recruiting Manager and Head of Workforce Resourcing for Corporate Projects and Strategic Transformation activity. Without changes to roles and responsibilities we are unlikely to achieve the Trust Corporate target of Time to Hire by 31st Dec 2025 - 62 Days and a Trust wide Vacancy rate target by 31st Dec 2025, of 6.5%

Impact:
The plan offers a change to the Recruitment structure, and the roles and responsibilities, which will support services in filling current vacances and future recruitment needs with gaps managed by more efficient time to hire.

2. Scope

In Scope: General Recruitment	Out of Scope: Medical /Temporary Staffing Recruitment

3. Programme Goal(s)

Time to Hire
Trust Vacancy Rate
Positive feedback from Recruiting Managers and Applicants regarding the service received

4. Key Exit Criteria (what will success look like)

Time to Hire – 62 days by Dec 2025 – review of future target
Trust Vacancy Rate – 6.5% as at 31 Dec 2025 – review of future target
Positive feedback from Recruiting Managers and Applicants regarding the service received recognising improvements to service

5. Short term objectives 2024/25

Time to Hire 68 days – as at 31 Dec 2025

Trust Vacancy Rate 6.5% - as at 31 Dec 2025

6. Medium term objectives 2026/7

Time to Hire 60 Days – as at 31st Dec 2027

Vacancy Rates 5% - as at 31 Dec 2027

7. Key Programme Milestones

Milestones	Lead	By When	Status
Time to Hire 68 Days	TGP	Dec 2025	In progress
Trust Vacancy rate 6.5%	TGP	Dec 2025	In progress
Time to Hire 60 Days	TGP	Dec 2027	
Trust Vacancy rate 5%	TGP	Dec 2027	

8. Key Risks

Risks
1. Providing continuity of service through change process
2. Delays in the Workforce Planning process means information on recruitment needs is delayed or unconfirmed
3. Lack of skills and experience within the team to establish and maintain relationships with key stakeholders that lead to shared knowledge and ownership of gaps in establishment and time to hire
4. There is currently no resource to manage Social Media and Marketing activity which is key to attraction for hard to fill posts, and recruitment events

9. Driver metrics

Driver Metrics (max of 3)	Target
Time to Hire	68 Days
Trust Vacancy rate	6.5%

10. Impact: planned benefits relating to True North strategic priorities

Population and System: Lower vacancy levels and speedier time to hire ensure that services have staffing to meet their Workforce plans which are aligned to the needs of the population

Patient Experience: better staffing levels – better patient outcomes

Quality Outcomes and Safety: resources at a level to provide safe Care

Sustainable Services: reduction in Bank and Agency used to cover vacancies

Our People: Timely filling of vacancies lead to greater staff satisfaction retention and engagement rates

15. Temporary Workforce Plan

Date Agreed: xx/xx/2024
Programme lead: Melissa Duncan

1. Problem Statement

Background:
A temporary workforce is an essential component for any organisation that requires agility to flex it's staffing in line with service demand.

Problem:
There is an overreliance on mobilising Temporary Staffing as BAU within the Trust.

Impact:
A high level of temporary staffing negatively impacts an organisation's ability to deliver against set targets where results rely on consistent, stable, well formed, and managed teams.

2. Scope

In Scope:
All back and agency (Temporary Staffing) usage at UHD

Out of Scope:
Insourcing arrangements, independent contracts, project outsourcing ie G-Cloud, fixed term contacts

3. Programme Goal(s)

To reduce our reliance on the temporary workforce

4. Key Exit Criteria (what will success look like)

Overall reduction in temporary workforce utilisation in line with targets, with less than 15% of temporary hours filled by agency. Agency rates within NHS Cap Compliance or SW region rate card (Medical) and a continued forecast to achieve % agency of total pay target.

5. Short term objectives 2024/25

Average agency costs as a percentage of total pay costs remain below the national target
Baseline: 3.4%
Target: 3.2% (31st March 2025)
[WATCH METRIC]

Our reliance on the temporary workforce has reduced Baseline: 11.5% (of current workforce)
Target: 8.5% (31st December 2025)
[WATCH METRIC]

6. Medium term objectives 2026/7

Average agency costs as a percentage of total pay costs meet the local target
Baseline: 3.2% (31st March 2025)
Target: <3% (31st March 2027)
[WATCH METRIC]

Our reliance on the temporary workforce has reduced
Baseline: 8.5% (31st December 2025)
Target: 5.5% (31st December 2027)
[DRIVER METRIC]

7. Key Programme Milestones

Milestones	Lead	By When	Status
'Breakglass' SOP and associated eform launched	MD/MH	December 2024	In progress
Check and Challenge meetings (as part of Safer Staffing Transformation Enabling Group)	MD/MH/TM	November 2024	In progress
Medical Locums Additional Duties and Escalated rates Standard Operating Procedure	MD/BJ	December 2024	In progress
Bank to substantive fast track recruitment process	MD/LPC	December 2024	In progress
Temporary Staffing Manager Tool kits	MD	January 2025	In progress
Bank to Substantive recruitment campaign	MD/TGP	January 2025	In progress

8. Key Risks

- Stakeholder engagement and capacity to support improvements
- Lack of availability of in demand skill sets driving agency engagement
- Winter pressures leading to opening of unfunded / escalation beds
- Increase in 'bed-blockers'
- Increased turnover and long-term sickness
- Increased demand in patients with enhanced care needs
- Reduced order fill due to agency cap compliance

9. Driver metrics

Driver Metrics (max of 3)	Target
Agency % of Total Pay	<3%
Temporary WTE as % of Workforce	5.5%
Bank to Substantive joining rate	5%

10. Impact: planned benefits relating to True North strategic priorities

Population and System: Support predictability of rostering, upskilling the workforce and developing high performing teams

Patient Experience: Proactive rostering, consistency of care, high performing teams enhancing patient experience

Quality Outcomes and Safety: A consistent workforce supports increased patient safety

Sustainable Services: Reducing high-cost agency supply ensures every pound is used wisely

Our People: Driving stable teams and predictable staffing

16. Corporate Project – Safest Staffing

Date Agreed: xx/xx/2024
Programme lead: Lisa Cain

1. Problem Statement

Background:

If we do not have a healthy, sustainable workforce that is organized for success, we will not be able to provide high quality, safe and effective services resulting in poor patient and staff experience and increased premium staffing costs.

Problem:

Our workforce systems are still showing the impact of merger and huge amounts of workforce movements across the Trust. This has resulted in large volumes of data cleanse and alignment across all systems. All systems continue to be improved ensuring the best data quality possible.

Impact: A people function that is organised around the optimum employee journey supporting Care Groups and Corporate Directorates to deliver their priorities.

2. Scope

In Scope:

- ESR/Stamp Report Project
- Health Roster
- Healthrota (Medical Rostering/Job Planning)
- BEAT
- TRAC
- Compliance

Out of Scope:

- Suite of analytical reports

3. Programme Goal(s)

Workforce IT systems that support the effective deployment of human resources.

4. Key Exit Criteria (what will success look like)

- Time to hire – 60 days by 31/12/2025
- Consistent annual leave management at 14%
- All medics on Healthrota by 31/3/2026
- A controlled and embedded Fixed Term contract process

5. Short term objectives 2024/25

Improvement in the management of annual leave
Baseline: Up to 18% of staff off on annual leave
Target: <16% of staff on annual leave during July & August and <14% of staff on annual leave the rest of the year (31st March 2025)
[WATCH METRIC]

Improvement in the management of fixed term contracts
Review of all fixed term contracts by 31st December 2024
[WATCH METRIC]

6. Medium term objectives 2026/7

All medical staff on e-rostering system to support demand/ capacity modelling
Baseline: tbc
Target: 100% (31st March 2026)
[WATCH METRIC]

Improvement in our time to hire
Baseline: Average 60 days (31st December 2025)
Target: Average <50 days (31st December 2027)
[WATCH METRIC]

7. Key Programme Milestones

Milestones	Lead	By When	Status
Improvement in management of fixed term contracts	Lisa Cain	31/12/2024	On track
Improvement in the management of annual leave	Lisa Cain	31/3/2025	On track
All medical staff on rostering systems to support capacity and demand	Lisa Cain	31/3/2026	On track
Improvement in our time to hire to 60 days	Tracy Gill-Parker	31/12/2025	On track
Improvement in our time to hire to 50 days	Tracy Gill-Parker	31/12/2027	On track

8. Key Risks

Risks

1. Poor fixed term contract management resulting in increased WTE
2. Poor roster management increasing annual leave percentages across the Trust
3. Lack of required information from Care Groups to enable Medical roster implementation

9. Driver metrics

Driver Metrics (max of 3)	Target
Improvement in our time to hire **Baseline: Average 68 days** **Target: Average <60 days (31st December 2025)**	60 days

10. Impact: planned benefits relating to True North strategic priorities

Population and System:

Patient Experience:

Quality Outcomes and Safety:

Sustainable Services:

Our People:

17. Temporary Staffing Model

Date Agreed: October 2024
Programme lead: Irene Mardon Deputy Chief People Officer

1. Problem Statement

Background:
Temporary staffing solutions are integral to patient safety. Across Dorset t the three healthcare providers Trusts: Dorset Healthcare (DHC), Dorset County Hospital (DCH) and University Hospitals Dorset (UHD) have formed the Our Dorset Provider Collaborative (ODPC). There is a need to reduce dependence on temporary workforce while ensuring safe staffing levels. The NHS Long Term Workforce Plan 2023 (england.nhs.uk) proposed the establishment and expansion of collaborative banks, which allow for greater flexibility and mobility of staff across different healthcare settings.

Problem:
The provider collaborative met on the 11th of September and reached the decision for UHD to progress to an outsourced model and DCH and DHC would continue with the joint working arrangements and review in six months' time. This would allow DCH and DHC to learn from UHD's experiences.

Impact:
The Temporary Staffing Team at UHD have been without continued and visible senior leadership within their team for the last year to safely support and manage proactively, demand and capacity and changing needs in the trust. Over time risks and costs have risen along with the over reliance of use within our temporary workforce .

2. Scope

In Scope:. All substantive staff working as a multi post holder (Substantive member of staff who also is employed as a bank worker) or Bank only workers working as a medical locum or covering roles that require clinical or corporate / admin and clerical cover

Out of Scope:

3. Programme Goal(s)

1. To set up and support a people function that is organised around the optimum employee journey supporting the Care Groups and Corporate Directorates to deliver their priorities
2. To deliver a cost-effective temporary staffing model that meets the needs of the Trust

4. Key Exit Criteria (what will success look like)

Temporary staffing use is reduced and stabilised aligned to organisational needs
Agency costs are reduced
Data and reports provide guidance to use, activity and spend

5. Short term objectives 2024/25

New Bank and Agency model in place and operational by 30th June 2025

6. Medium term objectives 2026/7

Bank and Agency model fully integrated into the Trust's operating model by 31st March 2026

7. Key Programme Milestones

Milestones	Lead	By When	Status
Phase 1: Scoping: Scope and decide on ODPC option as a collaborative or as separate trusts	IM	September 2024	completed
Phase 2 : Design & Develop Develop service specification for the future temporary staffing service in collaboration with NHS.SCW.	IM and MD	March 2025	
Phase 3: Engage & Implement: Engage proposals with all relevant stakeholders with view to implement	TR and IM	June 2025	
Phase 4: Review and Evaluation Quarterly reviews post implementation	TR and IM	Q2 onwards 2025	

8. Key Risks

1. Financial –Costs around set up may deter progress
2. Cost efficiencies not realised in drafting of proposal

9. Driver metrics

Driver Metrics (max of 3)	Target
New Bank and Agency model in place and operational by 30th June 2025	30.6.25
Data and reports provide oversight of use, spend and appropriate cover of roles	30.6.25

10. Impact: planned benefits relating to True North strategic priorities

Population and System:

Patient Experience: A good flow of services into moving the Royal Bournemouth Hospital into being the Urgent Care Centre and Poole the Planned Care Centre will continue to provide enhanced safe care and good patient engagement

Quality Outcomes and Safety: Patient care is focussed on quality care and safety by use of skilled staff when cover and need arises

Sustainable Services: Cost efficiencies and spend align with sustainability aims

Our People Cover and resources to maintain care and staffing is in place which in turn may improve staff engagement

18. HRBP Business Partner Model

Date Agreed: xx/xx/2024
Programme lead: Lisa White, Associate Director of HR Operations

1. Problem Statement

Background:
The current HR Operations operating model comprises of one team delivering both Employee Relations (ER) and HR Business Partner (HRBP) services. ER case management and Employment Tribunal cases (which are increasing in number and complexity) take a disproportionate amount of HRBP capacity, therefore the current HR Operations model and workloads are having an adverse effect on the ability to support the Care Groups/Directorates' HR and People Strategic priorities.

Problem:
HRBPs are unable to fulfil the full strategic remit of their roles. There is no / limited capacity to support Care Groups/Directorates with their people priorities, such as; using data and information from the Staff Survey, Workforce Race Equality Standards & Workforce Disability Standards and therefore supporting groups who have a poorer experience in the workplace than others. ER services: are provided by HR Operations in a reactive way that works against prevention and continuous improvement of formal ER case management.

Impact:
The Care Groups and Corporate directorates do not have the required level of HR professional leadership and support to most effectively develop and deliver their people and culture plans and priorities. ER cases are increasing with a lack of capability, confidence and commitment of line managers to carry out their responsibilities for owning and managing employee relations. These negatively impacts staff experience.

2. Scope

In Scope: Re structure of HR Operations team, development of team and new ways of working.

Out of Scope: Care Groups/Directorates application of processes and policies.

3. Programme Goal(s)

- Have in place capable and confident dedicated teams for HR business partnering and ER for each Care Group and Corporate/Operations function.
- Build the capability, confidence and commitment of line managers to carry out their responsibilities for owning and managing employee relations.
- Build the commitment of ER Managers and Advisors to manage ER cases to achieve agreed metrics on quality, delivery, timeliness and satisfaction levels.

4. Key Exit Criteria (what will success look like)

An HR business partnership model in place, which through a business driven, methodical approach systematically develops people solutions aligned with business objectives, whilst enabling employees to flourish.

5. Short term objectives 2024/25

Implement a strategic HR Business Partner model that pro-actively supports the Care Groups and Corporate directorates to develop and deliver their people and culture plans and priorities.

6. Medium term objectives 2026/7

Deliver the benefits of the new operating model progressively over 2025/26 – and will ensure ***all*** teams in the People function work in a results focused, joined up way to deliver Care Group and HR Strategy aims, goals, targets – with the HRBP at the centre of this.

7. Key Programme Milestones

Milestones	Lead	By When	Status
Engagement with key stakeholders to develop plans; TMG, Care Groups and Staff Side and HR Operational team.	LW	Oct 2024	On going
Staff consultation process around change proposal.	LW	Nov-Dec 2024	Not Started
Appoint to new structures and carry out quick wins and plan further improvements.	LW	Jan – Apr 2025	Not Started
Review and Evaluate benefits of new model	LW	April 2026	Not Started

8. Key Risks

1. If Care Groups/Directorates do not take accountability and support HR professionals working at the top of their licence then the full benefits will not be realised.
2. Recruitment to vacant roles in the ER structure.

9. Driver metrics

Driver Metrics (max of 3)	Target
New HRBP model in place	1.4.25

10. Impact: planned benefits relating to True North strategic priorities

Population and System:

Patient Experience:

Quality Outcomes and Safety:

Sustainable Services:

Our People: A strategic HR partnership that supports delivery of the Trust's people and culture priorities.

19. On-Call

Date Agreed: xx/xx/2024
Programme lead: Lisa White, Associate Director of HR Operations

1. Problem Statement

Background:
The current Agenda for Change (AFC) on-call provision does not conform to the principles equal pay for work of equal value consistently across the Trust. AFC terms and conditions confirm that payments for on-call need to be agreed locally and consistent with the principles set out in Annex 29.

Problem:
Bournemouth and Christchurch Hospitals (RBH/CC) previously (pre-merger) underwent an on-call review and staff consultation to move to a single on-call availability rate and align to AFC Annex 29. Poole Hospital (PH) did not undertake such a review and there are now 31 areas (228 staff) within Poole Hospital with varying availability rates.

Impact:
This is having an adverse impact on fairness, equity and staff morale. This also creates a risk to delivery of our transformational change plans and good employee relations.

2. Scope

In Scope: Single UHD On-Call Policy with harmonised availability rates across the Trust. A pay protection agreement to support this agreement. Potential R&R payments.

Out of Scope: Change to Compensatory Rest Guidelines.

3. Programme Goal(s)

- Implement an agreed on-call provision with associated Policy, aligning all staff to a consistent availability rate that is financially viable and uses the NHS pound wisely. By April 2025.
- Agree a fair staff pay protection arrangement for staff that are entitled to use the legacy pay protection policy.

4. Key Exit Criteria (what will success look like)

A consistent approach to on-call across UHD, in line with AFC and with staff being rewarded fairly and consistently.

5. Short term objectives 2024/25

Aim:
A Trust wide On-Call provision that is equitable, affordable and meets the needs of the Trust.

6. Medium term objectives 2026/7

Review of pay protection arrangements and other payments (such as Recruitment and Retention (R&R) /additional payments) in place – April 2026.

7. Key Programme Milestones

Milestones	Leads	By When	Status
Phase 1: Initial Scoping: *Current on-call arrangements / practices.*	LW/LC	Sept 24	Completed
Phase 2 : Staff Side and Stakeholder Engagement: *Staff Side group in place to negotiate and agree local policy . TMG and SPF for ratification.*	LW	Oct-Dec 2024	In progress
Phase 3: Prepare for Implementation: *Staff consultations.*	Transformational Change HR Managers	Jan – Apr 2025	Not Started
Phase 4: Implement: *new policy and on-call payments, with pay protection/other agreed pay arrangements.*	LW/LC/ Transformational Change HR Managers	April 2025	Not Started

8. Key Risks

1. Non-agreement of Trust on-call policy maintains the status quo of inequity and staff grievances/disputes.
2. Financial – an increase in on-call / other payments.

9. Driver metrics

Driver Metrics (max of 3)	Target
UHD on call policy and harmonised availability rates in place	1.4.25

10. Impact: planned benefits relating to True North strategic priorities

Population and System:

Patient Experience:

Quality Outcomes and Safety:

Sustainable Services:

Our People: An on-call system that is consistent, compliant with AFC, supports service delivery and uses the NHS pound wisely.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 08 January 2025

Agenda item: 8.2

Subject:	Equality, Diversity and Inclusion Annual Report (2023/4)
Prepared by:	Jonathan Harding, Head of Organisational Development
Presented by:	Tina Ricketts, Chief People 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)	BAF 3 and BAF 8	
Purpose of paper:	Review and Discussion	
Executive Summary:	This report provides an overview of our Equality, Diversity and Inclusion (EDI) activity in 2023-2024 including published data reports and our aspirations for 2024-2025 as part of our new People and Culture Strategy. The following are some of the key highlights involving our work and progress in 2023/24: • In our 2023 UHD NHS staff survey results "We are compassionate and inclusive" we maintained a score of 7.38 (compared to the national average of 7.24) • Our Workforce Race Equality Standard 2024 shows positive movement across most of our metrics with our Global Majority representation now at 23.87% • Our Workforce Disability Equality Standard 2024 shows positive movement across some of our metrics and Disability disclosure is now at 6.3% • Our Gender Pay Gap decreased to 3.53% • The Equality Delivery System (EDS) assessment increased to 18 in 2024 from 17 in 2023 • We held a number of engagement events including Cultural Celebration, UHD Pride, Purple Light Up and Menopause Awareness • A recent audit was undertaken with the Staff Networks providing the opportunity to seek greater alignment with our UHD objectives while strengthening their roles and purpose Our key Equality, Diversity and Inclusion objective for 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 Equality, Diversity and Inclusion Plan priorities: • strengthen our staff networks to better align to UHD strategic priorities and provide project support for engagement activity • with our Dorset Partners and our Recruitment Team we will introduce clear guidance and requirements to support 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% within the next 3 years. This ambitious target requires significant cultural improvement and sufficient vacancies. As of 23rd August 2024, Global Majority representation is 18% at Band 6, 5% at Band 8a, and 7% at Band 8c.
Background:	Throughout this report we have indicated the disparity in experience for Global Majority Staff and this disparity does extend to staff with other protected characteristics understanding this intersectionality will be key to our future progress.
Key Recommendations:	The Board is asked to • Approve the content of the Annual Equality, Diversity and Inclusion report for publication • Note that an accessible and plain English version of this report is being developed to comply with our public sector duty • Support the implementation of the 4 key actions outlined in this report to deliver our UHD One Team Equality, Diversity and Inclusion Plan
Implications associated with this item:	Council of Governors ☒ Equality, Equity, Diversity & Inclusion ☒ Financial ☐ Health Inequalities ☒ Operational Performance ☐ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☐ Regulatory ☐ Strategy/Transformation ☐ System ☐
CQC Reference:	Safe ☐ Effective ☐ Caring ☐ Responsive ☐ Well Led ☒ Use of Resources ☐

Report History: Committees/Meetings at which the item has been considered:	Date	Outcome
Trust Management Group	19/11/2024	For information.
People & Culture Committee	11/12/2024	Endorsed with a recommendation to the Board to approve.

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

University Hospitals Dorset
NHS Foundation Trust

Equality, Diversity and Inclusion

Annual Report 2023 - 2024

Contents

Foreword

We are proud to publish our 2023 / 24 EDI report, highlighting our key successes over the past year and our priorities for 2024 / 25. A lot has been achieved in the reporting period since the last report was published in October 2023, however we are not complacent in our aspiration to be an inclusive organisation.

At UHD we strive to ensure each individual patient and member of staff, regardless of their protected characteristics, has a positive experience of our services and we are a great place to work. We know that many of our people are also our patients and within the wider context of population health and reducing health inequalities, it is ever more important to achieve a strong link between equitable and inclusive services and the experience of our staff.

We also know that being truly inclusive involves commitment from all individuals across the Trust. By doing so, we enhance the compassionate and inclusive culture we need to recruit and retain a workforce that represents our patients, reflects our Trust's values and in turn, continually improves patient outcomes and experience.

Although we can now see Global Majority Staff represented at all levels of the organisation, we must continue to question ourselves as an aspiring Inclusive Employer. Our key EDI objective for 2024 and the next 3 years will be '**To have a representative workforce at all levels of the Trust.'**

This is supported by our UHD Anti-Racism Statement endorsed by the Board of Directors.

Our UHD Communications team continue to be instrumental in supporting our campaigns in collaboration with our Staff Networks and colleagues. This report only highlights a small fraction of the activity both Communications and the Staff Networks support.

Most importantly, as UK experienced a period of social unrest this year, Team UHD was galvanised in its condemnation against racism to support our staff and we will continue listening events and take actions in the pursuit of being a truly inclusive organisation.

Introduction

University Hospitals NHS Foundation Trust (UHD) was founded on 1 Oct 2020 under the Health and Social Care (Community Health and Standards) Act 2003 and is a statutory body.

We have over 10,000 staff serving a predominantly White British population, our Global Majority staff numbers have increased to 23.87% in 2024. As well as delivering excellent general hospital services, our Trust is home to a range of specialist services and facilities including:

- our flagship Dorset Cancer Centre, offering medical and clinical oncology services for the whole of Dorset, serving a total population of over 750,000
- a major trauma unit for east Dorset, serving a population of more than 500,000 people
- a state-of-the-art Cardiology Unit (the Dorset Heart Centre), and
- our award-winning orthopaedic service providing hip and knee replacements (the Derwent Unit)

Within UHD we pride ourselves on the delivery of safe and high-quality care. Every single person working within this organisation makes a difference to the quality of care provided.

We are active partners in the Dorset integrated care system (ICS), bringing together all parts of the NHS and local authorities to focus on improving the health of the local population. Within the ICS, we are part of the Dorset Provider Collaborative which is focused on reducing health inequalities in acute care across the local health and social care system through joint clinical pathways. In partnership with our hospital charity, we build and enhance clinical facilities to create an outstanding care environment for our patients and for our staff. We are growing our existing portfolio of innovation projects and our reputation in this field, to become a national leader for innovation within the NHS.

Patient First and Inclusion

Patient First is our vision to develop a sustainable culture of continuous improvement at UHD. At its heart is an acknowledgement that when staff thrive our patients experience sustained improvements in the quality and experience of their care.
We acknowledge this will require a different way of working to unleash the passion and skills of our staff, create a sense of belonging and promote a more inclusive service and workforce, so that all people will want to stay and positively contribute to the success of our organisation.

Patient First is the UHD Improvement Method to support the delivery of our refreshed strategy and strategic priorities.

Our values have been developed as a result of engaging with and listening to our staff to understand ‘what is important to them’? Our values underpin our vision and mission. They are the standards shared by all UHD staff. They guide our day-to-day decisions and the way we behave. They describe what is important to us and ‘the way we do things around here’. What is striking about the values developed by staff is their duality. Each one consistently and equally speaks to the values for staff **and** for patients. This is a very distinct feature.

What are we trying to accomplish?

Team UHD has five strategic themes support the delivery of our long-term vision:

Our Public Sector Equality Duty

As a public sector acute care service provider, we must comply with the Public Sector Equality Duty (S149) within the Equality Act (2010), which requires public bodies to have due regard to the need to:

- eliminate unlawful discrimination, harassment, victimisation and other conduct prohibited by the Act
- advance equality of opportunity between people who share a protected characteristic and those who do not
- foster good relations between people who share a protected characteristic and those who do not.

We take our duty seriously, but we want to go beyond compliance to truly valuing people and being inclusive. This is the thinking that underpins our agreed Trust's equality objectives, year on year.

Our Equality Objectives 2021 - 2024

In 2021, we published our 3-year Equality, Diversity and Inclusion strategy and embarked on a series of actions throughout 2021 - 2024. Recognising that much of the work needs to be sustained over the long term, our 2023-24 priorities reinforced objectives that were already in train, with renewed energy to ensure we continue achieving tangible outcomes.

We committed to:

- improve employee experience
- develop inclusive leadership capability
- increase equal opportunities for career development
- enhance staff network engagement
- improve collection and use of all EDI data and compliance against national standards
- develop patient co-production and engagement to reduce health inequalities

The following are some of the key highlights involving our work and progress in 2023/24:

- 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
- our Workforce Race Equality Standard 2024 shows positive movement across most of our metrics and the Global Majority Representation is now 23.87%
- our Workforce Disability Equality Standard 2024 shows positive movement across some of our metrics and Disability disclosure is now 6.3%
- Our 2024 Gender Pay Gap decreased to 3.53%
- the Equality Delivery System assessment increased to 18 in 2024 from 17 in 2023
- we held several key engagement events including Cultural Celebration, UHD Pride, Purple Light Up, Menopause Awareness championed inclusion at UHD
- a recent review was undertaken with the Staff Networks providing the opportunity to seek greater alignment with our UHD objectives while strengthening their roles and purpose

Equality Data Monitoring

People who come into contact with our organisation, either for care and treatment or employment are asked questions about protected characteristics such as age, disability, ethnicity and sexual orientation. We collect this data, known as equality monitoring information, for equality monitoring purposes. Analysing and understanding this data helps us formulate our plans and respond to people's individual needs.

The information we receive or write down about people is securely and confidentially stored on our electronic patient record or electronic staff record (ESR). Data extracted for analysis in this report is anonymised and used only to identify and respond to any findings, particularly those affecting minority and disadvantaged groups which share certain protected characteristics.

We must respond to a range of national standards relating to equality, provide data and demonstrate compliance and improvement progress annually. These are currently:

- Equality Delivery System (EDS2022)
- Workforce Race Equality Standard (WRES)
- Gender Pay Gap (GPG)
- Workforce Disability Equality Standard (WDES)
- Accessible Information Standards (AIS)

This section provides a summary of our reporting compliance and key findings.

Equality Delivery System

The Equality Delivery System (EDS) is a mandatory equality framework used by NHS organisations to review their performance against measures to improve access, experience and outcomes for people with protected characteristics as defined in the Equality Act (2010). It is also used to support development towards our Public Sector Equality Duty (PSED) with the goals and outcomes within EDS relating to the issues that matter to people using services, the workforce and the wider public. In January 2023, we commenced a transition from EDS 2 to the revised framework, EDS 2022 in collaboration with our NHS partners in the Dorset ICS and reported a developing assessment. In January 2024 a second assessment was undertaken grouped under the following 3 domains:

- commissioned or provided services, in partnership with the Dorset ICS
- workforce health and wellbeing internally at UHD
- inclusive leadership internally at UHD

We assessed ourselves against each of the 11 outcomes, using the following grading options:

Undeveloped activity (i.e. no evidence of activity for protected groups)	Developing activity (i.e. evidence of activity (often good) but not for all protected groups)	Achieving activity (i.e. good evidence of activity for most protected groups)	Excelling activity (i.e. good evidence of activity for all protected groups)

In our recent assessment (February 2024) we achieved an EDS Organisation Rating (overall rating) of 18. This score remains within the **developing activity** and improving on 2023.

To fully benefit from this assessment UHD will ensure our EDS findings are fully integrated into our Patient First Improvement Programme and our Equality, Diversity and Inclusion (EDI) priority action plan.

Workforce Race Equality Standards

The Workforce Race Equality Standard (WRES) came into force in 2016 and is an annual submission completed by all NHS healthcare providers. It compares information against nine key indicators regarding the experiences of Black, Asian and minority ethnic staff compared to White staff within the Trust. Key findings from our 2024 UHD WRES report compared to the previous year are shown in the table below.

Improvement areas are highlighted with a green arrow. The national position is shown for 2023 and the full cycle of WRES reporting will conclude with the national report and comparison with other NHS organisations in Quarter 4 2024/25.

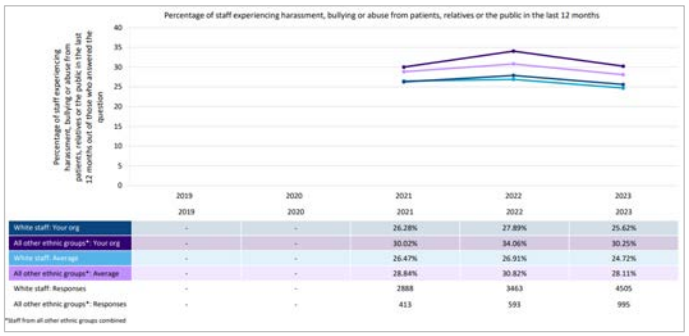
Compared to the 2023 WRES data, we have seen a positive and improving trend in a number of indicators, however the disparity gap is still large across a number of indicators. In summary, this report highlights the need for sustained action to address existing racial inequity and discrimination within UHD.

The key findings from the 2024 submission show:

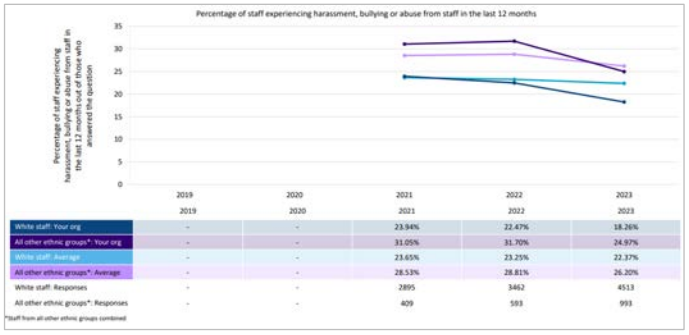
- Black Asian and Minority Ethnic or Global Majority represent 23.87% of the total workforce, an increase of 2.4% from the 2023 data position
- The UHD workforce now shows representation across all bands from Global Majority staff with Global Majority ‘Very Senior Manager’ representation for the first time
- White candidates remain 1.79 times more likely to be appointed from shortlisting than Global Majority staff
- Staff from our Global Majority are now twice as likely to enter the formal disciplinary process compared to White staff
- Global Majority staff remain less likely than White staff to access nonmandatory training and continued professional development opportunities
- Global Majority staff continue to experience more harassment, bullying or abuse from patients, relatives or the public than White staff
- Global majority staff report a higher level of experiencing harassment, bullying or abuse from other staff compared with White staff
- The perception around the equal opportunities for career progression or promotion within the Trust is lower amongst Global Majority staff than it is for White staff
- Global Majority staff are more than twice as likely as white staff to report personally experiencing discrimination at work by a Manager/Team leader or other colleagues
- The representation of Global Majority staff on the Trust Board is 12.87% with a disparity of -11% compared to organisational representation

WRES indicators		2021	2022	2023	2024 [1/4/23 –31/3/24]	Trend	2023 national
1.Percentage of black and minority (BME) staff [See also WRES metric 1 charts]	Overall %	16.8	18.7	21.5	23.87	↑	26.4
2. Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME		1.26	2.09	1.9	1.78	↑	1.59
3. Relative likelihood of BME staff entering the formal disciplinary process compared to white staff		1.17	1.22	1.0	1.97	↓	1.03
4. Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff		1.11	0.79	0.9	0.91	–	1.12
5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	BME %	27.0	30.0	34.1	30.0	↑	30.5
	White %	25.0	26.3	27.9	26.0		26.9
6. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	BME %	29.0	31.1	31.7	25.0	↑	27.5
	White %	22.0	23.9	22.5	18.0		21.7
7. Percentage of staff believing that trust provides equal opportunities for career progression and promotion	BME %	78.0	44.5	45.7	46.0	–	46.7
	White %	90.0	60.0	60.1	61.0		59.4
8. Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleague	BME %	17.0	16.8	20.3	16.0	↑	16.4
	White %	6.0	7.4	5.4	5.0		6.6
9 BME board membership [% difference]	[% difference]	13.7	12.2	15.0	11.0	↑	15.6

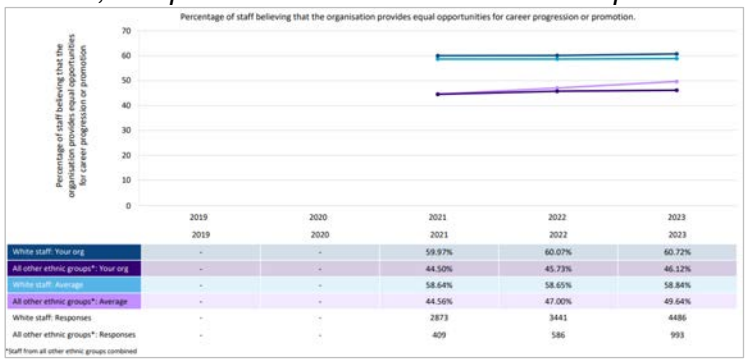
WRES 5: *30.25% of BME staff and 25.62% of White staff report experiencing harassment, bullying or abuse from patients, their relatives or the public in the last 12 months.*



WRES 6: *24.97% of BME staff and 18.26% of White staff report experiencing harassment, bullying or abuse from staff.*



WRES 7: *46.12% of BME staff believe that the Trust offers opportunities for career progression or promotion, compared to 60.72% of White staff respondents.*



	2019	2020	2021	2022	2023
White staff: Your org	-	-	59.97%	60.07%	60.72%
All other ethnic groups*: Your org	-	-	44.50%	45.73%	46.12%
White staff: Average	-	-	58.64%	58.65%	58.84%
All other ethnic groups*: Average	-	-	44.56%	47.00%	49.64%
White staff: Responses	-	-	2873	3441	4486
All other ethnic groups*: Responses	-	-	409	586	993

*Staff from all other ethnic groups combined

WRES 8: *15.79% of BME staff report experiencing discrimination at work from a manager or colleague, compared to 5.43% of White staff.*

	2019	2020	2021	2022	2023
White staff: Your org	-	-	7.40%	5.41%	5.43%
All other ethnic groups*: Your org	-	-	16.83%	20.27%	15.79%
White staff: Average	-	-	6.67%	6.52%	6.73%
All other ethnic groups*: Average	-	-	17.28%	17.33%	16.17%
White staff: Responses	-	-	2879	3454	4479
All other ethnic groups*: Responses	-	-	410	587	988

*Staff from all other ethnic groups combined

Based on a comparison to the 2023 data we have seen improvements in some indicators. However, the level of discrimination, harassment and bullying experienced by staff remains a significant concern. In this reporting period our external auditor has undertaken a review of our staff networks to inform future alignment to the Trust's needs.

This data has been shared with Diverse Ethnicity Network [DEN] staff network for collaborative solution planning. The focus will remain on fair recruitment, career progression, harassment and bullying and referral to formal disciplinary action.

Gender Pay Gap

The Gender Pay Gap (GPG) report consists of a set of calculations which enable organisations to identify the mean and median differences in hourly earnings between men and women. Organisations with over 250 employees must publish this information each year, using a snapshot data. The most recent report was published 31 March 2024.

It should be noted that the 2020 data was first published in March 2021, and this latest data snapshot took place on 31 March 2023, as per the regulations. Therefore, it will take some time for the impact of any actions to reduce the gender pay gap.

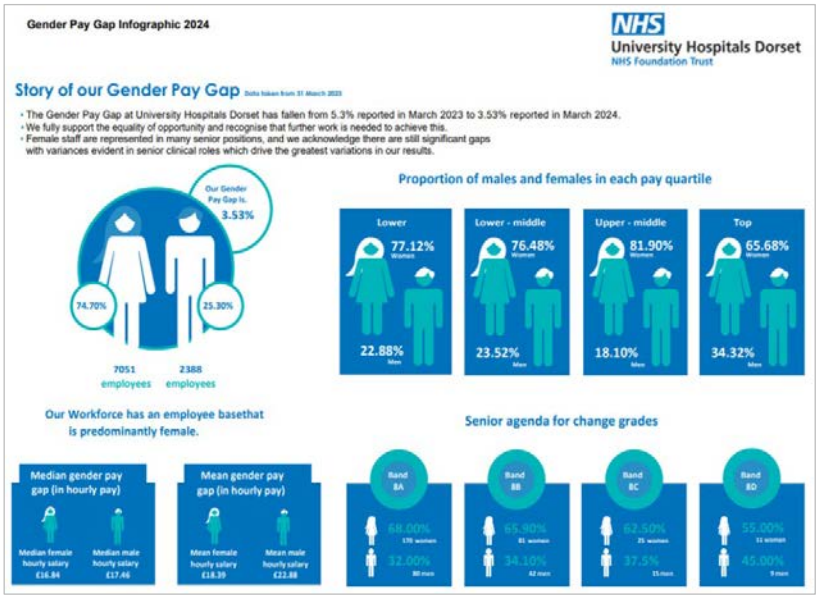
Separating the data for Agenda for Change and the Medical/Dental workforce gives a better understanding of where the greatest difference in pay and gender representation.

Key findings:

- our headcount increased by 148 to 9439 reported last year with 33 more female and 115 more males across UHD (31st March 2022 vs. 31st March 2023)
- this year our Gender Pay Gap is 3.53%. This is an improvement on last year's reported figure of 5.33% and continues the positive trend following the organisational merger in 2020
- there is an increase in representation at senior Manager level (8a, 8b, 8c and 9) of female staff. This is a positive move towards equitable representation with our workforce demographics
- the mean gender pay gap for the Trust overall is 19.63%. This has decreased by 1.32% from 20.95% reported last time
- if the Medical and Dental workforce are excluded from the calculation, the Trust's mean gender hourly pay gap would be 1.27%, compared to 19.63%. The Trust's median gender pay gap would be 9.78% in favour of female staff
- comparing the median hourly pay gap, women earn 96.5p for every £1 that men earn. Their median hourly pay is 3.53% lower than men
- there was no median bonus pay gap for 2023. When comparing mean (average) bonus pay, women's mean bonus pay is 35.96% lower than men. For the purpose of this report, the bonus payments are those made to consultants in the form of clinical excellence awards (CEAs), discretionary points and distinction awards.

The following actions will further support reducing the gender pay gap during 2024:

- review internal leadership development opportunities and encouraging our managers to have values-based appraisal and personal development discussions. This will impact the amount of UHD women who are ready for promotion to senior roles. We are recording and reporting on protected characteristics of delegates in all UHD programmes
- review recruitment guidance and training to include a more inclusive approach, notably through positive action. We will further develop and raise the profile of the UHD Women's network.



Workforce Disability Equality Standards

The Workforce Disability Equality Standard (WDES) came into force on 1st April 2019 and is a set of ten key measures (metrics) which enable NHS organisations to compare the workplace and career experiences between disabled and non-disabled staff. Key findings from our WDES data as of 31 March 2024 and in comparison, to previous years were:

Areas where there has been improvement from last year are highlighted with a green arrow. The national position is shown for 2023, the full cycle of WDES reporting will conclude with the national report and comparison with other NHS Organisations in the 4th quarter of 2024/25.

Key findings from the staff survey results incorporated into WDES reporting are:

- the declaration of Disability on the Electronic Staff Record (ESR) is now 6.3% compared to 5.6% in 2023
- the relative likelihood of a Disabled job applicant being appointed through shortlisting has improved from 1.24 reported in 2023 to 1.11 in 2024. A score of 1 indicates equal opportunity
- the relative likelihood of a Disabled colleague being in capability is 2.08. This means that Disabled staff are more than twice as likely to be in the capability process on the grounds of performance
- Disabled staff are more likely than non-disabled staff to experience bullying, harassment and abuse from patients, service users, relatives, members of the public, managers and colleagues than non-disabled counterparts. The gap is also increasing
- Disabled staff are less inclined to believe the Trust provides equal opportunities for career development as compared to those staff without disabilities
- Disabled staff feel more pressure than non-disabled staff to come to work when unwell
- 37.6% of Disabled staff reported that they felt valued for their contribution an increase from 31.48% reported in 2023
- 78.16% of Disabled staff reported they had the reasonable adjustment(s) required to perform their duties
- the staff engagement score for Disabled staff was 6.62, the first increase since merger
- there continues to be no declared representation of disabled staff on the Trust Board

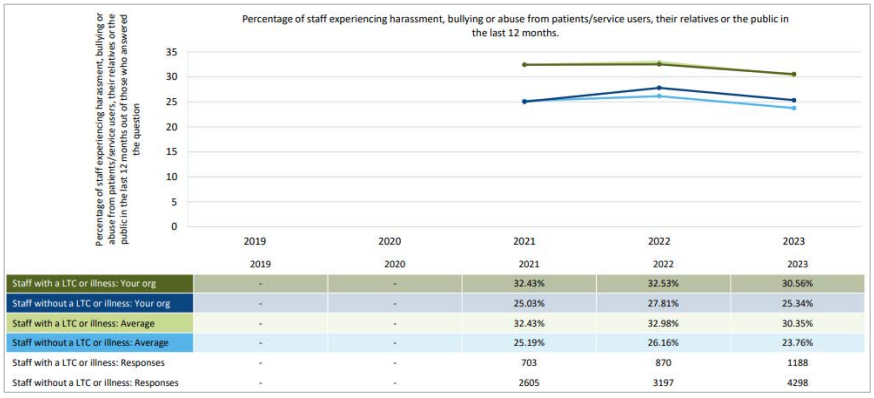
Workforce Disability Equality Standard 2024

Workforce Disability Equality Standard 2024 table 2.4.1		2021	2022	2023	2024	Trend	2023 national
1. Percentage of staff with a Disability compared to non-disabled staff [Disability declaration rate on ESR]	Overall	3.8	4.4	5.6	6.3	↑	4.9
2. Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.		0.96	1.2	1.24	1.11	↑	0.99
3 Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.		3.18	4.12	3.03	2.08	↑	2.17
4a I. Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients/service users, their relatives, or other members of the public	Disabled %	28.4	32	32.5	30.56	↑	33.2
	non-disabled %	24	25	27.8	25.34		26.0
4b ii. Managers	Disabled %	48.2	15.3	15.3	13.05	gap worsened	16.1
	non-disabled %	47.5	9.11	8.6	5.83	▬	9.2
4c iii. Other colleagues	Disabled %	25.1	25.0	26.6	24.35	gap worsened	24.8
	non-disabled %	16.7	19	17.8	14.21	▬	16.5
4d) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	Disabled %	46.4	45.8	47.8	48.78	↑	51.3
	non-disabled %	47.5	46.1	42.8	46.03		49.5
5. Percentage of Disabled staff compared to Non-Disabled staff believing that the Trust provides equal opportunities for career development.	Disabled %	27.2	29.1	28.8	25.21	↑	19.9

Workforce Disability Equality Standard 2024

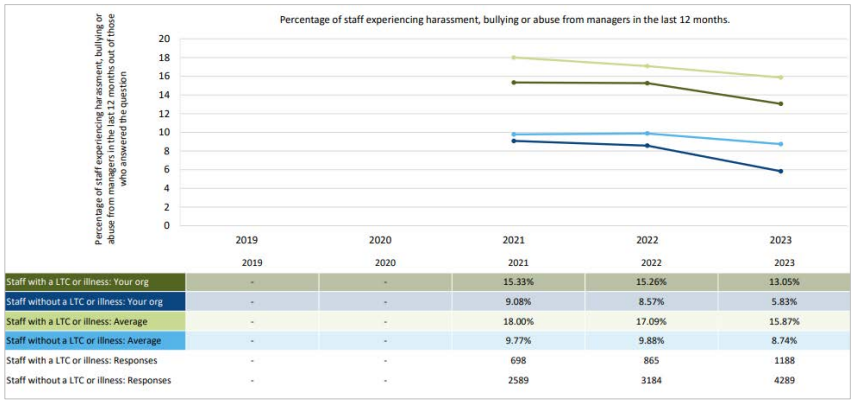
Workforce Disability Equality Standard 2024 table 2.4.1 cont'd		2021	2022	2023	2024	Trend	2023 national
6. Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	Disabled %	27.2	29.1	28.8	25.21	↑	27.7
	non-disabled %	23.7	21.0	19.6	16.17		19.9
7. Staff Survey Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	Disabled %	43.5	35	31.4	37.6	↑	35.2
	non-disabled %	46.5	43	40.8	45.99		45.0
8. Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to conduct their work. [%]		81.3	78.3	78.0	78.16	–	73.4
9a. The staff engagement score for Disabled staff, compared to non-Disabled staff and the overall engagement score for the organisation.	Disabled	7.0	6.6	6.5	6.62	↑	6.4
	non-disabled	7.3	7.0	6.9	6.96		6.9
9b. Has your trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No)	Disabled	Yes	Yes	Yes	Yes	WDES Survey – need to improve policies for Disabled staff	Yes
	non-disabled	Yes	Yes	Yes	Yes		Yes
10. Percentage difference between the organisation's Board voting membership and its organisation's overall workforce.	By voting membership of Board	not measured	.4	5.6	6.2	↓	5.7

WDES METRIC 4a: *The percentage of staff with a long-term condition or illness experiencing harassment, bullying or abuse from patients / service users, their relatives or the public has reduced to 30.56% compared to 32.53% reported in WDES 2023.*



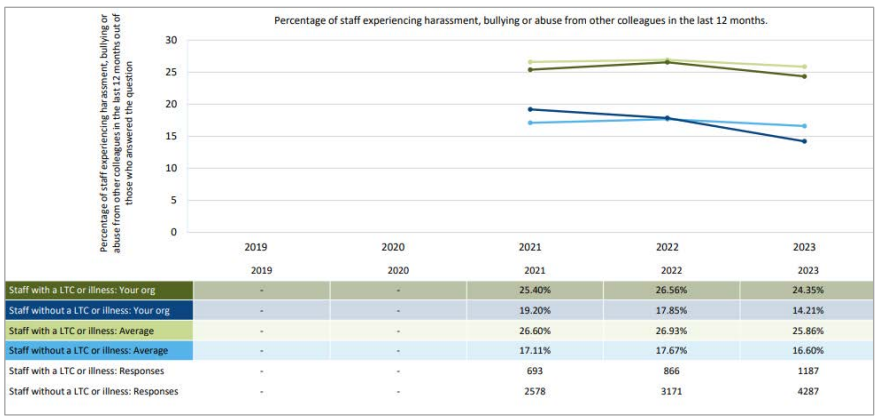
	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	-	-	32.43%	32.53%	30.56%
Staff without a LTC or illness: Your org	-	-	25.03%	27.81%	25.34%
Staff with a LTC or illness: Average	-	-	32.43%	32.98%	30.35%
Staff without a LTC or illness: Average	-	-	25.19%	26.16%	23.76%
Staff with a LTC or illness: Responses	-	-	703	870	1188
Staff without a LTC or illness: Responses	-	-	2605	3197	4298

WDES Metric 4b: *The percentage of staff with a long-term condition or illness experiencing harassment, bullying or abuse from managers reduced to 13.05% compared to 15.26% reported in WDES 2023.*



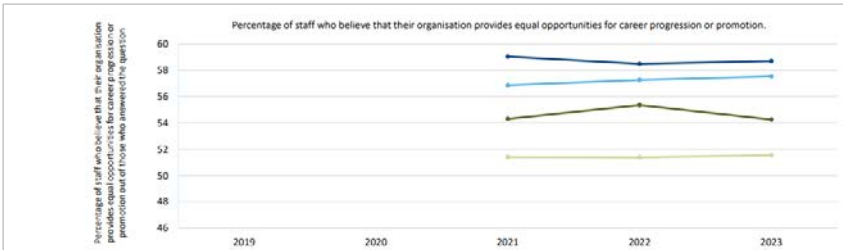
	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	-	-	15.33%	15.26%	13.05%
Staff without a LTC or illness: Your org	-	-	9.08%	8.57%	5.83%
Staff with a LTC or illness: Average	-	-	18.00%	17.09%	15.87%
Staff without a LTC or illness: Average	-	-	9.77%	9.88%	8.74%
Staff with a LTC or illness: Responses	-	-	698	865	1188
Staff without a LTC or illness: Responses	-	-	2589	3184	4289

WDES Metric 4c: *The percentage of staff with a long-term condition or illness experiencing harassment, bullying or abuse from other colleagues has reduced in to 24.35% compared to 26.56% reported in WDES 2023.*



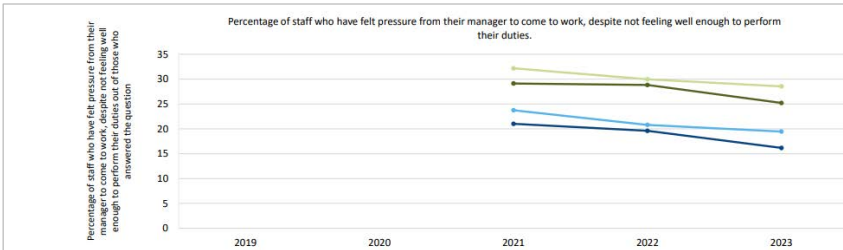
	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	-	-	25.40%	26.56%	24.35%
Staff without a LTC or illness: Your org	-	-	19.20%	17.85%	14.21%
Staff with a LTC or illness: Average	-	-	26.60%	26.93%	25.86%
Staff without a LTC or illness: Average	-	-	17.11%	17.67%	16.60%
Staff with a LTC or illness: Responses	-	-	693	866	1187
Staff without a LTC or illness: Responses	-	-	2578	3171	4287

WDES Metric 5: *The percentage of staff with a long-term condition or illness who believe that our organisation provides equal opportunities for career progression or promotion has reduced to 54.25% compared to 55.35% reported in WDES 2023.*



	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	-	-	54.30%	55.35%	54.25%
Staff without a LTC or illness: Your org	-	-	59.06%	58.50%	58.71%
Staff with a LTC or illness: Average	-	-	51.41%	51.39%	51.54%
Staff without a LTC or illness: Average	-	-	56.84%	57.25%	57.52%
Staff with a LTC or illness: Responses	-	-	698	860	1189
Staff without a LTC or illness: Responses	-	-	2589	3178	4282

WDES Metric 6: *The percentage of staff with a long-term condition or illness who felt pressure from their manager to come to work, despite not feeling well has maintained decreased to 25.21% compared to 28.83% reported in WDES 2023.*



	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	-	-	29.13%	28.83%	25.21%
Staff without a LTC or illness: Your org	-	-	21.01%	19.60%	16.17%
Staff with a LTC or illness: Average	-	-	32.18%	29.97%	28.55%
Staff without a LTC or illness: Average	-	-	23.74%	20.80%	19.46%
Staff with a LTC or illness: Responses	-	-	460	607	817
Staff without a LTC or illness: Responses	-	-	1228	1597	2060

Based on a comparison to the WDES 2023 data we have seen some improvements in our metrics. However, the disparity gap is still large across a number of the metrics and the level of discrimination, harassment and bullying experienced by Disabled staff remains a significant concern. In this reporting period our external auditor has undertaken a review of our staff networks to inform future alignment to the Trust's needs.

Accessible Information Standards

Since 2016, NHS organisations have been legally required to comply with the Accessible Information Standard (AIS). The AIS aim to ensure that people who have a disability or a sensory impairment can access communication materials in the way they require and are given information in a format they can understand. The AIS outlines the need to identify, record, flag, share and meet the communication and information needs of people using Trust services and their careers. In 2023 UHD introduced the Agyle system to flag additional needs for patients accessing services through their Care Plans in our Emergency Departments.

EDI Activity and Highlights

Staff Networks

The purpose of these employee-led groups is to provide support and guidance to other employees and provide insight and guidance to the organisation to assist in improving staff culture and experience.

The network group meetings are an opportunity to discuss challenges, progress and provide many opportunities for self and team development. Our network groups will develop and evolve over time.

Staff network groups are fully supported by the Senior Leadership Team and have explicitly given permission for employees to take reasonable time off to attend.

At UHD, we have a number of staff network groups with more in development:

- The Armed Forces Support Group
- The Diverse Ethnicity Network
- The European Staff Network
- The International Doctors' Support Group
- The ProAbility Staff Network
- The UHD Pride Network
- The Women's Network

For example, the Women's Network provides support and guidance to all women and all those who identify as women and allies working across UHD. There are numerous resources and links available through the intranet.

Due to the positive impact of our networks and the various stages of their maturity, our partner auditor has undertaken a series of focus groups and interviews with network leads and senior leaders to recommend how we can align the organisational priorities with our staff networks.

Freedom to Speak Up

"The silence of missing voices costs careers, relationships and lives".

Megan Reitz, 2023

Speaking up is an essential component of our cultural journey at UHD. To create workplaces safe to speak up, it is important not only to nurture those who have spoken up but also to look at what keeps others silent. As Megan Reitz reminds us it is just as important to follow the silence.

At UHD, we have many routes that our people can use to speak up including our line managers, occupational health, staff governors, using our LERN forms, chaplains, education team and our HR team. Freedom to Speak Up (FTSU) is another alternative route which is both well used and evaluated by staff who use it. For example, FTSU awareness sessions are provided during International Staff Induction.

This work is however more than the FTSU team. The role of the FTSU team is to highlight the challenges and act as an early warning system of where failings might occur. Our leaders, need to play a significant role in setting the tone for fostering a healthy speak up, listen up and follow up culture at UHD. Indeed, it is the experience of how our managers listen and act to concerns that we are often judged.

Consequently, we need to be curious as to why staff choose not to go to their line manager. Over the last 12 months, 47% of staff who come to the FTSU team say that they cannot go to their line manager because either they are the issue or that they are not addressing it. We need to better at this for us to be an embedded speaking up organisation.

Speaking up is entrenched within our objectives, strategy and improvement programme and we are seeing some early signs of green buds. This year, over 5,600 staff shared their voice through the staff survey: 59% of UHD.

This rich data tells us that over 50.63% staff feel our speaking up culture has improved from 2021 when only 46.31% felt the same. This is nearly a 10% increase from the previous 12 months and will contribute to our safety culture breakthrough objective for quality outcomes and safety. Clearly there is more to do as 49.4% of staff this year do not feel the same.

Charters and Partners

UHD advocates many charters and agreements with external organisations, we want UHD to be seen to be a safe and inclusive place to work and receive care, some of our charters include:

Armed Forces Covenant
The Armed Forces Covenant is a pledge to acknowledge and understand the needs of the Armed Forces community and aims to build a more open and honest relationship between employers, the Ministry of Defence and reservists. UHD holds the Gold Award.

Veteran Aware – Silver Status
Veteran Aware Trusts are leading the way in improving veterans' care within the NHS, as part of the Veterans Covenant Healthcare Alliance (VCHA).

Hate Crime Charter
There is no place, excuse or reason for hate crime in UHD. A hate crime is subjecting people to harassment, victimisation, intimidation or abuse because of their ethnicity, faith, religion, Disability or because they are lesbian, gay, bisexual or transgender this includes "Any incident, which constitutes a criminal offence, which is perceived by the victim or any other person as being motivated by prejudice or hate."

Disability Confident Employer
Disability confident is creating a movement of change, encouraging employers to think differently about disability and take action to improve how they recruit, retain and develop disabled people. Being disability confident is a unique opportunity to lead the way in your community, and you might just discover someone your business cannot do without.

Stonewall Diversity Champion
UHD aims to ensure all staff and patients feel welcome, notably our staff should feel respected and represented at work. Inclusion drives better individual, business and patient outcomes. When LGBTQ+ staff feel free to be themselves, everybody benefits.

Mindful Employer
Being a mindful employer demonstrates the UHD commitment to working toward achieving better mental health at work.

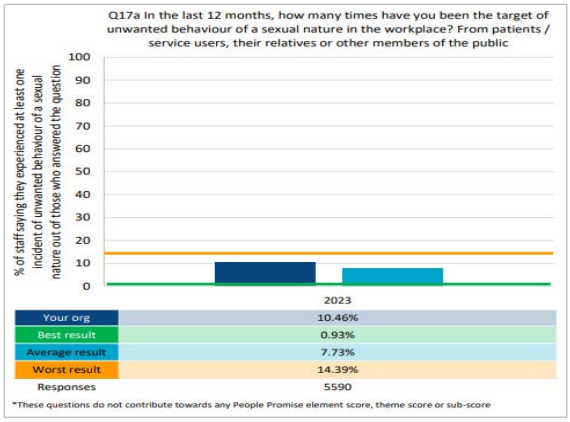
Sexual Safety Charter

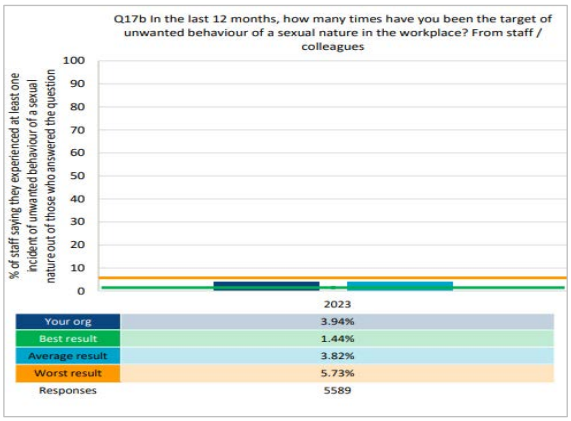
UHD is a member signatory to the NHS Sexual Safety Charter and we are committed to put in place the following principles.

As signatories to this charter, we commit to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce. These commitments will apply to everyone in our organisation equally. We will:

- actively work to eradicate sexual harassment and abuse in the workplace
- promote a culture that fosters openness and transparency, and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours
- take an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate
- provide appropriate support for those in our workforce who experience unwanted, inappropriate and/or harmful sexual behaviours
- clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour
- ensure appropriate, specific, and clear policies are in place. They will include appropriate and timely action against alleged perpetrators
- ensure appropriate, specific, and clear training is in place
- ensure appropriate reporting mechanisms are in place for those experiencing these behaviours
- take all reports seriously and appropriate and timely action will be taken in all cases
- capture and share data on prevalence and staff experience transparently.

A policy guidance document is due to be approved with the policy group. Once approved an engagement campaign will be launched and information will be available through the THRIVE Health and Wellbeing and EDI intranet pages. If we consider our 2023 NHS Staff Survey questions 17a and 17b there is an underlying need for a dedicated campaign. Q17a, over 500 staff or 10.46% responses indicate unwanted behaviour from the public. Q17b, over 200 staff of 3.94% indicate unwanted behaviour from staff or colleagues.





The UHD Living Library

A Living Library brings people together to share experiences, challenge stereotypes and raise awareness of the lived experience of others. Based on the Human Library movement our Living Library recruits volunteers to act as human books and tell their personal stories, sharing their lived experiences with staff that choose to “borrow” a human book. It provides a safe space for conversations to support colleagues, share best practice and use the power of personal conversation to positively challenge prejudice or discrimination. All book covers with the QR code will be displayed in our libraries, and on our library catalogue. The QR code will take the reader to a form, where again, they must consent to the terms and conditions. Library staff will then contact the book on their behalf and the book will confirm their availability. Library staff will advise the reader of the available dates and times.

Anti-Racism and See ME First

After the ‘Southport attack,’ riots broke out across England and Northern Ireland in July and August 2024. Misinformation led to crowds attacking mosques and public property. Some were set on fire, and shops looted. UHD became united against the abhorrent activity led through social media where activists soon directed their attention towards our UHD Global Majority staff. In an act of defiance and togetherness, the CEO led several listening events where all staff were able to share their lived experiences. For many, it was shocking to hear how our colleagues were treated and for those affected by these events support was offered. The listening events have continued and there will be actions to take to continue to galvanise UHD against Racism and all other inappropriate behaviours. Without challenge, racism can manifest within individuals and organisational processes, damaging everyone affected including the negative impact on our patient care. See ME First was launched in June 2023. See ME First, is a staff-led initiative aimed at supporting and educating staff towards ending discrimination in the workplace.

Through the See ME First campaign we have individually asked people to pledge to **challenge** discrimination when we see it and **support** any staff that experience discrimination by **listening** and encouraging them to **speak up** through the appropriate channels.

Looking back UHD had already started its Anti-Racism journey, a plan was discussed at Executive Board on 23 August 2023, the plan introduced a Trust Board Anti-Racism statement as the catalyst to a multi-layered and staged campaign that is driving a culture of speaking up and challenging inappropriate behaviour notably, racism.

UHD anti-racism statement (*27 July 2023*)

As the Trust Board of University Hospitals Dorset, we affirm that the Trust is an open, non-judgemental and inclusive organisation that will not tolerate racism or discrimination. We celebrate the diversity of our staff and community. We will treat all our staff equitably, with dignity and respect, whatever their race, gender, religion, age, disability, or sexual orientation.

Following a visit from Yvonne Coghill, NHS Race Observatory we have continued to monitor actions agreed with staff who attended listening events in November 2021.

Zero tolerance

Demonstrated with actions rather than ignoring what has been reported. We do not tolerate racism at UHD. It's not OK from patients either. We need to be ready to have the conversation about race - helping staff to talk openly about race and how to challenge negative behaviours. There needs to be more visible expression from our leaders – this will create a ripple effect.
We have: a Board sponsored Anti-Racism Statement, it extends to other abhorrent behaviour and includes wider context to other protected characteristics. Supporting guidance is published on the intranet so that everyone in UHD can speak up against racism. UHD does not tolerate Racism.

Report racism

There needs to be a clear escalation process and system to report. **We have:** an extensive network of Freedom to Speak Up champions in place. LERN forms were introduced specifically to record Racism.

Empowering minorities to speak-up

We need to encourage more engagement to help develop a culture where Black, Asian and minority ethnic staff can share their experiences, speak up and feel supported. **We have:** undertaken Board sponsored focus groups in 2023 with International Staff, the findings were also shared with the Trust Management Group. One of the outcomes supported recognition of prior experience so that pay disparity could be addressed and this is currently being considered.

Diverse leadership career progression

There is more work we need to do on inclusive and diverse recruitment and progression. Take positive action to ensure more Global Majority representation amongst managers. The disparity of progression to more senior posts is felt by our Black, Asian and ethnic minority colleagues. **We have:** ensured recruitment activity is monitored through TRAC and disparity through WRES. Inclusive recruitment takes place for senior positions, but we need to extend

this practice to all roles. UHD are working with the Dorset ICS to extend guidance to all posts to provide consistency in Dorset. In addition, Conscious Inclusion and Inclusive Leadership workshops are in place to address prejudice and judgement. We are aware that the disparity in career progression presents the need to monitor opportunities more closely including taking positive action when possible.

Mandatory anti-racism training for line manager and whole organisation

Promote cultural awareness and racial unity. Leaders need to be equipped to deal with the skills to deal with racism and encouraged to be more proactive – have conversations rather than 'wait for the complaint'. Appraisals review of how line managers have met EDI objectives. Acknowledge the importance of white allyship – move through the vulnerability, shame etc to acceptance and educate ourselves to understand how we take act. **We have:** developed UHD Conscious Inclusion and Inclusive Leadership workshops with the Dorset ICS to remove prejudice and judgement and inform cultural awareness. UHD produced a UHD version of Conscious Inclusion workshops specifically for UHD to provide the flexibility to deliver these sessions at scale and in time consider mandating attendance.

Empowering staff networks

They are excellent but often find themselves dealing with issues like 'unions' do, rather than helping to develop the organisation – vision and objectives. **We have:** completed a review of our Staff Networks in 2024 with our external partners. The findings included defining the strategic purpose of the networks and aligning trust and network objectives. A business case for a dedicated project support officer is being considered that will support the network leads and our EDI lead.

Holding people accountable

There should be clear consequences for people who have demonstrated racist behaviour, especially our staff. We should also consider declining treatment to patients as this happens in other organisations. **We have:** Developed a cultural awareness workshop that makes prejudice a conscious decision 'Conscious Inclusion.' In the workshop we discuss the concept of anti-racism and the implications related to staff conduct and the detrimental effect of racism on staff. Additionally, UHD has implemented violence and aggression guidance for patients. **We have:** learnt to educate bystanders who do not act on what they have seen or witnessed, and we will continue to promote this message.

Cultural Inclusion Celebration 24 July 2024

The second annual UHD Cultural Celebration was held on 24 July 2024. Its purpose is to unite the diverse cultures within our hospitals and celebrate the unique UHD culture. The aim is to enhance cultural integration, promote civility, and foster inclusion. When staff feel valued and appreciated for who they are, the quality of patient care improves. The planning committee comprised of members from across the organisation both clinical and non-clinical and various nationalities, ethnicities and backgrounds. The event received amazing support from Organisational Development (OD), executive sponsors, the CEO, other board members and the hospital charity with funding for freebies.

The day was celebrated with colleagues in colourful costumes, featuring dances from different cultures, music, a cultural quiz, choir performances, cultural poetry recitations, musical acts, fashion pageantry, a bake-off, and more with a single aim to celebrate our people and promote inclusion. Staff network leads shared the incredible work being done by their respective networks. Staff had the opportunity to explore information on various staff networks, Freedom to Speak Up (FTSU) and wellbeing resources. Sustainable coffee mugs and pens were distributed to attendees and free ice cream was provided for UHD staff across our seven hospital sites. A range of food representing many nationalities was provided by the hospital catering team and external catering, allowing attendees to enjoy authentic dishes. The external catering was able to donate 10% of their profit to UHD hospital charity.

A feedback session, supported by the library team identified what went well and areas for improvement for future celebrations. The ultimate success will be achieved when different care groups and departments hold their own celebrations, valuing their staff to maximise cultural integration and inclusion.

Black History Month

Black History Month is a time for reflection, education and inspiration. It is a time to honour the contributions and achievements of black people through history and to British society. This year's theme for 2024, 'reclaiming narratives' focuses on the voices and stories that have been marginalised or overlooked. UHD commissioned education sector DEED to present local black history at our events at Poole and Bournemouth.

For Example: *'In 1890s Thomas Lewis Johnson, a writer, missionary, former slave and anti-slavery campaigner settled with his family near Royal Bournemouth Hospital. His grave is just over a mile away from RBH and is part of our history and the black heritage of Dorset.'*

It is important we remember and share his story, so it is never forgotten.

In UHD, we are fortunate to have many colleagues from black heritage to enrich our diverse community. Several departments held their own Black History Month celebration enhancing cultural integration this year. Despite the efforts to manage unacceptable behaviours, sadly, we also recognise that some of our colleagues from Global Majority experience racism, discrimination, disparities in career progression and health inequalities. Pictures and posts were shared at Black History Month #UHDBHM.

Purple Light Up

#PurpleLightUp is a global movement that celebrates and draws attention to the economic

contribution of the 386 million Disabled employees around the world. Purple Space leads this movement, a mark of respect to the UN International Day of Persons with Disabilities (IDPD) held annually on 3 December.

The ProAbility network is proud to support this event, for our #TeamUHD people who live and work with hidden Disabilities and underlying health conditions. Purple Light Up Day falls within Disability History Month (16 November to 16 December). Disability History Month is a chance for everyone in #TeamUHD to come together and show support for disability equality. It is about celebrating the difference our NHS colleagues with diverse abilities make to the lives of our patients each day. In 2023 our ProAbility Staff Network was joined on 7 December by special guest speaker Haseeb Ahmad. Haseeb who is the Equality, Diversity and Inclusion lead at Leicestershire Partnership NHS Trust. He was registered blind at 17 years old and is a world record holder for Blind Ironman. It was a truly inspirational discussion.

We advocate wearing purple, planning is progressing for 2024.

Pride Day and Bourne Free

On 05 July 2024 our UHD Pride Network hosted UHD's first ever Pride Day in the marquee at Bournemouth. Senior Leaders, members and allies were involved.
Everyone was welcome, staff were able to meet the network leads members and allies and it was a celebration for our UHD LGBTQIA+ colleagues. On Saturday 6th July 2024 the network also participated in the local Bourne Free parade to celebrate Pride with our local community.

The Safe to be Me at UHD is a personal pledge to advocate and speak up for the human rights of the LGBTQIA+ community.

Leadership Development

Our leadership pathway maps out internal and external offers to support our leaders in their development throughout the entire employee life cycle from Induction through to appraisal and future development and beyond. It reflects the evolving development offers in line with the Patient First Improvement Methodology.

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.

Coaching is embedded into our leadership development workshops and programmes. UHD continue to develop a coaching culture, through the development of our existing coaches and training (ILM level 5) and another level 5 cohort is planned, adopting the apprenticeship framework so that we can continue to develop more leaders as coaches.

Each workshop and programme have preparation work that must be completed prior to attending. Our workbooks are accessible (in terms of font, size, printable but can also be viewed on screen). We aim to send out prep work (via email) a minimum of 2 weeks before the workshop to ensure that everyone has adequate time to complete. Delegates are also informed of the requirement to complete work beforehand at the point on booking.

All staff are informed that should they have any issues with accessing or understanding the content in the workbooks, to speak to one of us and we will be able to make any adjustments/support them further.

Workshop	Total Delegates	% non-White
Leading Teams Through Change (January 21 – March 24)	363	18.69%
Leading Your Team Through Integration (August 22 – March 24)	125	18.03%
Feedback Skills (January 22 – March 24)	212	25.51%
Coaching Conversations (July 21 – March 24)	282	20.43%
Courageous Conversations (January 22 – March 24)	157	21.95%
Managers Induction Module 1 (July 22 – March 24)	285	16.73%

Two in-house leadership programmes that also contain inclusive leadership and cultural awareness during the period from 1 April 2023 to 31 March 2024.

Programme	Total Delegates	% non-White British
Leadership Fundamentals	113	32.7%
Leadership in Action	47	8.5%

Dorset Leading for Inclusion: Change Agent Programme

Three senior leaders in UHD attended the Dorset Leading for Inclusion Change Agent Programme. 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.' The

purpose of developing a system pool of expertise and change agents is to scale and spread this approach to:

- lead the delivery of the Five ICS transformation objectives (linked to ICP strategy of prevention and early help, thriving communities, and working better together)
- support the continued development in their own organisations culture on ‘Leading for inclusion’ using this consistent methodology
- shape and drive an ICS wide approach to increasing diversity through inclusive recruitment practices, supporting delivery of social and economic value
- cascade the approach wider across our ICS.

Reverse Mentoring

Reverse Mentoring is a development programme for both the mentee and mentor and will positively influence change for a more inclusive culture for the benefit of all, including patients. At the time of writing this report, UHD were approaching the final stages of Cohort Three. Two of the three cohorts have been funded by the NHS Charities Together monies from the COVID-19 pandemic to support staff. We pride ourselves in the continuation of this programme as the learned experience for both mentees and mentors is invaluable. This is a six-month mentoring programme where the roles are reversed. The aim is to promote positive inclusion through understanding the experiences of mentors and for mentees to identify organisational barriers.

We have a notable glass ceiling for Global Majority Staff that will be highlighted in the Recruitment and Career progression summary.

Senior leaders who have been mentored by a colleague from an underrepresented community often form longer standing working relationships with colleagues thereby providing the opportunity for exposure.

Recruitment and Career Progression

The disparity in career progression does show a worsening position for 2024. It is reasonable that from an operational planning perspective the data informs the case for positive action to achieve our future Equality Objectives. The use of this calculation has not been adopted nationally as a requirement. Although this could be attributable to the significant targeted international recruitment drive for nurses.

Disparity ratio - lower to middle, including Bands 1-5	2.43	**2.42**
Disparity ratio - middle to upper, including Bands 6 & 7	2.56	3.06 
Disparity ratio - lower to upper, including Band 8a & above	6.22	7.40 

Bandings
1 to 5 lower
6 and 7 middle
Band 8a+ upper

The table shows the trajectory for Global Majority Staff progression highlighting an improvement in the lower to middle group from 2.43 in 2023 to 2.42 in 2024. It also highlights a worsening position in the middle to upper group from 2.56 in 2023 to 3.06 and a worsening position from lower to upper, 7.4 in 2024 from 6.22 reported in 2023.

From the NHS National Staff Survey, Global Majority staff report opportunities for career progression less favourably compared to White staff and this is reflected in the WRES 2024. From our TRAC recruitment system data (used to inform **WRES 2**) White candidates remain **1.79** times more likely to be appointed from shortlisting, although the position has improved since **1.9** reported in 2023.

An example for comparative purpose shows:

- from 9,512 **White** non-medical candidate applications, from the 3,314 interviewed 33.45% or **1108** were appointed
- from 19,246 **Black** [not including Asian, other Black and mixed] candidate applications, from the 873 interviewed 16.15% or **141** were appointed

There are obviously many variables not considered. The TRAC system continuously updates and this can create discrepancies when data is taken. However, there were 45,202 actual applications in this category. It feels morally correct to consider:

- more rigorous application of an Equality Impact Assessment
- Inclusive Recruitment practices
- Reasonable Adjustments

NHS Staff Survey 2023

The National Staff Survey 2023 was UHD's third year of comparative data structured around the 7 NHS People Promise pledges and 2 Themes [Staff Engagement and Morale].

The 2023 key findings:

- the UHD response rate was the highest to date with 59% up from 45.5% in 2022 and above the median national average of 45% for 122 acute and acute community Trusts
- the Engagement score was 6.96 out of 10 and Morale 5.95 out of 10 both increasing on 2022
- the score highest comparable themed score was 'We are compassionate and inclusive' with 7.38

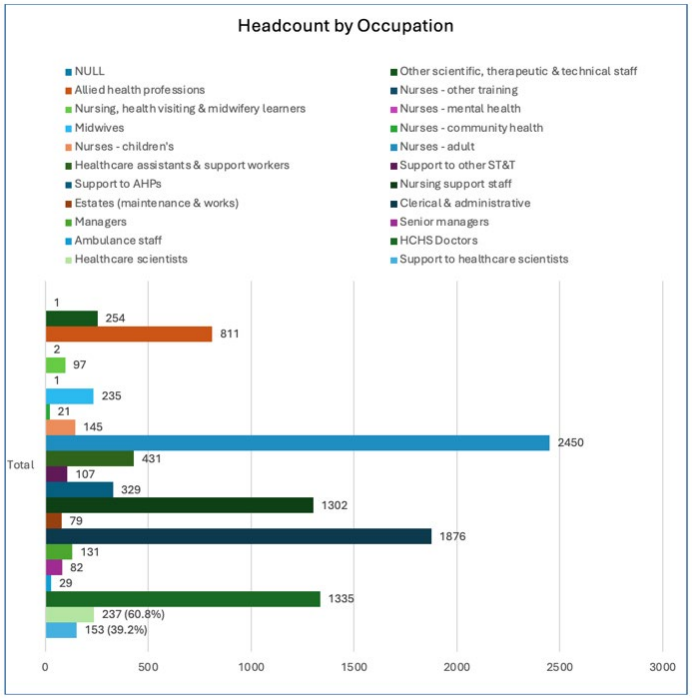
- the percentage of our BME colleagues who said they experience harassment, bullying and abuse from the public, patients, families has reduced to 30.25% (2022: 34.06%) and from other staff to 24.97% (2022: 31.70%), however this remains below the average scores in our comparator group.

NHS People Pulse Survey

The People Pulse is an opportunity to regularly share our views about our working experience. Our answers will be used to shape a range of support, both locally and nationally for all our NHS people. The survey should take no longer than 5 minutes to complete and is fully anonymous. There are a group of demographic questions at the end of the survey. These will allow for the results to be explored for different populations and this information can help tailor support in the right way. Some of the questions are optional and the survey is still strictly confidential, where only aggregated data with more than 10 responses will be reported on. Local team data is available allowing us to share success and teams to take local actions to address concerns.

Our Workforce Profile

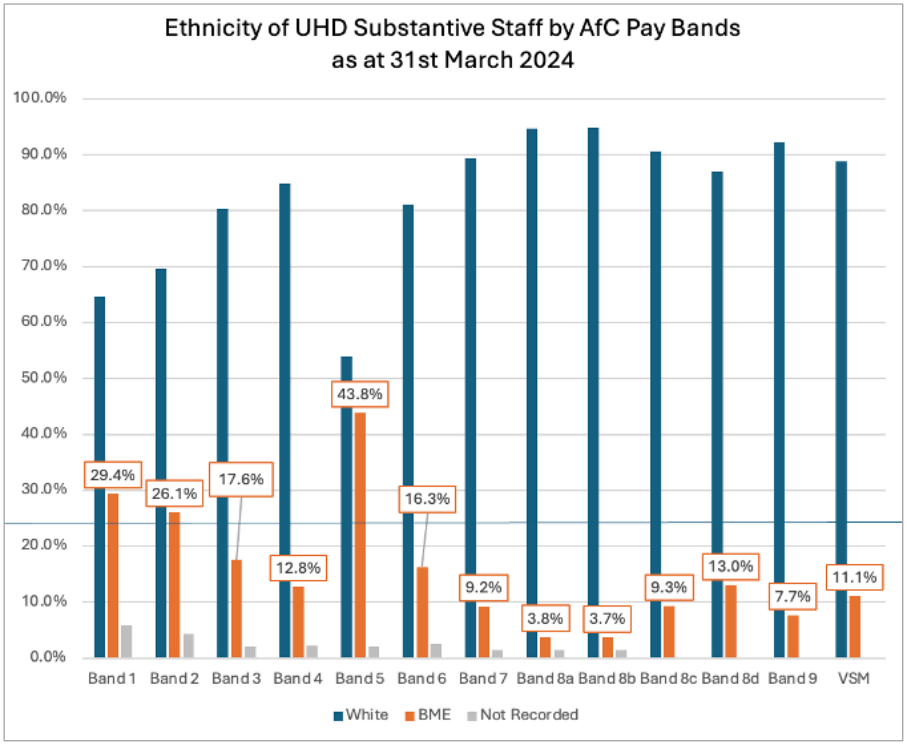
The workforce profile was taken as of 31 March 2024, this data will also feature in the 2024 WRES and WDES reports. Nursing is our largest occupational group. UHD has over 10,000 staff, an increase from 9,700 reported in 2023 serving a population base of 400,300 [Census: 2021 ONS] that extends to over 750,000 people across Dorset and surrounding areas. Where possible a 3-year data table has been provided alongside the visual protected characteristic charts. Our Trust staff have the right to leave equality and diversity data categories unspecified if they wish to.

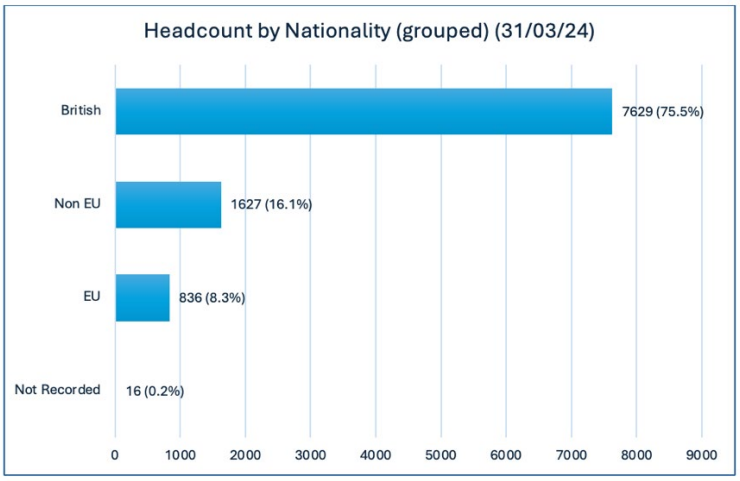


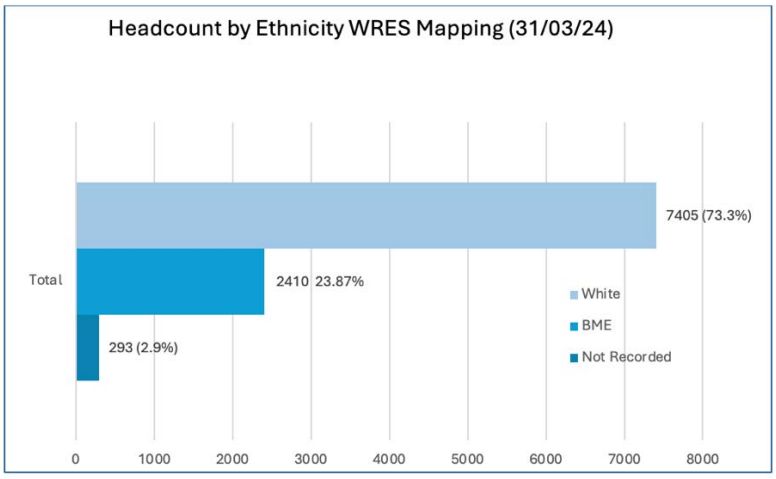
Ethnicity Profile

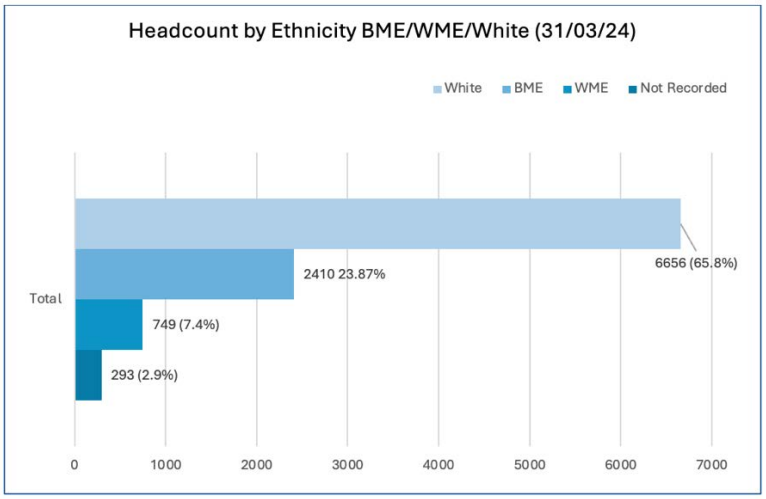
For the purposes of this report, we have defined staff categories as White, BME and ‘not stated’. The national electronic staff record does not give the option to select ‘do not wish to declare’ for ethnicity therefore, these are recorded by default as ‘not stated’.

The percentage of BME staff is now 23.87% up from 21.5% in 2023. UHD is reporting BME across all bands for the first time. The target line points to where BME representation should aim to be. The WRES indicator 9 for 2024 will report a reduced gap between the Board / Workforce demographic when compared to BME / Global Majority in the workforce.
The chart shows a clear lack of BME progression in Band 6 and above.









	31/03/2022		31/03/2023		31/03/2024	
Ethnicity (Grouped)	Headcount	%	Headcount	%	Headcount	%
Asian	872	9.12%	1,044	10.75%	1181	11.68%
Black	267	2.79%	336	3.46%	469	4.64%
Chinese	57	0.60%	51	0.52%	53	0.52%
Not Known	313	3.27%	288	2.96%	293	2.90%
Other	370	3.87%	381	3.92%	408	4.04%
White	7,441	77.84%	7,340	75.55%	7405	73.26%
Mixed	239	2.50%	276	2.84%	299	2.96%
Grand Total	**9,559**	**100.00%**	**9716**	**100.00%**	**10,108**	**100.00%**

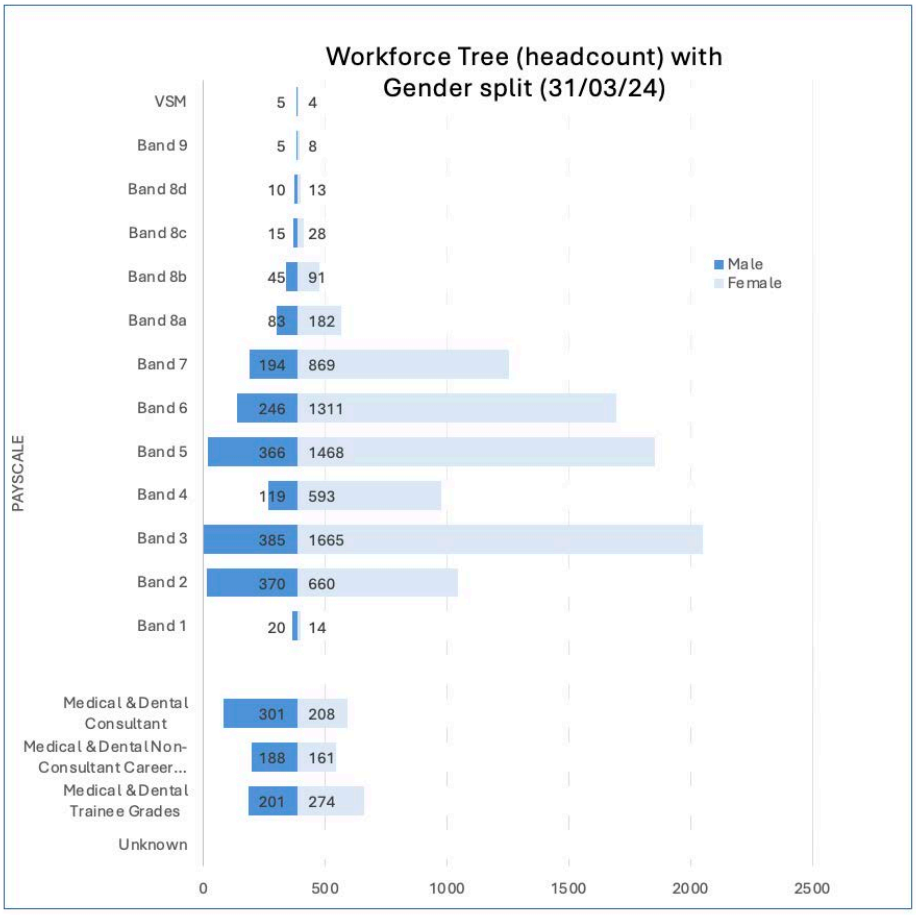
The 2021 ONS noted that the Dorset population increased to 379,584 residents up 4.0% from that reported in 2011. Bournemouth and Poole Council catchment increased by 5.7%. The Dorset population was reportedly 97.1% White.

Internally at UHD the case for increasing Global Majority representation above Band 6 is both neccesary for patient care and importantly a moral obligation to recognise service and the potential of our staff. **23.87% staff in UHD are from Global Majority.**

Gender Profile

The illustration shows that there are more female staff in Agenda for Change Bands 2 – 9 than male staff in each of these grades. There are 7551 (74.7%) female staff, compared to 2557 (25.3%) male staff. Overall UHD reported a slight increase in male staff headcount for 2023/4 and in the medical grades, there are more male consultants.

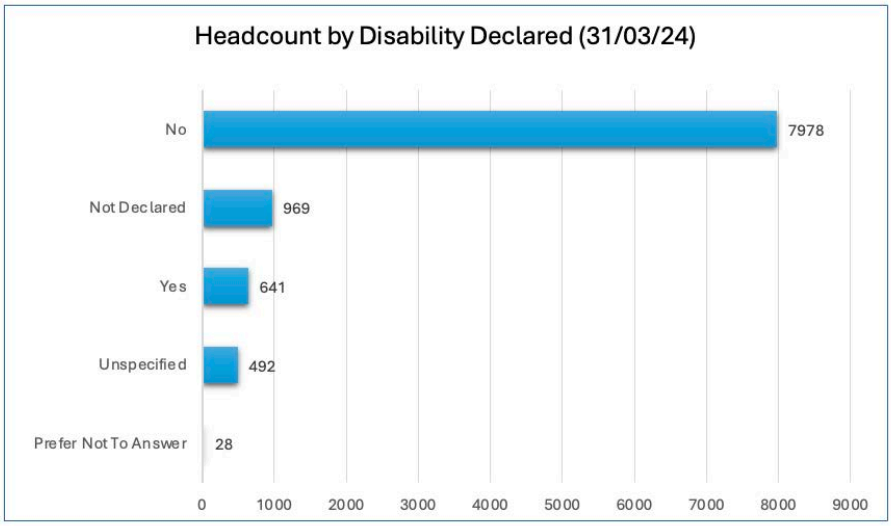
Notably the gender pay gap is closing reported as 3.53% in March 2024 down from 5.5% in March 2023. On ESR, we are unable to record non-binary gender which is a national NHS issue on gender reporting.



Disability Profile

The reported declaration for staff who are ‘Disabled’ has increased to 6.34% an increase from the 5.6% reported in 2023, taken from the Electronic Staff Record.

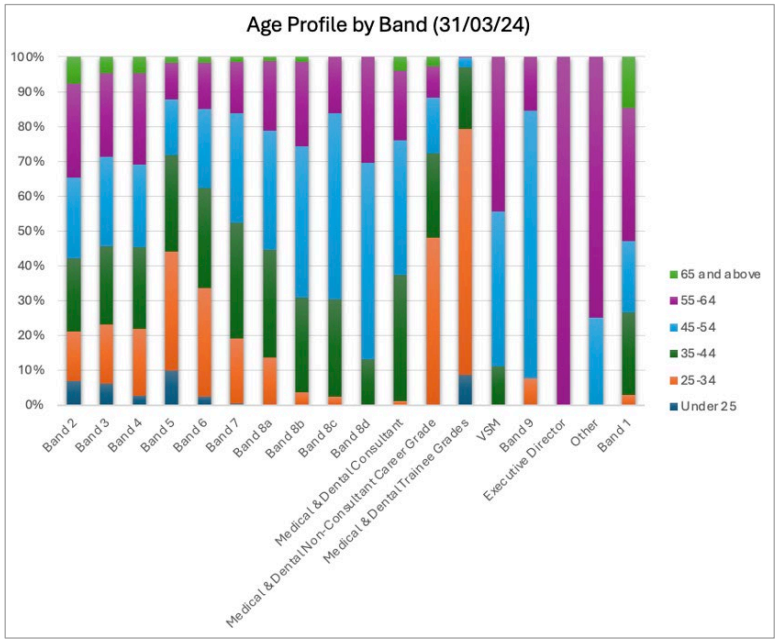
This is a significant increase that is largely attributable to our ProAbility Staff Network and their engagement. When considering the NHS Staff Survey our reported Disability / long term condition is reported to be much higher at 21.34%.



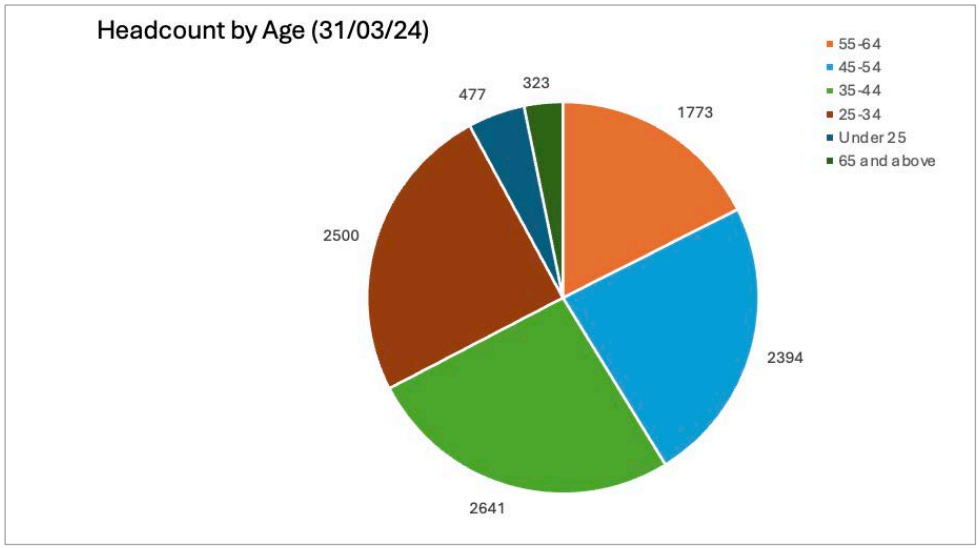
	31/03/2022		31/03/2023		31/03/2024	
Disability	Headcount	%	Headcount	%	Headcount	%
No	6,856	71.72%	7521	77.41%	7978	78.93%
Not Declared	1,552	16.24%	999	10.28%	969	9.59%
Prefer Not to Answer	17	0.18%	17	0.17%	28	0.28%
Unspecified	680	7.11%	637	6.56%	492	4.87%
Yes	454	4.75%	542	5.58%	641	6.34%
Grand Total	**9559**	**100.00%**	**9716**	**100.00%**	**10108**	**100.00%**

Age Profile

The largest workforce group is in ages 35-44 with 2641 staff, however above age 55 there are 2096 staff. The chart below illustrates the age profile by band.

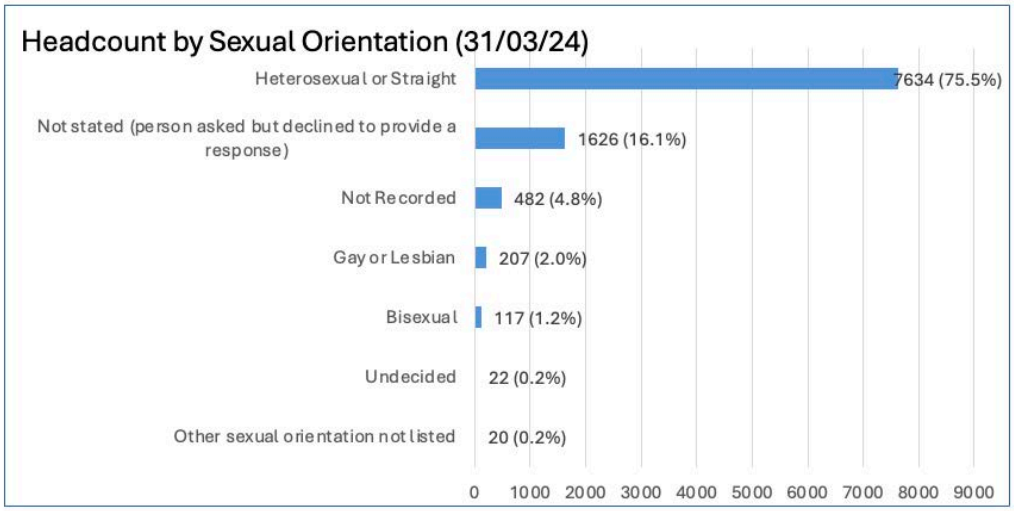


	31/03/2022		31/03/2023		31/03/2024	
Age Profile	Headcount	%	Headcount	%	Headcount	%
Under 25	481	5.03%	435	4.48%	477	4.72%
25-34	2,494	26.09%	2,446	25.17%	2,500	24.73%
35-44	2,325	24.32%	2,450	25.22%	2,641	26.13%
45-54	2,273	23.78%	2,315	23.83%	2,394	23.68%
55-64	1,706	17.85%	1,753	18.04%	1,773	17.54%
65 and above	280	2.93%	317	3.26%	323	3.20%
Grand Total	**9,559**	**100.00%**	**9716**	**100.00%**	**10108**	**100.00%**



Sexual Orientation Profile

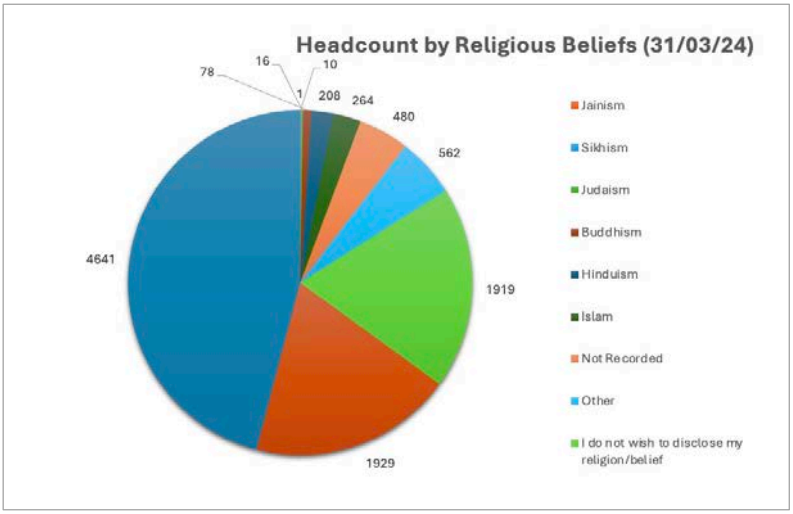
75.5% of staff identify as heterosexual, 2.0% gay or lesbian and 1.2% as bisexual. Declaration rates in the other sexual orientation groups have changed by less significantly from last year noted in the table. The percentage in the not stated category has fallen to 16.09%.



	31/03/2022		31/03/2023		31/03/2024	
Sexual Orientation	Headcount	%	Headcount	%	Headcount	%
Bisexual	129	1.35%	109	1.12%	117	1.16%
Gay or Lesbian	185	1.94%	177	1.82%	207	2.05%
Heterosexual or straight	6901	72.19%	7120	73.28%	7634	75.52%
Not Recorded	651	6.81%	578	5.95%	482	4.77%
Not stated (person asked but declined to provide a response)	1676	17.53%	1702	17.52%	1626	16.09%
Other sexual orientation not listed	11	0.12%	14	0.14%	20	0.20%
Undecided	6	0.06%	16	0.16%	22	0.22%
Grand Total	**9559**	**100.00%**	**9716**	**100.00%**	**10108**	**100.00%**

Religion and Beliefs Profile

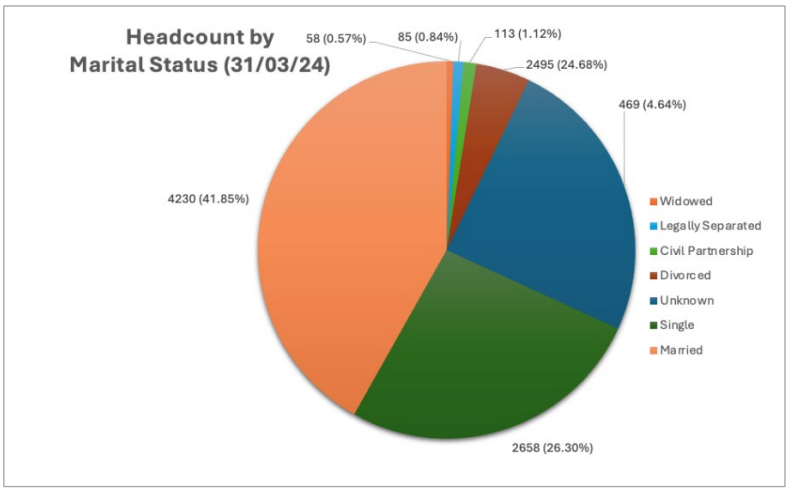
Staff feel comfortable not to disclose their religion in 2024. Our chaplaincy service provides multi faith options and are notably an important source of support for our staff and patients. The table shows the changing trends from 2022 to 2024 with an increasing disclosure for Atheism.



	31/03/2022		31/03/2023		31/03/2024	
Religious Beliefs	**Headcount**	**%**	**Headcount**	**%**	**Headcount**	**%**
Atheism	1609	16.83%	1759	18.10%	1929	19.08%
Buddhism	59	0.62%	68	0.70%	78	0.77%
Christianity	4322	45.21%	4402	45.31%	4641	45.91%
Hinduism	140	1.46%	170	1.75%	208	2.06%
I do not wish to disclose my religion/belief	1988	20.80%	1950	20.07%	1919	18.98%
Islam	192	2.01%	221	2.27%	264	2.61%
Jainism	1	0.01%	1	0.01%	1	0.01%
Judaism	17	0.18%	11	0.11%	16	0.16%
Not Recorded	647	6.77%	574	5.91%	480	4.75%
Other	572	5.98%	548	5.64%	562	5.56%
Sikhism	12	0.13%	12	0.12%	10	0.10%
Grand Total	**9559**	**100.00%**	**9716**	**100.00%**	**10108**	**100.00%**

Marriage and Civil Partnership Profile

The chart below shows the representation for marriage and civil partnership disclosure. In 2023, 4997 staff were married compared to 4230 reported in 2024. The number of unknowns has increased from 294 for 2023 to 469 in 2024.



Workforce by gender re-assignment

Data is currently not available to present information in a safe and confidential way. As a Trust we recognise the importance of creating an accepting and inclusive culture for staff who are transitioning. This includes support structures for people to feel able and safe to disclose their information confidently.

Parental Leave

The percentage of staff taking parental leave continues to be statistically significant for workforce planning and ward establishment reviews.

	31/03/2022		31/03/2023		31/03/2024	
Accessing Parental Leave	Headcount	%	Headcount	%	Headcount	%
No	9,086	95.05%	9247	95.17%	9,622	95.19%
Yes	473	4.95%	469	4.83%	486	4.81%
Grand Total	**9,559**	**100.00%**	**9716**	**100.00%**	**10,108**	**100.00%**

Our Patients

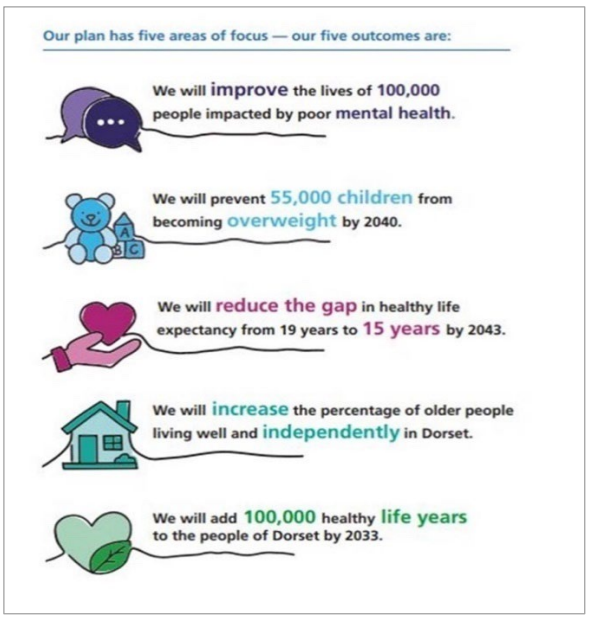
In delivering the many important health services developed over the years to meet a variety of needs, UHD does not tolerate any practices that result in the provision of a lower standard of service to any group or individual. In 2023/24, there has been good progress for patients in several areas, for example:

- reducing the elective wait times for a first outpatient appointment for patients with a learning disability following a GP referral to the Trust
- supporting workforce development, including awareness raising across staff groups, and providing access to population health and Health Inequalities training or coaching
- participating in the Equality Delivery System (EDS) annual assessment. This is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010
- continuing to deliver interventions to reduce Health Inequalities through our elective and urgent and emergency programmes, with a particular focus on reducing Did not attends or missed outpatient appointments and on high intensity users of emergency care
- reviews to inform work moving forwards including review of NHS England's statement under section 13SA (1) of the NHS Act 2006 on how NHS bodies should exercise their powers to collect, analyse and publish information related to health inequalities, our approach the Equality Impact Assessment, and plans as an anchor institution (across procurement, estates and environmental sustainability, workforce)

We have also strengthened our work with the wider Dorset System enabling us to progress our approaches to:

- improving data capture and completeness related patients and protected characteristics,
- working with communities and delivering research engagement; and
- how we collect, analyse and publish information related to variation in access, experience and outcomes for patients accessing our services, including monitoring the impacts of interventions using the Core20Plus5 model.

We continue to work closely with system partners on reducing health inequalities. Moving forward, there are five areas of commitment from the Dorset system:



Trust Membership

As a Foundation Trust, we are accountable to NHS England and also accountable to local people through our Council of Governors and members. In addition, there is a large range of inspection and other regulatory bodies which govern the activities of the Trust, including the Care Quality Commission (CQC). The Council of Governors, which represents around 14,000 members, is made up of members of the public, staff and appointed governors. They ensure the views of our members are heard and fed back to our Board of Directors and members of the public are kept up to date with developments within our hospitals.

Our Board of Directors is made up of full-time executives, who are responsible for the day-to-day running of the organisation, and part-time non-executive Directors. The Executive Directors work closely with the clinical leaders and managers throughout the hospitals in running the services. The Board also works closely with the Council of Governors. The Trust is organised under three clinical care groups and departments providing support services. We also work closely with a range of key health and social care partners to develop and deliver our services and we are part of the Dorset Integrated Care System (ICS).

Analysis of current membership		
Public constituency	**Number of members**	**Eligible membership**
Age (years):		
0-16	19	106,797
17-21	24	36,165
22+	13,795	495,701
Ethnicity:		
White	12,776	594,664
Mixed	106	27,880
Asian or Asian British	202	16,104
Black or Black British	37	8,821
Other	32	8,735
Socio-economic groupings*:		
AB	3,990	62,986
C1	4,228	89,412
C2	2,636	65,066
DE	2,947	66,246
Gender Analysis		
Male	5,017	312,574
Female	8,644	326,089

Please note: this analysis excludes a) 30 public members with no stated date of birth b) 715 members with no stated identity c) 207 members with no stated gender.

Our Workforce EDI Priorities (2024 – 2026)

Recognising that much of the work the needs to be sustained over the long term, our 2023 - 2024 priorities reinforced objectives that were already in train, with renewed energy to ensure we continue achieving tangible outcomes. Despite efforts to promote inclusion and equity it is evident that our staff still report prejudice and discrimination in organisational and individual behaviours, as reflected in lived experiences of our staff and our workforce data.

As part of our refreshed UHD People and Culture strategy, a revised *One Team* EDI Plan has been developed, informed by:

- the NHS EDI Six High Impact Actions Improvement Plan
- the recommendations from our PSED workforce reports
- recommendations from 'Too Hot to Handle' and the 'Macmillan Report'
- a focus group (in person and on-line) with UHD colleagues facilitated by Dr Habib Naqvi MBE, Director of NHS Race Observatory (Sept 24).
- the lived experience of our staff, shared through storytelling and ongoing listening events.

Throughout this report we have indicated the disparity in experience for Global Majority Staff, this disparity does extend to staff with other protected characteristics.

Through our Patient First methodology we have identified one key objective for UHD. Our new equality objective for 2024 – 2026 will be:

To have a representative workforce at all levels of the Trust.

As outlined in our *One Team* EDI Plan, to achieve this we will:

- strengthen our staff networks to work more closely with the UHD strategic needs and provide project support for engagement activity
- introduce clear guidance and requirements relating to inclusive recruitment with support from our Dorset Partners and our UHD Recruitment Team
- 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. This ambitious target requires significant cultural improvement and sufficient vacancies. As of 23/08/24, Global Majority representation is 18% at Band 6, 5% at Band 8a, and 7% at Band 8c.

Appendix 1: Useful Abbreviations

- BAME - Black, Asian and Minority Ethnic
- BME - Black Minority Ethnic
- EDI - Equality Diversity and inclusion
- EDIG - Equality Diversity and Inclusion Group
- FTSU: Freedom to Speak Up (Guardian)
- Global Majority – UHD terminology for Minority Ethnicity
- HR - Human Resources
- OD - Organisational Development
- PCC - People and Culture Committee
- WRES - Workforce Race Equality Standards
- WDES - Workforce Disability Equality Standards
- ICS – Integrated Care System
- IEN – Internationally Educated Nurse

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 08 January 2025

Agenda item: 9.1

Subject:	Risk Register Report - risks rated 15 and above
Prepared by:	Jo Sims, Associate Director for Quality Governance and Risk 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 247 approved risks on UHD's Risk register, of which 20 are rated as 15 and above.
Background:	The report is provided in accordance with the UHD Risk Management Strategy. 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	17/12/2024	Risks 1303 & 2132 were approved

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

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 November 2024 (updated post TMG on the 17/12/2024)

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 247 approved risks on UHDs Risk register, of which 20 are rated as 15 and above.

Population & System Risk	
Risk ID	2052
Risk Rating	20
Risk Title	Care of patients in non-clinical areas in the Emergency Department
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 • Ambulance handover SOP • Divert procedures including dynamic conveyancing • Escalation process
Gaps in controls	• Staffing is reliant on bank and agency workers and therefore levels are not always met • 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 • Decompress the Emergency Department to prevent crowding
Risk appetite scale	Cautious
Risk tolerance range	9-15
Tolerance breach?	Yes
Progress update	Risk remains, risk of corridor care, often for longer periods of time due to acuity and demand, recent coroner inquest where HISU patient with MH hx ligatured whilst being cared for in non-clinical area. Staffing now out over next three months to support care in non-clinical area - Review of escalations

Population & System Risk	
Risk ID	2132 (new risk agreed at TMG 17/12/24)
Risk Rating	16
Risk Title	Cystoscopes issues affecting patients and service provision
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 • The theatres team record the serial numbers of the cyctoscopes sent for repair to track if we are getting back the scopes • Quick turnaround of the scopes - prioritising the endoscopy service (by SSD team in BH). • Recording the information on why we have sent back the equipment to be able to challenge the decisions re the level of breakage. • 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 • The lack of consistent comms from the Manufacturer re: faulty scopes and reasons of scopes breaking.
Action plan(s)	• Report to MHRA • To explore other options for scopes repairs (different manufacturer) • To hold the meeting with Karl Storz to discuss the issues
Risk appetite scale	Cautious
Risk tolerance range	9-15
Tolerance breach?	Yes
Progress update	The risk has been approved at the Anaesthetics Governance meeting (14.11.2024) and at the SCG Governance Meeting (20.11.2024). Meeting minutes available on request.

Population & System Risk	
Risk ID	1970
Risk Rating	16
Risk Title	Glaucoma Virtual Review Backlog
Risk Description	If we don't address glaucoma reviews being done in a timely manner then there is a risk to patients of preventable, irreversible sight loss. There is also a risk to the Trust of litigation.
Executive sponsor	Chief Operating 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. • 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. • SOP - Technicians ask a series of questions which will inform them whether to flag the patient as a concern. • Timetable review for Glaucoma Nurse Specialists to enable them to support with virtual reviews.
Gaps in controls	• When a patient's pressure is high, but less than 30mmHg, or they have progressive field loss, as the patient is often not aware of the field loss, they can have permanent sight loss.
Action plan(s)	• To present the plan to set up additional clinics to the directorate • Recruit locum Glaucoma Consultant
Risk appetite scale	Cautious
Risk tolerance range	9-15
Tolerance breach?	Yes
Progress update	Risk rating to remain at 16 as not all systems are in place to support the reduction of Glaucoma backlog virtual reviews. Update received from Lead Orthoptist - Currently there are 2 Optometrists doing Glaucoma Virtual Review clinics. Between them they do 2 sessions per week. Update from Administration Manager - There are currently just over 200 Glaucoma Virtual Review Clinics outstanding to do. The team are up to reviewing tests patients had in September 2024. Interviews for the Glaucoma Consultant vacancy have taken place. (Outcome not yet communicated). Portland team will be brought in to help clear some of the Glaucoma patient backlog.

Population & System Risk	
Risk ID	1784
Risk Rating	16
Risk Title	Risk of not integrating teams and services and then reconfiguring to create the planned and emergency hospitals
Risk Description	Taking lessons from previous relocations, such as the one in Bristol, we have recognized the importance of integrating and operating services as a unified entity at least 6 to 9 months prior to any move. There will also be potential challenges associated with the hygiene factors such as staff rest areas and transport and we will need to have effective governance and communications in place to manage this.
Executive sponsor	Chief Strategy and Transformation Officer
Controls in place	• Prevention Evidence of effective governance workstreams • Speciality level plans in place • Meeting structure, attendance, escalation and resolution from speciality steering groups into CG and then Service Ready Group (SRG) • Service Reviews to assess readiness for moves with actions followed up by Care Groups • Robust critical path timeline that clearly articulates deliverables and interdependencies between specific deliverables • Good and effective management of individual programmes (Beach, NHP, Decants, Clinical Integration) • Focus on Critical Path actions • Detection: Internal Audit, NHP Scrutiny/Governance, external Gateway process, result of Service Review findings and progress on critical path actions. Go/No Go checklist and criteria
Gaps in controls	Moderate gaps: • Development and operational use of the integration dashboard • Changes to the build programme and interdependency with the reconfiguration programme • Assurance that actions identified at speciality, CG and during Speciality reviews are completed • Effective Working Groups in place to manage the hygiene factors (e.g. Travel Working Group and Improving Staff Experience Group)
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
Progress update	Risk remains the same. Review in January 2025. Full report updated and attached

Population & System Risk	
Risk ID	1460
Risk Rating	16
Risk Title	Inability to meet UEC 4-hour safety standard leading to an adverse impact on patient safety, statutory compliance and reputation
Risk Description	There is a potential risk of harm to patients waiting in excess of 4 hours in ED and being cared for in an inappropriate setting. There is also a risk to organisational performance, impacting on statutory compliance and reputation.
Executive sponsor	Chief Operating Officer
Controls in place	• Compliance with National 4 hr performance Standard • Performance review against metrics • Daily breach analysis • Efficient patient pathways and streaming process to SDEC's and UTC • Link to Risk 1426(Ambulance Queues) • Link to Risk 1387 and 1131 (Beds and Flow) • Patient assessment form (SHINE) • ED Trigger tool/ Delayed Care pathway • TAD Process evoked • Compliance with Trust and ED Escalation plans/SOPs • Avoidable lost time and patient delay • ED Primacy • IPS optimisation • All elements of initial assessment: TTT, TT first clinician and TT decision are all within 3 hrs of arrival • Diagnostic delays standards (blood tests/x-ray and CT) • 'Surge Management' criteria and plan • External transfers procedures (SWAST/EZEC/Other) compliant with patient category • Implementation of 4 and 12 hour escalation process and UHD ambulance divert policy. • 4 hour performance metrics linked to ED escalation • SWAST Corridor SOP • Escalation email/text process along with ED shift report template improvement
Gaps in controls	Gaps in assurance for sustainable delivery of 4-hour standard • SDEC pathways not in place 12 hours a day 7 days a week across all services. • Revised Escalation processes (ED and wider organisation) not yet embedded. • Gaps in recruitment remain a key challenge. • Capacity across the organisation to respond to the issues and take necessary action, including change management capacity, noting deployment of new ED IT System in June 2023 requiring priority. • UEC growth, MRTL numbers and industrial action could expose the Trust to reduced patient flow and performance • Type 3 data from MIU and UTC remains a manual process needs to be automated for new standards • Executive Enhanced support meeting has been put in place for the emergency department (Chief Medical Officer/Chief Nursing Officer & Chief Operating Officer).

	• ED Action plan to be reviewed and recast to reduce to a smaller number of actions over 30/60/90 days. • Clinical Engagement on supporting the Trust 4hour safety standard and further work on ensuring the Interprofessional standards are being followed. • Revised structure, focus and workplan for the Improving Hospital Flow Group developed for TMG review on 12th September. • Agyle IT ED System: Review of the operational configuration to ensure it supports the operational flow.
Action plan(s)	• System Exec meeting to review pressures, agree action and implementation plans • Revise and implement ED Action Plan (attached) • Improving Hospital Flow Programme report and actions • 4-hour standard 60 day plan • ED 4 Hour Safety Standard Implementation Plan
Risk appetite scale	Cautious
Risk tolerance range	9-15
Tolerance breach?	Yes
Progress update	Previous controls to support and improve ED flow remain ongoing. Redraft of UHD UEC action plan aligned to NHSE 12-week recovery plan with internal ED actions and actions to be developed through UEC board. November trajectory set at 76%, with breakdown of admitted and non-admitted contributions to support benchmarking. Redevelopment of trust-wide daily operational approach to support admitted performance. Updated UEC action plan

Population & System Risk	
Risk ID	1053
Risk Rating	16
Risk Title	Lack of capacity for elective & non elective activity and associated risk to patient harm due to LLOS and NCTR patients
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 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. There is daily oversight from discharge team of patients with no criteria to reside that are on P1-3. Care groups to confirm strategy of monitoring daily patients with no criteria to reside on P0. • Daily review of all NCTR patients with system partners by site Discharge team support and oversight with daily meetings Monday-Friday I believe. • Complex Care wards established both sites to focus expertise 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.

	Medical specialties looking to establish a similar model in the near future. • Discharge lounges both sites now established and actively pulling patients • Establishment of SPA data to track against • RTL/LLOS >21 LoS standards Weekly reviews of LLOS patients by senior matrons in MCG with Medical director with view of Longest LOS patients by CMO established. • D2A plans and home first principles to support external capacity - Home First Board and Delivery Groups 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) • HotW in situ for C2R Local and national reporting - (data completion/accuracy metrics) • HotW in situ for C2R Local and national reporting - (data completion/accuracy metrics) • LERN policy - There is a dashboard on cosmos which identifies any reported harms for patients with No criteria to reside. MCG report this info through quality forum and RAG. KLOE in panel meeting re; at point of incident did patient have a criteria to reside. • UEC performance metrics • Bed occupancy procedures and standards • Delivery of elective activity recovery plans 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 Strategic partner (Newton Group) engaged to commence in July a 10-week diagnostic across the Dorset system. Presentation to National Team on system wide approach System commissioned Newton to support ICB in reducing NCTR 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 • Challenges to accommodate patients who require elective care (due to outlying in elective beds) • Challenges to manage patient flow and bed capacity - getting patients into the right bed at the right time • The requirement and challenge to open and staff escalation capacity safely • Any delay in discharge can impact on flow and the ability to achieve the ED mean time standard and other UEC standards • 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. • Extended stay can increase the risk of hospital acquired infection and deterioration • 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. • Improve hospital flow using NHS ECIST tools. • Joint working with partner agencies and regional DOTC meetings. • System UEC Executive meeting to review current pressures and Q2 plan/in extremis actions • System wide risk assessment and action plan • Support for mental health patients who are medically fit for discharge/transfer • Internal Criteria to Reside Programme • Implementation of system Home First programme and associated pathways • UHD Capacity De-escalation Plan

	• ECIST CTA plan
Risk appetite scale	Cautious
Risk tolerance range	9-15
Tolerance breach?	Yes
Progress update	LLOS of stay reviews being established internally to target and reduce >14 day stays. Exec panel for oversight and complex cases, this is in its infancy. Weekly system meeting remain with oversight of work to reduce NCT2R, newton program of work being established.

Population & System Risk	
Risk ID	2070
Risk Rating	15
Risk Title	Using multiple UHD Theatres for surgery which currently do not have UPS or IPS
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
	  ○ Barn and Level 1 theatres have UPS back up - any patients needing to continue surgery will be transferred to these areas safely
	  ○ Move to open surgery if loss of stack/robotic systems
	  ○ Patients are to be made safe, woken and taken to recovery area
	  ○ Anaesthetic machines, theatre lights have approx 30 mins back up
	  ○ No surgery will continue unless life or limb in Level 1 or barn theatres
	• RBH
	  ○ Move to open surgery if loss of stack/robotic systems
	  ○ Patients are to be made safe, woken and taken to recovery area
	  ○ Anaesthetic machines, theatre lights have approx 30 mins back up
	  ○ No Surgery will continue unless life or limb

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 • The Surgical Care Group to escalate the risk to the Trust Board and Clinical Governance Group

	• 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
Progress update	Review of battery supplier - waiting for estates to confirm, Robotic battery backup being commissioned. DTBA Fire officers linked and risk assessment to be undertaken once installed following national and local compliance checks

Population & System Risk	
Risk ID	1665
Risk Rating	15
Risk Title	School age Neurodevelopmental service
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: - medicated and monitored to manage neurodevelopment issues - 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 • Local contractual expectation (provision of service and rejection of referrals) in place • Monitor of patient satisfaction via Complaints and claims • Escalation process in place and compliance monitored • Dorset Pathway in place and compliance monitored • Workforce template agreed • Monitoring of staff wellbeing through Absence, sickness & turnover
Gaps in controls	• National target achievement • Local contractual expectation (provision of service and rejection of referrals) • Poor patient satisfaction • Poor staff wellbeing
Action plan(s)	• Dedicated admin support for referral screening process • Reduce backlog of un-triaged referrals • Listening events & senior leadership visibility • Recruitment of nurse specialist to support workforce • Supporting SENCo's with regards to referrals • Medical recruitment

	• Process mapping exercise • To monitor the CDC School age service transformation plan • Engagement with ICB All Age Autism Pathway review • Medical / AHP recruitment
Risk appetite scale	Cautious
Risk tolerance range	9-15
Tolerance breach?	No
Progress update	Current priorities at ICS level is the approval of funding for 24/25 to be spent on short-term outsourcing to support reduction in the longest waits. Agreement at ND meeting to proceed and funding pots for UHD and DCH decided. Further work to standardise the outsourcing assessment pathway across Dorset is being worked on. Priority to get an agreed set of communications pan Dorset due to growing frustration with families and professionals due to the extended waiting times. Work also underway to risk stratify the waiting list / new referrals coming in to the service. Risk remains and current score appropriate.

Population & System Risk	
Risk ID	1502
Risk Rating	15
Risk Title	Mental Health Care in a Physical Health environment
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. In order to mitigate, there is a reliance on staff managing the patients risks and the environment.
Executive sponsor	Chief Operating Officer
Controls in place	• Safe staffing templates • Staff survey results and action plans • Training compliance • Service provision standards for Psych liaison • NICE standards • HSE standards • LERN policy • Managing challenging behaviour policy • Some ligature assessed areas • 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. • Staff are physical health trained and not all receive mental health training • staff may not have been trained to risk assess the environment for mental health patients • Not all areas have been risk assessed as a safe environment for mental health patients • Access to systems outside of UHD that contain mental health history

Action plan(s)	• Early intervention referral • Mental Health Training • RMN usage and requesting • Anti- ligature work • Mental Health Legislation • Section 17 leave • Least restrictive interventions policy • Training and Education Plan • Ligature light Policy and environmental risk factors • Right Care Right Person Trust implementation • To agree Metrics and KPIs in relation to Mental Health
Risk appetite scale	Cautious
Risk tolerance range	9-15
Tolerance breach?	No
Progress update	Environmental T&F group with project objectives set and moving forward with objectives and scoping. Work being undertaken by DCNO looking at workforce and supporting patients whilst in this environment.

Population & System Risk	
Risk ID	1395
Risk Rating	15
Risk Title	Lack of Capacity in Cellular Pathology Causing a Delay in Processing and Reporting
Risk Description	Very significant demand and capacity gap in department since 2019 exacerbated further by additional elective recovery activity.Insufficient medical, support and scientific staff available to maintain a safe clinically acceptable service due to increasing workload and complexity of requests. Delayed reporting of all cases, including cancers with direct adverse impact on patient referral-treatment times. UKAS accreditation may be affected. The number of DATIX entries and SI incidences may increase. High likelihood of staff burnout at all grades
Executive sponsor	Chief Operating Officer
Controls in place	• Business case for additional staff and incentive package submitted • Use of bank staff and locums where either are available • Use of overtime & recovery points where available • Monitoring and management of backlog with prioritisation of cases. Please refer to procedure on QPulse [B-CP-P-00043] • Implementation of push system • Review of clinical, scientific and support staff mix with every VRP (TRAC) • Contingency for Moh's, PGH & Cytology

	• Training for more staff to participate in Endoscopic Ultra-Soundography Fine Needle Aspiration and Endoscopic Broncho Ultra-Soundography Clinics • TAT monitoring – Weekly, monthly – all logged in QPulse • 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 • Significant gaps in staff structure • 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 • Trust to recruit 4 histopathologists to return to steady state • Department to accelerate BMS cut up training programmes • Department to accelerate BMS reporting training programmes • Department to implement order comms • Department to implement digital pathology • Department to implement AI • Trust to support demand management initiative • Funding Stream • Report for Finance committee • Report delays in recruitment • Trust to review MDT requirement to reduce commitment from pathology and radiology • 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
Progress update	Training for 2 x new ST2s underway in Poole. Department continues with insourcing and outsourcing work Seeking recovery from oncology for biomarker costs – SBAR in flight

Population & System Risk	
Risk ID	1303 (rating increased in month and agreed at TMG 17/12/24)
Risk Rating	15
Risk Title	Therapy Staffing impacting on flow
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 will negatively affect patient care & outcomes, optimisation of therapy treatments and the flow of patients through the Trust.
Executive sponsor	Chief Operating Office

Controls in place	• Staffing template • Recruitment policy • Sickness absence policy and procedures • LERN policy • Regional benchmarking-Critical Care provision standards • GPICS compliance • Provision of 7 day service in Critical Care standards • 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. • 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. • 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 • Approached DHC and RBCH for additional bank opportunities. Working on possibility of a shared bank across RBCH / PHFT. To agree honorary contracts. • Two locums have been sourced and the third one still being sought: start date of three months each from late July – late October 2019. • To engage with Live Well Dorset to provide insight on how we can support staff and manage turnover • Ensure induction processes and training plans for new graduates is comprehensive and timely. • Seek appropriate funding for therapy establishment • Recruitment • Operational management of therapy demand and capacity
Risk appetite scale	Cautious
Risk tolerance range	9-15
Tolerance breach?	No
Progress update	Risk presented at CGB 15/11/2024. NOF audit reflecting Trauma performance against NICE and CSP standards.

Quality (Outcome and Safety) Risk	
Risk ID	1961
Risk Rating	20
Risk Title	Failure of provision of service due to ageing sterilisers
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, • Escalation to Estates and the Estates Team will then investigate the reason for failure. • 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. • NHP funding no longer available • 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
Action plan(s)	• Replacement of sterilisers • Estates action - a technical and economic appraisal • 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
Progress update	Funding agreed, confirmed. Capital group supported. TMG – agreed. Finance committee - supported Capital agreed - 1 million this year 24/25 Planning meeting booked for 13/11/24 by Project manager to run through the works and discuss and confirm the brief, discuss programme, contractors etc

Quality (Outcome and Safety) Risk	
Risk ID	1855
Risk Rating	20
Risk Title	Lack of Breast Radiologists
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 • Review of Complaints reported • Known Cancer targets • Recruitment/retention processes • Weekend working and extra clinic in RBH • Waiting list to record backlog

Gaps in controls	• Lack of radiology capacity to sustain service. • 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 • Reduce Symptomatic Patient Backlog (Jigsaw/LBU)
Risk appetite scale	Minimal
Risk tolerance range	6-10
Tolerance breach?	Yes
Progress update	Discussed at Radiology Quality and Risk Meeting 07/11/24.

Quality (Outcome and Safety) Risk	
Risk ID	1214
Risk Rating	16
Risk Title	Risk of misdiagnosis/ incorrect treatment from use of ungoverned Point of Care devices
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 • Compliance with national standards • Service contracts • Point of Care co-ordinator • Contingency policy for majority tests by sending sample to the laboratory • Incidents • MDI procedures • Medical devices policy
Gaps in controls	• Ungoverned POCT devices non-compliant with MHRA standards • Non-compliance with national standards • Point of Care co-ordinator - single point of failure as insufficient staffing and succession planning not in place • No POC policy and standards • Scope does not include point of care ultrasound

Action plan(s)	• Quarterly EQA testing of glucose and ketone meters by Pathology • Audit of all Abbott blood sugar glucose and ketone equipment within service contact • Training for glucose and ketone meters provided by Abbott within contract, unable to evidence at trust level staff trained • Issues presented to HEG to raise awareness • Support for ketone monitors training/assurance by Diabetes CNS as time allows • Meeting between pathology diabetes CNS to review issues • Ward management of quality for blood gas analysers
Risk appetite scale	Minimal
Risk tolerance range	6-10
Tolerance breach?	Yes
Progress update	SBAR being drafted to support request for funds for staff to support with the audit, expected completion end of 2024.

Quality (Outcome and Safety) Risk	
Risk ID	1994
Risk Rating	16
Risk Title	Brachytherapy Low Dose Rate (LDR) and High Dose Rate (HDR) Ultrasound (US) equipment
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). 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. • Business case has been submitted to Care Group Board • 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 • There is currently no funding agreed for sourcing replacement equipment
Action plan(s)	Await outcome of SBAR presentation to Board and respond accordingly. Await outcome of Business case to secure funding for replacement of Ultrasound (US) equipment and respond accordingly. 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
Progress update	Discussed with finance deputy care group director. Approval sought and given by MEC chair to fund replacement. Once new US commissioned risk to be closed

Quality (Outcome and Safety) Risk	
Risk ID	1974
Risk Rating	16
Risk Title	Significant time delays for macular injection treatment
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. • Appointed a fourth Macular Nurse Practitioner (training and education will be required to ensure competencies are met and signed off). • Additional lists added, when staffing allows • Ophthalmology ED for emergency cases • 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. • 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. • 2 x macular coordinators reviewing patient wait times and prioritising • Direct line to macular coordinators who can escalate to Clinicians • Spreadsheet available for range of clinicians to review for oversight. • Regular Macular meeting to focus on long waiters and agree actions required (monthly and weekly meetings) • Creating a 'core team' within outpatients to work in macular training needs identified and started to roll out. This will also support retention • 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 • Budget to be identified to enable estates work to be completed and training to be given • The 4th Macular Nurse Practitioner will require a full training program. • Recruitment for replacement consultant needs to be undertaken (finance agreed)
Action plan(s)	• Recruitment of consultant • Support recruitment and retention • Identify space for macular service • Recruit additional Health Care Support Workers • 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
Progress update	Confirmation received that the IG forms and other forms required for the Opodi macular injector nurse have now been completed. 5 further HCAs have been accepted for the Eye OPD bank program. A training session has been scheduled. The staff will then do supernumerary shifts in Eye OPD and with the Macular Team to complete their competencies. Equipment for the Treatment Room to be ordered. Informal absence reviews have been held with Macular staff as per absence policy. Key themes from these and recent listening events with the team will be taken to a meeting with the Administration Manager and Macular Co-ordinator

Quality (Outcome and Safety) Risk	
Risk ID	1378
Risk Rating	15
Risk Title	Lack of Electronic results acknowledgement system
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. Combined with risk register item 1197 10/2/21. Provision of a clinical service for breast site specific disease that may require radiological, cytology or histology intervention to support diagnoses. All services that may require a radiological /histological /cytology intervention and therefore subject to an amended report. System does not alert requesting physician of change. Risk involves Surgery, Radiology, Pathology, and Informatics.
Executive sponsor	Chief Medical Officer
Controls in place	• Teams based notifications standards • External regulatory compliance standards • Compliance with GMC guidance re: the responsible clinician • Clinical in-patient worklist procedures • Health of the ward procedures • Royal College standard regarding referrers responsibilities • IT strategy • LERN policy
Gaps in controls	• ICE not fully implemented
Action plan(s)	• Referrer awareness • ICE App

Risk appetite scale	Minimal
Risk tolerance range	6-10
Tolerance breach?	Yes
Progress update	ICE filing is now in live use at the Trust. Currently filing status is sitting at 50% filed. It has been agreed that the target for filing is 90% to close this risk.

Quality (Outcome and Safety) Risk	
Risk ID	1276
Risk Rating	15
Risk Title	Unsafe and delayed patient care due to delays in surgery for # Neck of Femur patients
Risk Description	Risk of failure to achieve the NHFD standard that no more than 15% of patients have to wait longer than 36hrs post admission to undergo their surgery following a #NoF. Evidence shows that if patients wait more than 36hrs post injury for a #NoF they will have a worse outcome and longer recovery.
Executive sponsor	Chief Medical Officer
Controls in place	• NHFD standard • NICE standards • Validate procedures • Harm review procedures • CQC action plan • CQC KLOE
Gaps in controls	• Unable to consistently achieve target
Action plan(s)	• New structure for TAC team, Appoint new Trauma consultant • Proposal for a dedicated Trauma assessment and admissions unit. • Recovery plan
Risk appetite scale	Minimal
Risk tolerance range	6-10
Tolerance breach?	Yes
Progress update	In month position deteriorated due to surge in admissions of both #NOF and other trauma. Mitigated through additional capacity in month.

Sustainable Services	
Risk ID	1950
Risk Rating	20
Risk Title	The Trust Electronic Patient Record (EPR) will be unsupported from April 2027 and is not fit for purpose
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.
	• The majority of the trust IT systems that make up the EPR ecosystem have the following controls in place:
	  ○ Underpinning legal contracts with software suppliers
	  ○ Immutable backups (i.e. cannot be affected by malware)
	  ○ staff training programmes
	  ○ Active Information Asset Owners who undertake appropriate audits in line with the Data Security and Protection Toolkit
	  ○ UHD wide Business Continuity Plan
	  ○ Dedicated Subject Matter Experts in the clinical applications who maintain them in their optimal state
	  ○ Teams of people working to ensure that the underlying IT Infrastructure is maintained in an optimal state

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). • No effective single user interface for clinicians to manage their core care processes. • Local departmental Business Continuity Plans are not yet in place – these are in development with a plan to develop by March 2024.
Action plan(s)	• Option appraisal • Business continuity Plan • EPR internal mitigation
Risk appetite scale	Cautious
Risk tolerance range	9-15
Tolerance breach?	Yes
Progress update	The Business Continuity plan was tested during the EPR planned downtime. This is now a finalised document and process with some minor updates being completed. The EHR Business case is now affordable and is going back into the approval process during the week of the 25th of November.

Sustainable Services	
Risk ID	1595
Risk Rating	16
Risk Title	Medium Term Financial Sustainability
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. • Cost improvement programmes. • Contractual settlement with commissioners. • 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) • Alignment of approved nursing templates, e-roster templates and budgeted establishment. Mitigation; Full safe staffing review including realignment of approved templates, rosters and budgets underway (led =CNO) • Incomplete medical job plans and inconsistent premium medical rates. Mitigation: refreshed job planning policy, use of electronic systems, review of premium rates (Lead=CMO) • Inconsistent approach to the opening of unfunded escalation capacity. Mitigation: New SOP to inform consistent escalation process (Lead = COO)
Action plan(s)	• Medium Term Financial Sustainability
Risk appetite scale	Cautious
Risk tolerance range	9-15
Tolerance breach?	Yes
Progress update	The Risk was reviewed by FPC as part the financial report, no changes were noted.

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	12	4	3	1
	Likely (4)	3	31	28	15	2
	Possible (3)	2	27	49	15	1
	Unlikely (2)		7	29	7	0
	Rare (1)		2	2	2	1

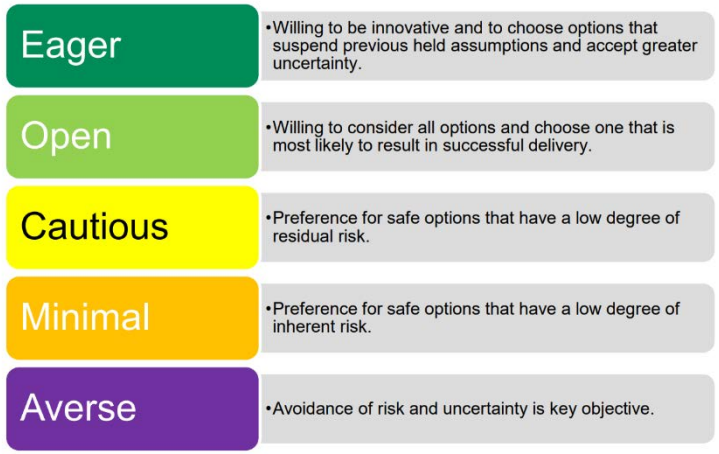
Current Risk score by month – rolling year (at the point of report date – taken as preceding month)

Current Risk Score– UHD total	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24
Very Low (1-3)	8	6	6	6	6	7	5	5	5	5	6	6
Low (4-6)	72	78	76	72	74	70	67	70	72	69	68	73
Moderate (8-10)	89	91	97	97	101	100	107	99	98	107	107	105
Moderate (12)	21	20	19	16	15	15	15	24	28	38	44	43
High (15 -25)	**23**	**21**	**19**	**19**	**17**	**17**	**17**	**19**	**15**	**16**	**16**	**20**
Total number of risks under review	**213**	**216**	**217**	**210**	**213**	**210**	**211**	**217**	**218**	**235**	**241**	**247**

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 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.

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. 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.

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

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**

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

Table 2 Likelihood score (L)

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

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

Appendix - Attendance at Part 1 Board Meetings

Part 1		01 May 2024	03 July 2024	04 September 2024	6 November 2024
	Beverley Bryant				
	Pankaj Dave				
	Judy Gillow			A	
	Siobhan Harrington				
	Sarah Herbert				
	Fiona Hoskins				
	John Lelliott				
	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				
	Ewan Gauvin				
	Alison Honour				A
	Irene Mardon				
	Lorraine Tonge				
	John Vinney	A	A	A	
	Klauda Zwolinska				
Was the meeting quorate?		Y	Y	Y	Y

Key

	Not in Attendance
A	Apologies
D	Delegate Sent