University Hospitals Dorset NHS Foundation Trust

Interim Board of Directors Part 1

Wednesday 27 January 2021

13:15 – 15:15

Via Microsoft Teams

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

University Hospitals Dorset
NHS Foundation Trust

INTERIM BOARD OF DIRECTORS PART 1
HELD IN PUBLIC

The next meeting of the University Hospitals Dorset NHS Foundation Trust held in public will commence at 13:15 on Wednesday 27 January 2021 via Microsoft Teams.

If you are unable to attend please notify the Company Secretary's Team, telephone 0300 019 2980

David Moss
Chairman

Please note that mobile devices and laptops may be in use during the meeting to access papers, record actions and notes as appropriate.

AGENDA – PUBLIC MEETING

13:15	1	Apologies for Absence:		
	2	Declarations of Interest		
	3	Patient Story		
	4	For Accuracy and to Agree: Minutes of the Interim Boards of Directors Meeting held on 25 November 2020		Chairman
	5	Matters Arising – Action List		Chairman
13:35	6	Chief Executive's Report		CE
	7	**RISK**		
	7.1	Update on Covid-19 (presentation)		CNO/COO
13:55	**8**	**QUALITY AND PERFORMANCE**		
	8.1	For discussion	Integrated Quality, Performance, Workforce and Finance Report	Chief Officers
	8.2	For information	Update on recovery of diagnostic and elective work (verbal)	COO
	8.3	For approval	Ockenden Report: assurance framework and safety action plan (verbal)	CNO
	8.4	For information	Quality Impact Assessment Overview Report	CNO
	8.5	For information	Six Month Safe Staffing Review (Q1 & Q2) 2020	CNO

14:40	**9**	**STRATEGY AND TRANSFORMATION**		
	9.1	For information	Update on Transformation (to include Estates) (presentation)	CSO
	9.2	For information	National Zero Carbon Strategy	CSO
14:50	**10**	**GOVERNANCE**		
	10.1	For approval	Charitable Funds Expenditure over £250k	CFO
	10.2	For approval	Board of Directors Governance Cycle	CoSec
	10.3	For approval	Chairman v Chief Executive Responsibilities Statement	CoSec
	10.4	For information	Statement on the Composition of the Non-Executive Directors	CoSec
	10.5	For approval	Board Policy for Engagement with the Council of Governors	CoSec
	10.6	For information	UHD Declaration of Directors' Interests and Fit and Proper Persons Declarations	CoSec

11 Questions from the Appointed Governors and Public arising from the agenda

Appointed Governors and Members of the public are requested to submit questions relating to the agenda by no later than Sunday 24 January 2021 to carrie.stone@uhd.nhs.uk

12 Any Other Business

13 Key points of communication

14 Date and Time of Next Meeting:

Wednesday 31 March 2021 at 13:15 via Microsoft Teams

15 2021 Meeting Dates: 31 March 2021; 26 May 2021; 28 July 2021; 29 September 2021; 24 November 2021.

16 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.

15:15 **17** NB: A glossary of abbreviations that may be used in the Board of Directors papers will be found at the back of the Part 1 papers.

AGENDA – PRIVATE MEETING

15:30	**18**	Welcome & Apologies for Absence:		Chairman
	19	Declarations of Interest		Chairman
	20	**APPROVAL OF MINUTES AND ACTIONS:**		
	20.1	For Accuracy and to Agree: Part 2 Minutes of meeting held on 25 November 2020		Chairman
	20.2	For Accuracy and to Agree: Part 2 Minutes of electronically facilitated meeting: 23rd December 2020		Chairman
	20.3	Matters Arising – Action List		Co Sec
15:40	**21**	**QUALITY, PERFORMANCE & RISK**		
	21.1	For information	Serious Incident Report	CMO
	21.2	For information	Risk Registers: New Red Risks	CNO
	22	**STRATEGY AND TRANSFORMATION**		
	22.1	For information	ICS Development	CEO/CSO/ A Betts
	23	**GOVERNANCE**		
	23.1	For approval	Yeoman's Way Business Case.	CSO
	23.2	For approval	HIP2 Capital Project	CSO
	23.3	For approval	Supply of Pathology Services for One Dorset	CFO
	23.4	For approval	Charities Merger	CFO
	23.5	For approval	MRI Scanner – Poole	CFO
	23.6	For information	Update on Operational Planning (verbal)	CFO/CSO
	23.7	For information	Update on the Joint Investment Committee	CFO
	23.8	For information	Board Committees: Exception Reports	Non-Exec Chairs
	24	Any other business		
	24.1	Key points of communication to staff		
	25	Board Reflection on the Current Meeting: • What has gone well; • What do we need to do more of; • What do we need to do less of.		
	26	Date and Time of Next Private Board Meeting: Interim Board of Directors Part 2 Meeting on Wednesday 24 February 2021 at 11 am via Microsoft Teams.		
17:00	**27**	Close of meeting.		

*Late paper

University Hospitals Dorset
NHS Foundation Trust

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

INTERIM BOARD OF DIRECTORS PART 1 – PUBLIC MEETING

Minutes of the meeting of the University Hospitals Dorset NHS Foundation Trust Interim Board of Directors held in public at 13:15 on Wednesday 25 November 2020 via Microsoft Teams.

Present:	Mr David Moss	Chairman
	Mr Pankaj Dave	Non-Executive Director
	Mr Philip Green	Non-Executive Director
	Mr Stephen Mount	Non-Executive Director
	Prof Christine Hallett	Non-Executive Director
	Prof Cliff Shearman	Non-Executive Director
	Mr John Lelliott	Non-Executive Director
	Mrs Caroline Tapster	Non-Executive Director
	Mrs Debbie Fleming	Chief Executive
	Dr Alyson O'Donnell	Chief Medical Officer
	Mrs Paula Shobbrook	Chief Nursing Officer
	Mr Peter Gill	Chief Informatics and IT Officer
	Mr Peter Papworth	Chief Finance Officer
	Ms Karen Allman	Chief People Officer
	Mr Richard Renaut	Chief Strategy and Transformation Officer
	Mr Mark Mould	Chief Operating Officer
In attendance:		
	Ms Zoe Jones	Corporate Governance Manager
	Mr Stephen Killen	Programme Director One Acute Network
	Mr Richard Moremon	Head of Communications (Transformation)
	Ms Karen Bowers	Matron (item 3)
	Ms Helen Martin	Freedom to Speak up Guardian (item 8.4)
	Mrs Carrie Stone	Company Secretary
	Ms Becci Watling	Endocrine Nurse Specialist (item 3)
	Mr Mike Weaver	Interim Assistant Company Secretary (minute taker)

BOD 164/20 Welcome and Apologies for Absence

Mr Moss welcomed everyone to the public Board of Directors meeting. Mr Moss welcomed newly appointed governors to the meeting and previous Public Governors. Mr Moss welcomed Ms Layton from the CQC, Dr Shah, Dermatologist, Chief Resident and a member of the Freedom to Speak Up Team and Ms Zoe Jones, Corporate Governance Manager who would be in attendance at the meeting today.

No apologies were noted.

BOD 165/20 Declarations of Interest

There were no declarations of interest noted.

BOD 166/20 Patient Story

Mrs Shobbrook welcomed Ms Watling, Endocrine Clinical Nurse Specialist and Ms Karen Bowers, Matron to the meeting. Ms Watling described a patient journey involving a patient with Addison's Disease.

Mr Moss thanked Ms Watling for a very moving, thought provoking patient story. Ms Bowers paid tribute to the two nurses and three consultants who provide the Endocrine Service. Mr Moss paid his own tribute to the excellent work undertaken by the team. Mr Shobbrook noted this was a great example of learning that illustrated how governance systems served to support early identification. What was particularly impressive was the work the team were doing across the system e.g. SWAST and the fact that an article about the service was published in The Endocrinologist.

Ms Watling and Ms Bowers left the meeting.

BOD 167/20 For Accuracy and to Agree: Joint Part 1 minutes of the PHFT and RBCHFT Boards of Directors Meeting held on 30 September 2020

The minutes were AGREED as a correct record of the meeting.

BOD 168/20 Matters Arising – Action List

It was NOTED and AGREED that all matters arising had been executed unless subject to this or a future meeting.

BOD 169/20 Chief Executive's Update

Mrs Fleming presented her report and highlighted the following key points:

- Earlier in the week all members of the Board received a note from Mrs Fleming that served to reiterate how challenged the Trust was with the second wave of COVID-19 and other associated matters that would be reported later in the meeting.
- Unlike the first wave of COVID-19, the Trust had not been asked to suspend its corporate activities. Even during the first wave of COVID-19 the Chief Executive's Report was published and the Trust worked hard to keep the public updated on what was happening in the hospital.
- The Trust was extremely busy operationally and remained focused on matters that required attention.
- In the view of staff and leaders within the Trust the second wave of COVID-19 was thought to be busier than the first wave. The numbers of patients admitted to the hospital had been higher in the second wave. Intensive care had been very busy and continued to be so. The Trust continued to undertake planned care work. Whilst the news of a vaccine was very welcome it did create another significant task to implement a programme of vaccination. A higher number of staff had been impacted by COVID-19 in the second wave. In addition to other staff sickness there were 300 staff off with COVID-19 related issues. The Trust was very challenged with its staffing.
- As part of the National Imaging Strategy, all Trusts had been asked to join one of the new regional imaging networks of which there are 21 across the country. The Trust had been allocated to the South East Three Imaging Network which was consistent with other Wessex networks. The Trust had to respond by the end of November with a formal letter to the Regional and National Teams at NHSI and NHSE confirming it was content with the proposed regional imaging network, content to work with its regional partners to form a partnership model and agree a leadership team with the right project resources.

- As part of agreeing to join one of the new regional imaging networks the Trust was asked not to enter into any long-term procurement arrangements that might be important if the Trust was working on a bigger geography. Mrs Fleming confirmed the Trust was not being prevented from continuing with current procurement plans as a result of agreeing to join a regional imaging network, which would be better for patients, Dr Ruth Williams, Deputy Chief Medical Officer, would form a key part in the new network and had been involved in early discussions.
- The Board was asked to approve the letter confirming joining the South East Three Imaging Network.
- Dr O'Donnell asked the Board to note a Radiology Vanguard had been in place for four years and there had already been a great deal of collaboration within the Dorset system. The National Imaging Strategy was a five-year programme of work.

Prof Shearman asked the Trust to confirm the image quality, transfer ability and other specifications would be as good as, if not better, than what was already in place. Dr O'Donnell confirmed it was expected the network would enable better access and ease of transfer of images particularly around tertiary pathways going both ways in order to avoid people having to repeat imaging unnecessarily and so improve diagnostics. The arrangements were likely to be very similar to that in the pathology network where work had been undertaken to align laboratory systems across the network.

Mrs Fleming was delighted to inform the Board that Mrs Shobbrook had been awarded the designation of visiting professor at Bournemouth University. This was in support of work undertaken with the Faculty of Health and Social Sciences.

Members of the Board NOTED and APPROVED the proposal for the Trust to confirm its commitment to join the South East Three Imaging Network.

The report was NOTED.

BOD 170/20 University Hospitals Dorset NHS Foundation Trust - Recovering Our Activity and Covid Update Briefing Paper

Mr Mould presented an update on COVID-19 and how the Trust was working to recover elective activity. Key points were noted as follows:

- The infection rate and local circumstances continued to vary across the country and therefore the Trust needed to respond according to local circumstances. The second wave of COVID-19 is different to the first wave. The increasing complexity of demands on all services in the context of a reduced workforce due to COVID-19 means the Trust is facing an increasing challenge to balance capacity and covid / non-covid pathways.
- The Trusts guiding principles are to plan and manage the COVID-19 demand during the second wave, safely maintain non-COVID-19 activity and services as much as possible and do all that can be done to support the health and wellbeing of staff.
- The Trust Incident Management structure included a tactical group that met twice a day and strategic group that met at least three times during the week. The Trust has a tactical group on site on a Saturday and Sunday that responds to the Director on-call.
- At any point in time the Trust was able to report the number of COVID-19 positive patients in the organisation broken down by ward. Mr Mould asked the Board to note the number of available beds in the Critical Care Blue

Beds.

- At this point in time there were 162 members of staff isolating, 121 who were symptomatic and 68 shielding.

Mrs Shobbrook continued the presentation. Key points were noted as follows:

- In addition to the Trust Incident Management structure described by Mr Mould the Trust held a daily control outbreak meeting in line with the Trust's Infection Prevention and Control practices, chaired by Mrs Shobbrook or one of her deputies.
- Infection Prevention and Control was key to ensuring the Trust was able to manage operationally across the organisation. Key to this aim was ensuring the COVID-19 positive and COVID-19 negative pathways are kept separate.
- The Trust works closely with the Dorset teams. There appeared to be a levelling out of cases as a consequence of the lockdown. However, this had yet to have an impact on the organisation.
- The Trust was focused on maintaining Infection Prevention and Control measures critical to breaking the chain of infection. This included cohorting patients, reducing the movement of staff, PPE, social distancing, estates and cleaning, training and visitor guidance.
- There had been a change to the national recommendations for screening. Patients are screened on admission, day three and day five.

Ms Allman provided an update on the Trust's Flu Vaccination Programme. Key points were noted as follows:

- The Trust continued with its commitment to achieve a high level of staff flu vaccination in 2020/2021.
- The Trust continued to offer drop-in clinics, 24-hour mobile vaccination and a flexible 'bleep' service.
- There were over 130 peer vaccinators. The Trust was awaiting guidance as to how soon staff may receive the COVID-19 vaccination after the flu vaccination.
- It would be a challenge to achieve 100% staff vaccination by the end of the year, although the Trust would continue to drive forward.

Mr Gill provided an update on the Trust COVID-19 Vaccination Programme. Key points were noted as follows:

- The first cohort to receive the COVID-19 vaccination was expected to be NHS staff and members of the public aged 80 and over.
- The Trust was working to mobilize systems that are ready to deploy the vaccine by Tuesday 1 December.
- The Pfizer vaccine was a logistical challenge. It needed to be stored at -80 degrees, two doses were required, and it could not be moved once it had been thawed. As a consequence it was not suitable for Primary Care Delivery. Primary Care are expected to wait for approval of the Astra Zeneca / Oxford vaccine.
- Mr Gill expressed his thanks to Executive colleagues for their support. Following a request for volunteers from Dr O'Donnell, 27 medical staff had volunteered to support the vaccination programme.

Dr O'Donnell provided an update on Lateral Flow Testing. Key points were noted as follows:

- Lateral Flow Testing was an important part of the Trust's Infection Prevention and Control measures.
- A significant number of staff that had tested positive for COVID-19 had been asymptomatic and that was the same picture seen nationally.

- The Trust had taken delivery of self-testing kits that provided a result in 20 to 30 minutes. The pilot programme for rolling out self-testing kits was starting today. With thanks to Mr Gill and his team the Trust had set up a web platform to gather data and signpost people to the most appropriate place if they tested positive. Subject to a successful pilot, the programme would be introduced to priority staff groups and then into the wider organisation over the next one to two weeks.

Ms Allman provided an update on the staff wellbeing programme. Key points were noted as follows:

- The Trust continued to develop its programme of support for staff that included access to specialist services and safe spaces where staff may rest and eat.
- There was a particular focus on supporting BAME colleagues, making sure they were linked into all the services they need. This was supported by the excellent Trust BAME network. The Trust was working alongside Pro Ability colleagues to recognise additional specific needs.
- Information was out in the public domain for staff to access and they had the opportunity through the links and all staff briefings to raise any concerns they may have. Staff may also access the Freedom to Speak Up Team if they chose to.
- The Trust was constantly reviewing how it may continue to support its staff.

Mr Mould presented an update on EU Transition. Key points were noted as follows:

- The Trust continued to monitor and respond to any requests for information or actions that needed to be taken with regards to preparation and planning for the EU Transition.
- The Trust needed to remain agile enough to consider other matters that may impact on the Trust e.g. Avian Flu.
- A concern regarding Avian Influenza, with infection of wild birds in the South West including Weymouth had led to an Avian Influenza Prevention zone across the whole of England. Whilst Public Health England had advised that the risk to public health from Avian Flu was very low, UHD had pathways in place for both Emergency Departments.

Mr Mould presented an update on Phase 3 Covid Recovery. Key points were noted as follows:

- The Trust holds weekly operational meeting to review progress with Phase 3 Covid Recovery. The Trust was making good progress. However, for a number of months the Trust's elective activity was impacted by COVID-19 and it would prove difficult if not impossible to recover all the lost activity especially with the current Infection Prevention and Control measures in place and the need to operate separate patient pathways. Some patients had decided to postpone their procedure until a time when COVID-19 was not as prevalent in the population as it is at the present time.
- The Trust had a number of Quality Improvement Programmes in place in ED and the Elective Recovery Programme.

Prof Hallett asked to see more detail of how the Trust was tackling health inequalities as part of its Non-Covid Elective Recovery Programme. Mr Moss noted the Board had discussed Equality and Diversity at a seminar that morning. Mr Moss suggested the Board should note the need to discuss health inequalities when the Trust received the data and guidance as to what was expected of the Trust.

Mr Mould agreed to include reference to performance regarding health inequalities in future IPR's. **Action: MM**

The report was NOTED.

BOD 171/20 Winter Plan / Phase 2 Covid Plan

Mr Mould introduced the final iteration of the University Hospitals Dorset Winter plan and asked the Board to approve the final iteration. Key points were noted as follows:

- An appendix to the Winter plan included a more detailed Covid Phase 2 response plan which described all the escalation areas that had been worked on as part of the plan.
- The plan included the COVID-19, EU Transition, Influenza, Avian Flu and Winter in general.
- The plan included the System Draft Surge Plan in order to assure the Board it was aligned with the winter plan. The final iteration of the System Draft Surge Plan would need to be signed off by the Integrated Care System.

The Board NOTED and APPROVED the University Hospitals Dorset NHS Foundation Trust Operational Plan for Quarters Three and Four.

BOD 172/20 Integrated Performance Report (IPR) October 2020

Mr Mould presented a report on the operational performance of the Trust during October 2020 that included recovery plans. Key points were noted as follows:

- Referral to Treatment (RTT): the Trust had seen an improvement from August to September and September to October in particular the percentage of people seen within 18 weeks. However, there were an increasing number of people waiting a longer length of time. Even with all the plans in place the Trust expected the number of people waiting over 52 weeks to increase by the end of March 2021. The increase was circa 300 people per month.
- Diagnostics Waiting Times and Activity (DM01): 91% of people across the organisation were now receiving their diagnostics in six weeks. An incredible achievement.
- Emergency Department: challenges around both Emergency Departments continued both in egress and there were an increasing number of people attending the Emergency Departments. There were challenges around testing capacity at the front door and patients needed to be managed through the COVID-19 positive and COVID-19 negative pathways.
- Ambulance handovers were a big challenge to the Trust. The Trust had agreed a plan with the Clinical Commissioning Group (CCG) to improve performance.
- The Trust continued to work towards meeting the 62 Cancer Wait time standard (CWT). This was mainly due to significant increase in referral numbers , a trend across Wessex Cancer Alliance but more so at UHD, the catch up of the diagnostic tests back log that had progressed. The October / November position on cancer was unvalidated. However, the Trust expected to see a further improved position.
- In terns of activity recovery the Trust was starting to see around 80% of activity across most areas compared to previous years. The Trust's Finance and Performance Committee undertook a detailed review of the number of people in particular specialities.

Mrs Shobbrook provided an update on the key performance indicators relating to quality, safety and patient experience. The following key points were highlighted:

- The Quality Committee reviewed the quality metrics in detail at its meeting on 23 November.
- With the current operational and COVID-19 pressures there had been an increase in the number of patient moves, particularly out of hours in order to assist with supporting COVID-19 pathways.
- The Trust had maintained stable performance with regard to the fundamentals of care metrics despite the ongoing operational pressures. The number of Pressure Ulcers and Inpatient Falls remained stable.
- With a continued focus on Infection Prevention and Control practice there had been a fall in the number of reported Hospital Acquired Infections including MRSA, MSSA. C.diff and E.coli.

Ms Allman provided an update on the key performance indicators relating to Workforce. The following key points were highlighted:

- Staff sickness absence had increased. The introduction of self-testing kits referred to by Dr O'Donnell under item 170/20 would help to manage the process better
- A cohort of overseas nurses were due to join the Trust on 14 December. Staff will receive a welcome pack and reside in shared accommodation in their cluster for a period of isolation before they commence their role. The Trust is working to make the period of isolation as positive as possible. During this time staff will complete their statutory and mandatory training.

Mr Papworth presented a report on financial performance for Month 7. The following key points were highlighted:

- The Board approved the Month 7 to 12 plan at its meeting in Private on 28 October 2020.
- At the end of October the Trust was £26,000 behind plan. The Trust was not unduly concerned and continued to forecast achievement of the plan. There was significant volatility in the Trust's expenditure base given the unprecedented circumstances the Trust was facing. It was therefore difficult to forecast with certainty.
- The Trust had received confirmation of funding for lateral flow testing and the mass vaccination programme and awaits further detail of how and when the funding will flow to the Trust.
- There was volatility in the Trust Capital Plan, a very significant capital plan worth circa. £53m that was increased by £24m in new funding received in year. Whilst this was very welcome this did place pressure on the team to deliver the capital programme by the end of March 2021. As reported previously, the Trust had formalised a £6m underspend that was passed back to the ICS and onto SWAT for them to utilise in year.
- The Chancellor had set out his plans in the spending review. UK borrowing had increased to £34b, 19% of GDP, the highest recorded level in peacetime history. The NHS was expected to receive an extra £3b in funding to tackle the backlog of long waiting patients, mental health referrals and support existing pressures. The Trust awaited further details of the level funding to be received by the Trust and incorporate this into operational planning.
- The NHS had been excluded from the announced pay freeze for public sector workers. Funding for COVID-19 next year will total circa £55b.

Mr Moss thanked members of the Board for their reports, noting the Integrated Performance Report (IPR) was intended to be a concise way of summarising Trust performance. Mrs Tapster confirmed the Quality Committee reviewed the quality and safety aspects of the IPR at its meeting on 23 November. The Committee also received detailed reports from each Care Group that drilled down into issues around risk, serious incidents and safety

Mrs Tapster noted nationally, there had been difficulties with discharging medically ready to leave patients to care homes because of a lack of designated homes to receive patients and asked to know the position in Dorset. Mr Papworth reported a number of care homes in Dorset had wanted to be designated homes but subsequently had to withdraw their offer because of problems with their indemnity insurance. Dr O'Donnell noted of the 15 care homes that put themselves forward to be designated care homes in Dorset only one was able to consider taking it forward. There were no designated acre homes in the whole of the South West. This position was being rapidly reviewed and it was likely there would be other models of care e.g. community hospital bed spaces that would be brought into use. Mr Mould confirmed community hospitals are taking COVID-19 positive patients who would have gone into residential and nursing care homes. The interim care workforce across the system was supporting COVID-19 positive patients back into their own home and such measures are important in maintaining the flow of patients from UHD.

Mr Dave noted a number of patients were choosing to cancel their appointments or not attend for treatment and asked was it a reasonable assumption to say that once the Trust returned to business as usual the length of stay may increase and acuity of patients may become more serious.

Mr Mould confirmed the Trust records and assigns a code to patients who choose not to attend for their appointment. This allowed the Trust to keep track of patients on the waiting list who still want or need to attend an appointment but have declined to attend at this present time. Dr O'Donnell noted where patients are needing emergency treatment they are accessing that as they normally would. The Trust was not seeing a higher level of acuity when patients are presenting for treatment. There are concerns with regard to a reported decrease in referrals into the two week wait pathways. The Trust had re-established its diagnostic pathways over the last two months. Concerns existed with regard to patients with a cancer diagnosis who may present in a later stage of their pathway and this may impact on their outlook. The Trust was therefore working to maintain as much of its diagnostic and elective pathway as possible in order to minimise the risk of patients with a cancer diagnosis presenting in a later stage of their pathway.

Mr Mount noted the quality, breadth and depth of information reported in the IPR compared very favourably with some of the best in class, commercial performance reports. The IPR provides a very strong underpinning for looking at performance of the Trust going forward.

Mr Lelliott noted the contract with the independent sector was due to end in December and asked to know whether the contract would be extended. Mr Mould confirmed the Trust had been notified today the contract would be terminated on 24 December, a week earlier than previously planned. The Trust was working with the independent sector to secure as much capacity as possible between January and the end of March 2021. The Trust was also gathering activity information and consulted with all specialities to identify what capacity was needed. At present the national contract had not been signed. It was hoped the activity between January and March would be funded by the Treasury. From April onwards the Dorset system would need to identify the resource required to tackle the total backlog during 2021/2022.

The report was NOTED.

BOD 173/20 Mortality Report

Dr O'Donnell presented the first combined mortality report, with the key points noted as follows:

- The Trust had held the inaugural meeting of the Combined Mortality Surveillance Group for UHD. The meeting was well attended and included representatives from both Trust sites.
- This was the first time the Trust had been able to produce directly comparable metrics for the two sites as well as the overall Trust mortality metrics.
- All metrics were as expected, or better than expected.
- The Trust was close to achieving 100% screening of all deaths by the medical examiner.
- The mortality review process was continuing and going well. There was some deep dive work underway to understand coding and coding differences and that work was progressing well.
- Dr O'Donnell reported on a mortality review at Poole Hospital following a COVID-19 outbreak in one of the older people's services. It was important to note the review was looking at deaths associated with COVID-19, not necessarily death that was caused by COVID-19. The Trust had put a very robust process in place to look at the whole cohort and findings would be reported to a future meeting of the Quality Committee.

Mr Green noted work was progressing well with understanding the divergence in Summary Hospital-level Mortality Indicator (SHMI) and the Hospital Standardised Mortality Ratio (HSMR) reported at Poole Hospital and asked to know when the Trust would be in a position to report its definitive findings and advise if there are any safety implications.

Dr O'Donnell confirmed there was nothing at this stage that would indicate there were any safety implications. There was an element in relation to how Poole Hospital captured palliative care coding and there were also differences in how the palliative care teams work which had an impact on the HSMR. There were a number of diagnostic relative risks that were being reviewed, although the COVID-19 work had taken precedence, and this had slowed progress with the work. The Trust had chosen to review the pneumonia care pathway because it was the nest surrogate for general medical pathways and if there was any significant patient safety concern that would be seen in this pathway. Dr O'Donnell assured the Board there were no patient safety concerns to be reported at this time. It would take between 6 to 9 months before the numbers converged. Dr O'Donnell confirmed the Board would be kept updated as work progressed.

The report was NOTED.

BOD 174/20 Freedom to Speak Up Bi-annual report

Mr Moss welcomed Ms Martin, Freedom to Speak Up Guardian to the meeting. Ms Martin presented the Freedom to Speak Up Bi-annual report, with the key points noted as follows:

- This paper was a bi-annual regulatory requirement to update the Board on speaking up and the purpose of this paper was to celebrate progress in creating our speaking up culture within 2020/21, understand why staff are raising concerns and what had been learnt and ask the Board to approve the annual board commitment to the Sir Robert Francis principles and declaration of behaviours.

- UHD was proud to confirm that its governance for speaking up was now supported by Non-Executive Director, Christine Hallett. This role would be alongside the executive lead which remained the CEO, Mrs Fleming.
- The FTSU team was now well established across all sites of UHD and had been in place since 2017. This October, the Trust celebrated the third national Speak Up Month which happened to coincide with the launch of UHD. Throughout October the Trust supported the national programme Alphabet of Speak Up and took the opportunity to promote the Trust FTSU network. During October, the team spoke to over 700 staff, visited all three sites and relaunched the FTSU branding. Following conversations with staff there was a 65% increase in referrals compared to the previous month.
- The FTSU index for both Trusts had increased since 2019 and was higher than the national average.
- The Model Hospital had just released a culture and engagement module.
- The FTSU team had been very busy since April. Activity at Bournemouth peaked at the same time as the first COVID-19 peak and activity at Poole Hospital increased after work and activities in October. Year to date the number of referrals had gone up on all four sites compared to 2019.
- The leading reason why staff approached the FTSU team was to do with process and policy. Fifty per cent of issues raised included management processes such as appraisals, return to work support, rotas, feedback from interviews, supporting staff through merger, support during formal processes, sickness management and coding. A number of these issues clearly will have needed expert HR advice and further signposting with the FTSU team supporting staff during this time.
- 34% of total referrals across all sites were related to COVID issues (15, 25% at Poole and 34, 44% at RBH). COVID related themes included guidance for patients and staff, PPE, testing, working environment, working from home decisions and staff redeployment.
- The Trust had focused on the learning from these themes. Ms Martin presented a summary of Lived experiences from staff during Covid.
- The majority of cases brought to the FTSU team circa 50% are referred to the line manager. The FTSU team act as a conduit and provide reassurance and guidance to assist in that process. A number of cases were signposted to colleagues in Human Resources, Occupational Health, Risk and Governance. In Bournemouth 16% or referrals were escalated up to a senior level and at Poole 8% were escalated up to a senior level.
- The focus for 2020/2021 would include embedding learning, supporting the key themes, supporting the EDI strategy and keeping the ambassador team with support and development. A key piece of work going forward would be to consider the medical workforce.
- Ms Martin asked the Board to continue role modelling, speak up themselves and encourage others to do so, be curious in the questions they have and celebrate when people do speak up. Ms Martin asked the Board to promote speaking up as a cultural cornerstone and welcomed the new Trust values that included being open and honest.

Mr Moss thanked Ms Martin for an interesting report that reflected the very valuable work undertaken by the FTSU team. Mr Lelliott asked to know if the FTSU team worked with the networks relating to Equality, Diversity and Inclusion (EDI) and was there triangulation between FTSU and EDI. Ms Martin confirmed the FTSU team analysed feedback in order to identify how many people that had spoken up, came from a BAME cultural background. The FTSU team worked very closely with the BAME network and they often referred to each other. There was a joint trolley round during the FTSU month.

Mr Green expressed his thanks to Ms Martin for her report and the work undertaken by herself and the ambassadorial team. When reviewing individual concerns was there the opportunity to track those back to CQC inspection reports and recommendations and perhaps even the CQC Insight Reports to see if there were any emerging themes. Ms Martin agreed there was the opportunity to triangulate all sources of data including the annual staff survey. The team would also visit areas where there was no apparent data. The team worked closely with the CQC Engagement Manager.

Prof Shearman reported it was disappointing to note the low level of feedback from medical staff and asked if the Trust triangulated FTSU data with GMC trainee feedback which would pick up bullying and harassment. Prof Shearman observed there was a need for a different solution for medical staff as many worked in a hierarchical system which made it difficult for staff to perhaps raise concerns. Ms Martin confirmed the Trust did look at GMC trainee feedback. The FTSU ambassadors included two chief residents who were able to provide insight and peer to peer support. The Trust had just been shortlisted for a Health Service Journal (HSJ) Award, Speaking up at Royal Bournemouth and Christchurch Hospitals: An International Medical Graduate (IMG) experience.

Mrs Shobbrook thanked Ms Martin for the FTSU support in relation to COVID. Concerns had been raised, some anonymously, and FTSU was one of the ways staff could provide feedback and receive support from the Trust.

Mr Mount proposed Ms Martin and Mr Moremon should be invited back to update the Board on how the work of the FTSU Team could help inform future development of the Trust's culture and values and provide feedback for future staff appraisals. Prof Hallett reported the Trust was very fortunate to have the work of Ms Martin and the ambassadors. The Trust had a national profile for this work as well as a strong track record locally. This was vital work and was done very well in UHD.

The Board NOTED and APPROVED the annual board commitment to Sir Robert Francis principles and declaration of behaviours.

BOD 175/20 Update on Transformation (to include Estates)

Mr Renaut provided an update to the Board of Directors on key aspects of communication relating to the construction changes across the Bournemouth and Poole Hospital sites, with the key points noted as follows:

- The Board were asked to note a slide set and briefing document that set out the communications for what would become a major building programme across the Trust's estate.
- Mr Killen introduced a short animation that showed the development of Poole Hospital's new theatre complex. Overall there would be 15 theatres. As well as the new theatre complex, the project included development of a new Urgent Treatment Centre, expansion of the outpatients department, cancer and diagnostic services as well as the community hub. Construction work was expected to start in November 2020 and is expected to be completed in early 2023.
- Mr Killen introduced a short animation that showed the development of the Bournemouth Hospital site that included development of Maternity and Children's Emergency and Critical Care Unit. The work also included ward refurbishments, multi storey car park extension, new pathology hub as well as upgrades to energy IT and other infrastructure. The Trust was expected to take possession from summer 2024 onwards. The road works and landscaping were expected to be finished by September 2024.

Mr Moss noted communication to staff, the public and other stakeholders was going to be a very important part of the Trust's work over the next 5 years. Mr Moremon reported he would be looking after the communications of all of the transformation programme going on across the Trust. The Trust had a very good partnership with IHP who would be supporting communications. This morning the team were out delivering the first edition of the project newsletter, a copy of which was included in the meeting pack. Mrs Fleming noted it was important to connect so directly with the local population that was served by the Trust.

The report was NOTED.

BOD 176/20 Charitable Funds Expenditure over £250k

The Board NOTED there were no items to approve.

BOD 177/20 Poole Charity Accounts 2019/20 and Letter of Representation

Mr Papworth presented the Poole 2019/20 Trustee's Report and Accounts, with the key points noted as follows:

- The 2019/20 Accounts and Trustee's Report had been prepared in line with national guidance.
- The 2019/20 Accounts and Trustee's Report had been audited with an unqualified opinion with no recommendations or audit adjustments.
- It was a standard letter of representation with no specific wording or changes for the charity.
- The Trustee's Report and Accounts were presented to the Charitable Funds Committee meeting on 6 November 2020 and recommended to the Board of Directors for approval.
- Mr Papworth expressed his thanks to all volunteers, staff and donors and thanked the local community for its outstanding support for the charity.

Mr Moss noted the Trust was very fortunate to have such strong commitment from people working to raise money for the Poole and Bournemouth charities.

The Board NOTED and APPROVED the Poole Charity 2019/20 Trustee's Report and Accounts

BOD 178/20 Bournemouth Charity 2019/20 Trustee's Report and Accounts

Mr Papworth presented the Bournemouth Charity 2019/20 Trustee's Report and Accounts, with the key points noted as follows:

- The 2019/20 Accounts and Trustee's Report had been prepared in line with national guidance.
- The 2019/20 Accounts and Trustee's Report had been audited with an unqualified opinion with no recommendations or audit adjustments.
- It was a standard letter of representation with no specific wording or changes for the charity.
- The Trustee's Report and Accounts were presented to the Charitable Funds Committee meeting on 6 November 2020 and recommended to the Board of Directors for approval.
- As before, Mr Papworth expressed his thanks to all volunteers, staff and donors and thanked the local community for its outstanding support for the charity

Mr Moss noted the Board would be discussing plans for the development of the Trusts charitable funds that would include plans for bringing the charitable funds together and looking at how they would be organised in the future. Mr Papworth confirmed there would be a verbal update at the Trust Board meeting in Private today and there would be a formal recommendation to the Trust Board in January 2021.

The Board NOTED and APPROVED the Bournemouth Charity 2019/20 Trustee's Report and Accounts

BOD 179/20 Questions from the Council of Governors and the Public arising from the agenda

Mr Moss noted the Trust had four appointed Governors and elections were taking place for public and staff governors. The results of the election were expected within the next two weeks. The Board looked forward to welcoming the new staff and public governors.

Mr Moss noted the following question received in advance from Mr Howard Fincher, a former Governor of RBCH.

This question is about adult cancer treatment services, for which the two main treatments are distributed across the two main Trust sites - chemotherapy at Bournemouth and radiotherapy at Poole. Many post-merger priorities for clinical services reconfiguration have been published, but I have not seen adult cancer treatment services mentioned in this context. So looking forward to the coming decade, what is the likely shape of adult cancer treatment services in the Trust - and where will the newer treatments of immunotherapy and targeted therapy fit in as they become more widely available?

The following response was provided to Mr Fincher:

The Dorset Cancer Centre currently provides a range of services across the county. This includes Radiotherapy at Poole Hospital and Dorset County Hospital, and chemotherapy and outpatient services in Poole, Royal Bournemouth and Dorset County Hospitals, as well as some clinics in community hospitals, for example there is a chemotherapy service in Wareham, and outpatient clinics in Swanage and Wimborne.

As part of the reconfiguration of Poole and Royal Bournemouth Hospitals, Oncology and Haematology inpatient and acute oncology services will move to Royal Bournemouth Hospital and be part of the major emergency site, so they are close to the main emergency department and critical care. Outpatient and chemotherapy services will continue to run on both sites and in the community as they do now. Radiotherapy will also remain on the Poole site at the moment, although longer term plans are for radiotherapy to move to the major emergency site to be close to the oncology ward in line with the equipment replacements that are due in eight to ten years' time.

Immunotherapy and targeted therapy treatments of many different types and regimens are already being given to patients receiving care in UHD. The use of these drugs is evolving rapidly, and the chemotherapy service is adapting to cope with the changing demands on it. The likelihood is there will be more chemotherapy clinics in the community in the future, as demands for these services increase and in line with bringing care close to home.

Dr O'Donnell reported the oncology and haematology teams have been actively involved in service redesign. The Dorset Cancer service provides treatment to patients across the county. At present, the inpatient oncology centre is in Poole and there is outpatient chemotherapy and outpatient services in Poole, Bournemouth, Dorset County and community hospital clinics and chemotherapy services in a number of local hospitals. All of those community services will continue post reconfiguration and in fact there are a number of new treatments coming online that will mean there are likely to be more treatment options that will be delivered close to home or even in people's homes. In terms of inpatient beds the expectation is that once the major emergency site is built the oncology services will be co-located with intensive care services, surgery and all the other acute services that need to be co-located with oncology services. Radiotherapy will continue to be provided on the Poole site ay least in the interim period until the bunkers for the Linux machines need to be replaced, 8 to 10 years in the future. The imperative is to keep as many services as close to home as possible. Mr Moss added the palliative care service will continue to be Forest Home and the Macmillan Unit in Christchurch.

Councillor Beryl Ezzard, Appointed Governor, Dorset Council asked to know if the plans for Poole and Bournemouth Hospitals were available to the general public and whether they have been through the planning process.

Mr Renaut confirmed both plans had received planning approval from BPC (and previous to that completed judicial review and Secretary of state / IRP approval). Mr Renaut confirmed information was in the public domain and but as per the Board papers the Trust would promote these plans further.

Councillor Ezzard thanked Mr Renaut for his response and noted previous discussion with regard to journey times to Bournemouth Hospital from Swanage and Wareham and the Purbecks. Mr Moss was aware of concerns with regard to travel times, particularly in the Purbeck area. The Trust would be able to provide more information with regard to that matter.

With regard to the construction changes across the Bournemouth and Poole Hospital sites Councillor Paul Hilliard, Appointed Governor, BCP Council asked the Trust to ensure that throughout the programme of work the Trust maintained clear signage for parking and clear directional signs for the hospital entrance and wards. Cllr Hilliard noted the Echo ran a story that reported there were a 1000 COVID-19 positive in the BCP area and asked to know how many COVID-19 positive cases there were in BCP.

Mrs Shobbrook reported the Trust was testing and identifying those people with COVID-19. Across the country and in BCP there were people in the community that have COVID-19 but had no symptoms. When patients came into the hospital they received a swab and so it was possible to identify if they were carrying the virus or not. The Trust had very clear pathways for patients attending the Emergency Department who were COVID positive and COVID negative. Patients that were due to attend for elective care received a swab and isolate before they come into hospital.

Mr Moss noted the need for effective sign posting.

BOD 180/20 Any Other Business

None declared

BOD 181/20 Key Points of Communication to staff

Mr Moss noted the following points for communication to staff:-

1. Covid Recovery and Winter Planning.
2. Vaccination.
3. Freedom to Speak Up.
4. The Transformation Programme and construction changes across the Bournemouth and Poole Hospital sites.
5. The Poole and Bournemouth Hospital Charity.

Mr Moss thanked everybody for their contributions at today's meeting.

BOD 182/20 Date and Time of the Next Meeting

Wednesday 27 January 2021 at 13:15 via Microsoft Teams

Agreed as a correct record of the meeting:

*Chairman*_____ *Date* _____

NHS
University Hospitals Dorset
NHS Foundation Trust

MATTERS ARISING: ACTION TRACKER JANUARY 2021

Meeting Date	Minute No.	Matter Arising / Action	Trust / Lead	Due Date	Update
25/11/2020	170/20	Mr Mould agreed to include reference to performance regarding health inequalities in future IPR's.	MM	27/01/21	To be discussed under matters arising

FUTURE ACTIONS: NONE

Meeting Date	Minute No.	Matter Arising / Action	Trust / Lead	Due Date	Update

Key:	Outstanding	In Progress	Complete	Future Action

BOARD OF DIRECTORS MEETING
27 January 2021
CHIEF EXECUTIVE REPORT

1. Update on Covid-19 Pressures

Members will be aware that the situation nationally and locally has become even more challenging since the start of 2021, given the recent rapid spread of Covid-19. At the time of writing, infection rates in England are 622 per 100,000 people, the rates in the south west are 390 per 100,000, whilst the rates in BCP council and Dorset Council are 891 and 333 respectively.

Within our hospitals, we have never been so busy. At the time of writing, there are 435 Covid-19 patients receiving care within our wards, with 27 patients receiving treatment within our two Intensive Care Units. We continue to work with our local partners in Dorset and the Independent Sector to capitalise on capacity and resources across the system, so as to be able to meet the increased demand.

The Trust is currently operating in Major Incident mode (OPEL 4) but we are committed to prioritising the safety of all our patients. Due to the numbers of patients that have Covid-19, bed limitations and staff shortages, we have had to make a difficult decision to make some reduction in our elective procedures and operations. All outpatient appointments will remain as virtual clinics unless an examination is required, with patient lists being reviewed daily so as to prioritise those with highest clinical need.

This is clearly an extremely difficult and distressing time for those waiting for hospital care. Every effort is being made to maintain effective communications with patients whose planned care has been disrupted.

We are all encouraged by the recent national lockdown which should mean that Covid-19 numbers start to reduce again over the next few weeks. Most importantly, excellent progress is being made nationally and locally in rolling out the vaccine, the route by which our country will eventually return to normality.

Plans are in place on both acute sites to manage blue (Covid) and green (non-Covid) pathways and these are reviewed on a daily basis at our Outbreak Control and tactical meetings. All infection, prevention and control (IPC) measures are in place, and regularly reviewed, in line with national guidance. This includes the following:

- Cohorting and segregation of patients
- Testing of patients and staff
- Reducing the movement of staff
- Ensuring that the appropriate PPE is worn by all staff
- Implementing and encouraging all staff to adhere to social distancing measures
- Estates and cleaning
- Reviewing training needs
- Updating visitor's guidance

Despite all the challenges that we are facing, and that fact that at times, we are not able to maintain services to our usual standard, the Trust has done incredibly well in maintaining essential services throughout the pandemic.

2. Staff wellbeing and resilience

The Trust is working hard to ensure that staff are appropriately supported during these incredibly challenging times. Throughout the Covid-19 pandemic we have been developing and reviewing our offer to staff, to ensure that this meets their needs, and to assist them in maintaining resilience.

Our offer includes a mix of both internal UHD support and access to external agencies, including (but not limited to) the following:

- creating safe spaces and rest areas so that staff have access to somewhere quiet to relax
- providing access to specialist counselling and psychological support
- providing nutritional support – ensuring that our clinical staff providing care to patients (particularly in the 'blue' areas of the Trust) are receiving adequate supplies of food and drink
- seeking feedback from our staff via a range of methods, for example – wellbeing conversations, schwartz rounds (reflective practice forums), staff surveys, spiritual and pastoral care and access to our Freedom to Speak Up Guardian and the team
- creating 'mini sessions' for self-care e.g. breathing techniques, sleep and coping with stress
- promoting wellbeing walks and physical activity
- mobilising inoculation programmes – i.e. flu jab and Covid-19 vaccine
- establishing a Health & Wellbeing Executive Champion
- providing further support including trauma risk assessments and mental health First Aiders

We are constantly listening to feedback from staff and introducing changes as necessary, to ensure that any issues/concerns are addressed, and additional supports are introduced. Very importantly, we are seeking to maintain an open, positive culture where staff feel confident to raise concerns, and where it is acceptable to ask for help.

Finally, I should like to thank all those charities, businesses and individuals who have continued to donate resources aimed at supporting our staff. These donations have made an enormous difference in ensuring that we are able to move swiftly in response to the various needs expressed.

3. Update on the Covid-19 Vaccine

The Trust commenced vaccinating staff and other priority groups, in line with national guidance on 28 December 2020, utilising the Pfizer vaccination. Since then, we have been consistently expanding the service, administering increasing numbers each day. The Trust is administering vaccinations in line with national guidance to the priority groups, as laid down by the Joint Committee on Vaccination and Immunisations (JCVI). This means that we are providing the vaccination for Care Home staff and NHS staff. The roll out of the programme is going extremely well (both nationally and locally), and we have already vaccinated a large proportion of our staff. This means that we have prioritised those staff who themselves are most vulnerable and those who are working in the areas with the greatest risk. We have now made an offer to all UHD staff to have the vaccination.

Both the Pfizer and the AstraZeneca vaccinations will ultimately be given in two doses for maximum protection. However, the Joint Committee on Vaccination and Immunisations (JCVI) has carefully reviewed the evidence on the level of protection following a first dose of either vaccine, and it has been nationally mandated that second doses should be given at 10-12 weeks. It has been agreed that this approach will provide the broadest possible public health benefit.

Once again, I should like to express my thanks to all those who have worked so hard to set up the new vaccination service and make sure it works well. Seeing the programme up and running is hugely encouraging - indeed, it is a clear signal that there will be an end to this current lockdown and the pandemic.

4. Update on Covid Testing

I am pleased to confirm that the capacity for rapid testing across the Trust has expanded significantly this month, which means that we are now able to get swifter results for those patients admitted in an emergency. This will have a beneficial impact on patient flow through the Emergency Department, and should assist in reducing ambulance handover delays. Nevertheless, this service remains under great pressures, and we are continuing to seek further opportunities for increasing the number of rapid tests available – particularly on the Poole site.

Work continues to expand our standard covid testing service – that is, be able to meet the very high demand for routine covid-19 tests that only require a "same-day" turnaround time. Bournemouth University (BU) continues to support some of this work, assisting with the training of staff and our work to improve processes. We shall also start using a new platform in February – the Perkin Elmer - which is expected to be a 'game changer' in the volume of tests that we can undertake on site. By February, we expect to be able to carry out 500 tests per day, with same day results, and in time, this is expected to increase up to 1,200 tests per day once it is running 24/7.

Very importantly, we have now started testing asymptomatic staff in line with national guidance, using lateral flow testing kits. This testing commenced in early December 2020 when we first received the necessary supplies as part of the national roll out, and I am pleased to confirm that 8882 kits have now been allocated to staff, starting with those in patient/public facing services. Additional supplies have now been received and all staff should have received their first kit by Friday 22 January.

Furthermore, the national ordering system has now commenced and UHD have submitted a request for delivery of 15,000 for late January / early February in order to re-stock staff supplies and commence maternity testing for mothers and support partners, as per national guidance.

5. Developments in Maternity Services

Members will be aware that the Ockenden Report was published in December 2020 highlighting the emerging findings and recommendations from the independent review of maternity services at the Shrewsbury and Telford Hospitals NHS Trust. Despite considerable progress having been made nationally in improving maternity safety, there continues to be too much variation in the experience and outcomes for women and their families. The Ockenden Report and its 7 Immediate and Essential Actions (IEA) describe the efforts required to bring forward lasting improvements in our maternity services.

On 14 December 2020, NHS England & NHS Improvement (NHSE/I) wrote to all Trusts following the publication of the Ockenden Report, requesting confirmation that the 12 urgent clinical priorities from the IEAs had been implemented. The priorities come under the following themes:

- Enhanced safety
- Listening to women and their families
- Staff training and working together
- Managing complex pregnancy
- Risk assessment throughout pregnancy
- Monitoring fetal wellbeing
- Informed consent

Our Quality Committee received a briefing on the Ockenden Report and the steps being taken within UHD at its meeting on 21 December 2020. Since then, the Trust has submitted its response to the South West Regional Chief Midwife (Helen Williams), confirming that we have already achieved and fully implemented 10 of the 12 key priorities outlined within the report. Furthermore, the Local Maternity System (LMS) in Dorset is appropriately sighted on this information and its Chair (Nicola Lucey) has written to the regional team to express her full support of our submission.

Due to the Covid-19 pandemic and current operational pressures, NHSE/I has now extended the deadline for the submission of the more detailed Assurance Assessment Tool until 15 February 2021. This tool will enable us to complete a detailed gap analysis to support the development of our individual maternity safety action plans, which will need to be implemented throughout 2021.

Meanwhile, the Trust continues to carry out and update detailed risk assessments in conjunction with the Infection Control team, relating to the visiting policy during the Covid-19 pandemic. Unfortunately, the maternity unit on the Poole site is an old building, and was never designed to provide care for the high number of patients that currently use this facility. Members will be aware that one of the most important benefits of our transformation programme will be to establish a new, modern, purpose-built maternity unit on the Royal Bournemouth site, but unfortunately, this development is still some years away.

The limited space available within the Poole maternity unit increases the risk of infection for patients, visitors and staff. Therefore, we still have to impose some restriction on visiting and partners attending for certain scans/treatments.

The Trust is very keen to commence lateral flow testing for women and their support partners, which would enable them to come on site more frequently. However, until such time as more lateral flow tests are made available as part of the national roll out, the Trust is unable to do this.

It is anticipated that more kits will become available by late January / beginning of February, and these will be brought into use as soon as possible as per IPC guidelines. We aim for support partners to be able to return to the unit, but we will only be in a position to review and potentially allow this once we are in receipt of further expected national guidance. In the meantime, we must maintain our strict visiting rules.

Nevertheless, we have been engaging and listening to women as we have been working through these issues, and it is important to note that partners **are able to attend** the following important events:

- the 20 week scan;
- the birth of their baby.

In this way, the Trust is doing its very best to ensure that mothers have familiar support with them at such a special time, and that the importance of family bonding continues to be properly recognised.

It is recognised that the Covid-19 pandemic and these additional restrictions can create significant stress for families. The situation is being continually reassessed in line with national guidance, so that we can offer the best experience for patients and their families, consistent with safe clinical practice.

6. Developing our New Organisation

Establishing the Council of Governors

I am delighted to confirm that the new Council of Governors (CoG) for (UHD) was fully established on 1 January 2021, following the elections for public and staff governors.

The following were elected to the Bournemouth Constituency:

- Judith Adda;
- Sharon Collett;
- Marjorie Houghton;
- Keith Mitchell;
- Sue Parsons
- Diane Smelt.

Christchurch, East Dorset and the Rest of England constituency:

- Richard Allen;
- Chris Archibold;
- Carole Light;
- Robin Sadler;
- Sandy Wilson.

Poole and the Rest of Dorset constituency:

- Robert Bufton;
- Christine Cooney;
- Andrew McLeod;
- Patricia Scott;
- David Triplow;
- Michelle Whitehurst.

The Staff Constituencies are as follows:

- Marie Cleary
- Cameron Ingham
- Markus Pettit
- Kani Trehorn.

Our key stakeholders are also asked to appoint Governors from their respective organisations to join our CoG. NHS Dorset CCG nominated Dr David Richardson, Dorset Council nominated Cllr Beryl Ezzard, Bournemouth, Christchurch and Poole Council nominated Cllr Paul Hilliard and Bournemouth University nominated Professor Steven Tee. In January 2021, the UHD Volunteers Group nominated Mr Connor Morton, bringing the total of appointed Governors to 5. Each has a tenure of 3 years from the dates of their respective appointments.

The outcome of the elections has been published on the Trust's website and we shall shortly be providing photographs of all the new Trust's Governors. The first meeting of the Council of Governors will take place on Thursday, 28 January 2021 with the papers available to view on the Trust's website later this week.

Developing our Values

Members will be aware that we formally adopted a new set of values for University Hospitals Dorset in October 2020. The new UHD values are as follows:-

- We are caring
- We are one team
- We listen to understand
- We are open and honest
- We are always improving

- We are inclusive

This work is extremely important in that these values will be used as part of our recruitment and appraisal processes and will shape the way in which we behave towards our patients and each other. As such, this agreement marks a vital stage in the development of our organisation and will shape the culture within UHD for many years to come.

Further work has since been carried out since then to develop the visual identify for these values, and we expect to launch this in February 2021.

7. Update on the Capital Programme

The University Hospitals Dorset extensive multi-year capital programme continues, utilising funds that have been allocated to the Trust for a number of different purposes. This includes Covid-19 allocations, transformation capital, and funds that have been released to support backlog maintenance activities across all three of our sites. Although some members of the Strategy, Transformation and Estates team have been seconded to other parts of the Trust to support colleagues in dealing with the pandemic, the majority of staff within the team have remained focused on delivering the transformation programmes. Only in this way can we ensure that essential projects are delivered by the end of 2020/21, and indeed, over the next 5-10 years.

In earlier updates, it has been noted that representatives of UHD would be attending the Joint Investment Committee (a combined meeting of DHSC and NHSE/I) on 13 November 2020 to agree the Outline Business Case. However, this meeting was postponed and actually took place on the 1 December 2020.

The Trust has received very positive feedback from the meeting, with the team being described as follows: *"[the Trust]… was professional, well planned, balanced and demonstrated detailed grip. It was great to hear the Trust's enthusiasm for the project and to have the opportunity to confirm to the committee your commitment to deliver the project for the benefit of the population you serve"*.

We have since heard that the Joint Investment Committee supported our case to go forward, although we are still awaiting formal confirmation on this from Ministers and/or Treasury.

Meanwhile, the Trust has been working very closely with BCP Council to achieve full planning permission regarding the developments on the Bournemouth Hospital site and to agree the reserved matters. The Trust had originally hoped that BCP Council would approve the Section 106 and formally confirm the outline planning decision by the 8 December 2020, but formal approval was not secured until 13 January 2020. The Trust will now be submitting a Reserved Matters application and it is hoped that the essential enabling works are able to commence in March 2021. Unfortunately, this represents a four-week delay before work can start on site, compared to our original plans.

Staff and visitors will notice some changes across the Poole Hospital and Royal Bournemouth sites over the next few months. Work on the Poole theatres has already commenced as detailed in my previous report, and work will soon be starting on the development of the new retail pharmacy and the new west entrance (Eye Unit) on the Royal Bournemouth Hospital site.

Looking ahead, it is hoped that the Guaranteed Maximum Prices for several of our projects will be confirmed in the early part of 2021. This will allow us to finalise and submit the Full Business Case when we receive formal approval of the OBC from Treasury.

Finally, it is important to note that the team has now commenced the clinical design phase relating to the bed solution across our sites. These changes will be delivered through the "New Hospital Programme" funding that is expected to be allocated to UHD as part of the Dorset system, with the Strategic Outline Case for all these proposals being submitted at the

end of January. A “Round Table” event with the National New Hospital Programme Team is due to take place in January, and the Board will be further updated on the outcome of this next month.

8. Developing the Dorset System

Members will be aware that NHS England & NHS Improvement recently published a consultation document ‘Integrated Care: next steps to build strong and effective integrated care systems across England’, detailing the vision for a more effective and responsive care system across England. The document sets out how NHS organisations, local councils, frontline professionals and others will join forces in an integrated care system (ICS) in every part of England from April 2021. All organisations/systems were asked to provide responses to four key questions by 8 January 2021.

- Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?

- Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?

- Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?

- Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

There has been much discussion about this consultation at various meetings nationally and locally, and in general, there is support for the proposals contained within the document, aimed at strengthening system working. The UHD response to the consultation was made on 8 January 2021, and we agreed with three of the four proposals, with the only ‘disagree’ being the transfer of NHS England commissioned services to each ICS. This was largely based on financial risk and the availability of skills and expertise that might not be transferred effectively to each ICS in order to commission these services, many of which are more suitably commissioned at a regional or national level. We also contributed to the consultation by feeding in to the wider Dorset ICS response, which was very similar to that of the Trust.

It is anticipated that the outcome of this consultation will be published within in the next month or two, although like every other initiative, this will depend on progress in reducing the spread of Covid-19. Further updates will follow and will be provided to Board members as the national picture develops further throughout 2021/22.

In the meantime, UHD representatives will continue to work collaboratively with our local partners in developing the future ICS for Dorset, noting that there are both opportunities and risks for UHD associated with this policy.

9. EU Transition

Members will be aware that the UK formally left the European Union (EU) on the 31 December 2020 and the free movement of people, goods and services ceased on 1 January 2021. The Trust has a formal EU Transition Task & Finish Group which continues to monitor and oversee risks and mitigations. Furthermore, we continue to submit daily returns to NHSE&I and so far no issues have been raised.

The following areas have been involved:

- **Data –** NHS organisations and staff have been advised to continue to handle data as they currently do (which is covered by GDPR). An agreement has been reached which includes a provision to provide for the continued free flow of personal data from the EU and EEA EFTA States to the UK until adequacy decisions are adopted, and for no longer than six months. The UK has, on a transitional basis, deemed the EU and EEA EFTA States to be adequate to allow to for data flows from the UK. The organisation's data protection officer has put in place safeguards to ensure that data continues to flow to and from the UK and the EEA after the end of the transition period. This safeguard against any interruption of the free flow of data from the EU.
- **Supplies –** the UK is well prepared for any disruption to supplies with 6 week's stock of medication/devices readily available (including vaccines). The Poole Hospital site has recently received an extra delivery of Roche reagents to mitigate against any problems with the supply chain. Both internal and external mechanisms are in place to escalate any shortages/concerns; none so far have been raised.
- **Reciprocal healthcare –** a new UK Global Health Insurance Card (GHIC) will be available from the new year in recognition of the new agreement with the EU, replacing the EHIC and allowing UK nationals to continue to have access to emergency and necessary healthcare cover when they travel to the EU. However, people will still be able to use their EHIC after 1 January when travelling to the EU. Current cards will remain valid until their expiry date.
- **Research and Clinical Networks –** the NHS and government are working with organisations sponsoring and running clinical trials and investigations to ensure that research continues as normal in the coming months.
- **Workforce –** employment contracts will not change for EU citizens already working with us, recognition of professional qualifications continues for 2 years and most healthcare roles are exempt from restrictions of the Immigration bill. The immigration surcharge does not apply to registered professional or family members. UHD continues to support EU staff members.

10. Transformation and Innovation

I am pleased to inform members that UHD is down to the last 12 places in a bid submitted to the Health Foundation Adopting Innovation Fund. This programme will provide funding for four Innovation Hubs across the UK, with up to £475,000 for each hub, for two and a half years.

The development of an Innovation Hub in Dorset is aimed at supporting spread and adoption of improvements across the system that have been proven, but aren't yet widespread. The work builds on a recent review carried out by the Academic Health Sciences Network of our two former Trusts, whereby it was found that there was much good practice, but opportunities for improvements in terms of spotting innovation, supporting it and evaluating roll out.

This is an extremely exciting and unique opportunity to create change that will further improve patient care. It is very much hoped that our bid will ultimately be successful.

11. Operational priorities for winter and 2021/22

On 23 December 2020, the Trust received a letter from the national team outlining the operational priorities for winter and throughout 2021/22. This included some initial guidance in relation to the financial planning process for 2021/22, with confirmation that detailed guidance and revised allocations would be published in January. However, it has subsequently been confirmed that a planning and contracting round will not be initiated before the end of March given the relentless pressure Trusts are facing. The current financial arrangements will therefore be rolled over for the first quarter of 2021/22 with a planning process expected to inform the financial plan for the remainder of the new financial year. This is expected to see a return to previous financial arrangements, supported by additional funding

for ongoing Covid-19 cost pressures together with the £1 billion of funding for elective recovery announced as part of the Autumn Spending Review.

The Trust will keep abreast of national developments and will re-set its annual planning processes accordingly.

12. Development of the Caldicott Principles

Members will be aware that the appropriate sharing of information is pivotal to the provision of safe and effective care across the health and social care system. The Caldicott Principles were originally developed in 1997 following a review as to how the NHS handled patient information. The results led to the creation of six initial principles relating to patient confidentiality. The Caldicott Principles are now known as being the fundamentals that organisations should follow to protect any information that could identify a patient, such as their name and their records. A further seventh principle was introduced in 2013 and an eighth new principle has recently been introduced: *inform patients and service users about how their confidential information is used*.

New guidance will be published this year, which will explicitly define the Caldicott Guardians' role and responsibilities, and UHD will do everything possible to mobilise a range of steps to ensure that patients, service users and/or their representatives have clear expectations of how and why their confidential information is used, and the choices that they have. Our Caldicott Guardian is Alyson O'Donnell (Chief Medical Officer) whilst Peter Gill (Chief Informatics & IT Officer) is the Senior Responsible Officer.

13. Good News

I am delighted to report that Minnie Klepacz (Ophthalmology Matron & BAME Lead) has been recognised in the *Covid Kindness UK:2020* book for her incredible efforts to support others and her founding of the Filipino Nurses Association UK, going over and beyond her daily matron duties. Members will be aware that Minnie was also awarded the British Empire Medal for her services to nursing during the pandemic. Across the Trust, we are all immensely proud we are of Minnie and grateful to her for her ongoing commitment to her patients and her colleagues.

Members will aware that the Bournemouth Echo highlighted the issues facing the Trust and the dedication of our teams in a feature that was published on 11 January 2021. Andy Martin, Newsquest's regional associate director explored the human stories behind the headlines as UHD faces the unprecedented challenge of delivering healthcare amid the continuing pandemic. The report showcased 'what it's like inside' within both RBH and Poole Hospitals, with Andy having interviewed a range of colleagues including our deputy chief medical officer (Dr Matt Thomas), medical director for medicine (Dr Tristan Richardson), medical director for surgery (Dr Rob Howell), emergency planning officer (Libby Beesley), emergency department consultant (Dr Dave Martin) critical care matron (Eoin Scott), emergency department matron (Brice Hopkins), associate director of operations (BJ Waltho) and more.

Mrs Debbie Fleming
Chief Executive

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 27 January 2021

Agenda item: 8.1

Subject:	University Hospitals Dorset NHS Foundation Trust Integrated Performance Report (IPR) December 2020

Prepared by:	Executive Directors, Donna Parker, Jackie Coles, David Mills, Fiona Hoskins, Louise Hamilton-Welsh, Andrew Goodwin
Presented by:	Executive Directors for specific service areas

Purpose of paper:	To inform the Board of Directors and Sub Committees members on the performance of the Trust during December 2020 and consider the content of recovery plans
Background:	Our integrated performance report (IPR) will be published monthly and includes a set of indicators covering the main aspects of the Trust's performance relating to safety, quality, experience, workforce and operational performance. It gives the public and staff better quality information about the performance of our hospital in the areas that matter to them. It shows the indicators that are used to measure performance for each of the Trust's operational areas and how well key services are delivering. The IPR is a detailed report that gives a range of forums ability if needed to deep dive into a particular area of interest for additional information and scrutiny. The document provides a single 'shared truth' of performance across the organisation. All NHS organisations received a letter from Amanda Pritchard (Chief Operating Officer NHSE/I) and Julian Kelly (NHS Chief Financial Officer) on 23 December 2020 detailing the ongoing Operational priorities for winter and 2021/22 recognising the extraordinary challenge of Covid-19 wave 3. **Key priorities for the rest of 2020/21:** A. Responding to Covid-19 demand B. Pulling out all the stops to implement the Covid-19 vaccination programme. C. Maximising capacity in all settings to treat non-Covid-19 patients D. Responding to other emergency demand and managing winter pressures E. Supporting the health and wellbeing of our workforce F. Recover non-covid services

Key points for Board members:

Areas of Board Focus

1. Increasing number of covid positive patients occupying beds has increased further the number elective patients waiting for treatment. The level of staff sickness to maintain all services during the 3rd wave covid and the impact this may have on the fundamentals of care. Increased future costs of addressing the number of patients waiting treatment. Impact on hospital reputation.

2. Increased occupancy across the organisation reducing hospital flow, creating increased pressures in the emergency departments/admission portals and ambulance handover and wait to be seen times. Potential impact on patient experience. Current number of patients who are medically ready to leave and not meeting criteria to reside. Workforce availability to meet escalating capacity levels, driving increased agency costs and potential impact on quality. Impact on hospital reputation.

Operational Performance

Emergency Care

Following merger, the Royal Bournemouth Hospital site is moving to the reporting of the proposed new urgent and emergency care standards as a University Hospitals Dorset wide approach. This joins the Poole Hospital site which had been one of 14 trusts across England to test these. Internally, as part of the transition, we are continuing to monitor the traditional 4 hour standard on the Royal Bournemouth Hospital site. Consultation Guidance has now been circulated relating to the proposed national metrics for EDs

Operational (Field testing standards) and Internal Care Standards

(colours based on change from last month)

		Dec-20		
Standard	**Aim**	**Poole**	**RBCH**	**Combined**
Operational (Field testing standards)				
Mean time in the dept	200 mins	235 mins	259 mins	248 mins
Time to assessment	15 mins	4 mins	8 mins	6 mins
Internal Care Standards				
Time to triage (*RBCH: to assessment*)	15 mins	4 mins	8 mins	6 mins
Time to first clinician seen (*RBCH: to Dr seen*)	60 mins	70 mins	108 mins	91 mins
Time waited for a bed (*RBCH: DTA to left dept*)	60 mins	183 mins	135 mins	156 mins

The other key emergency care related standards/metrics are:

- Ambulance handover delays:
  - *30+ min delay trajectory for improvement submitted to CCG. Some improvement seen in November and early December, but significant challenges late December particularly relating to department and Covid isolation capacity together with surges*
  - *60+ min delays – unfortunately these challenges meant we did have a number of breaches*
- Occupancy, flow and criteria to reside (long waits for medically optimised for discharge patients) – *Occupancy and bed days attributable to long waiting patients.*

Key points for Board members:	***Emergency Dept*** Both departments saw similar levels of attendances and emergency admissions in December compared to November and levels remained below last year's. Ambulance conveyances were below last year at Poole site, though remained similar to last year's levels at RBH site. Both departments saw an increase in Type 1 meantime in December and continued to be challenged above 200 mins. Time to clinician improved at the Poole site though remained challenged at the Bournemouth site, however, mean bed wait deteriorated on both sites with the pressure of rapid covid testing capacity and different bed pathways dependent on 'Blue or green' outcome. Increasing incidence of Covid-19 across the BCP and Dorset areas meant an increasing level of patients presenting to the EDs with suspected Covid-19. This put increasing pressure on the department capacity, in particular, isolation capacity. The impact of Covid and increased acuity also saw delays in admissions from the EDs. The complexity of minimising patient moves in the hospital (e.g. whilst awaiting swab results) to protect patients, as well as downstream capacity (including where beds closed to achieve social distancing), delayed flow into assessment units. Ongoing monitoring of the 30+min ambulance handover improvement trajectory agreed with our commissioners continued. November and early December did see some improvements but this and the 60+min standard was extremely challenged with the increasing acuity and presentations of suspected Covid-19 patients. However, this remains work in progress to reach a more consistent, sustainable position. Progress against ambulance and ED improvement plans include: • Separate admission unit for confirmed Covid-19 patients • Additional isolation capacity created within ED • Increased Covid-19 wards to support flow to downstream capacity • Nurse template review completed across both sites – *further work to review the model and flow within the department to be reviewed at RBH, including ambulatory areas. Noting, significant staff challenges across the Trust due to Covid related absence* • NHS111 First pilots commenced booking into AEC and Frailty Same Day Emergency Care (SDEC) • NHS111 First booking into ED continues, further NHS111 recruitment • Work to refresh the defined 'purpose'/model for ED to support discussions and pathway/process developments with hospital-wide specialities • Doctors being redirected at handover for more flexible approach to covering department areas, noting new junior doctors commenced December • Joint UHD escalation process being reviewed supported by work with SWAST, including review of pathways for ambulance conveyance • HALO support to ambulance handovers

Key points for Board members:	***Occupancy, Flow and Discharge*** (*See exception report in IPR pack*). Higher acuity and high levels of occupancy were born out in longer waits for a bed at the front door. Whilst overall occupancy was 85% across both sites, significant bed closures to meet infection control protocols and limited flexibility in use of specialist beds (e.g., Paediatric, End of Live etc.) challenged our available inpatient capacity. Swabbing protocols and turnaround times, including awaiting results in a bay before moving patients has exacerbated the complexity of managing flow. This is overseen by daily site-based Flow meetings, supported by Inpatient Capacity and Infection Control groups; with escalation to the joint UHD Tactical and Strategic Groups as required. Improvements made over the last month have included: establishing a separate Covid-19 admission unit, increasing Covid-19 ward capacity and 24/7 swab processing. Positively, focused work with partners and additional community hospital and community/social care capacity saw patients medically optimised for discharge in the hospital stabilise. Consequently, we also saw a reduction in bed days for patients with a length of stay over 21 days and for over 7 days remained stable. However, concern remains about the sustainability of this improvement and ability to achieve a further step change particularly as we approach the next Covid-19 peak. The Home First Programme and internally supporting D2A workstreams continue, though a number of challenges have remained: • Potential for positive patients tests for up to 90 days creating complexity for discharge – noting new Dorset protocol for discharges 14+ days post positive swab now in place. • Community and care home closures due to infection control protocols and staff shortages • Capacity for covid positive patients no longer requiring acute care. • Work in progress to establish internal data collection at ward level to fully understand patients who do/don't meet Criteria to Reside. **Actions are detailed in the *exception report* but include:** • Streamlining processes, especially those that do not require full MDT approach. • Development of twice daily metrics to increase understanding and target areas for improvement. • Reconfiguration of community hospital capacity to support blue pathways. • Additional community hospital and care capacity • Internal QI programme to drive internal improvements around Board rounds/data collection in determining patients who do/don't meet Criteria to Reside.

Key points for Board members:

Surge and Escalation Planning

Our Winter and Covid Plans remain under regular review. These have included additional beds, workforce and critical care capacity, as well as escalation plans based on increasing incidence/admissions, bed closures and staffing levels, amongst others. We continue to strive to maintain our elective Phase 3 plans, though noting pressures on all inpatient areas has meant a reduction at this present time. System support for the discharge of Medically Optimised patients remains key. Furthermore, we are continuing to seek and support improvements to urgent care through our Urgent & Emergency Care Quality & Performance Improvement Programme, noting the significant challenges of managing Covid demand.

Regional winter sitrep and trigger exception reporting is ongoing. Both sites have been required to provide reports on trigger due to: delays in ED or ambulance handovers, levels of closed beds due to infection control, and/or elective cancellations. This reflects the picture nationally.

The 2nd phase of capital works to improve the Frailty Unit was completed in December though this is currently forming our Covid-19 admission unit to support pathways for these patients and overall flow. All 'winter' beds are now open across both sites

Referral to Treatment (RTT)

Providers and commissioners are required to plan on the basis that their RTT waiting list, measured as the number of patients on an incomplete pathway, will be no higher in March 2021 than in March 2019. At the end of December 20 there were 44,117 patients on the waiting list, more than the combined March 2019 position of 42,587, this is an improved position from November 20.

There are 3,439 patients waiting over 52 weeks, an increase of 197 patients from last month but lower than the trajectory submitted to the South West region which was 3725 for December 20.

	Mar 19	Nov 20	Dec 20	
Waiting List Size	42,587	44,349	44,117	**+1,530 v March 19**
Referral to treatment 18-week performance		63.4%	64.8%	**+1.4% v Nov 20**
RTT incomplete pathways >52+ weeks		3,242	3,439	**+197 v Oct 20**

The overall waiting list is still at a higher level than last year with a corresponding small increase in backlog of patients waiting over 18 weeks, this has resulted in an increase in performance from 63.4% to 64.8%. Whilst the number of patients waiting over 26 weeks has reduced indicating opportunity to start recovering in April 2021, there has been a rise in patients waiting over 40 and 52 weeks.

Key points for Board members:

Factors impacting on standard.

Clinical Processing Capacity	The Trust's 18 week RTT performance is 64.8% against the 92% standard; this is mainly due to the impact of COVID-19 and the need to cancel elective work in Quarter 1 in line with national guidance and restoration of routine elective services safely during Quarter 2, as COVID-19 numbers rose through Quarter 3 there was a rise in the number of patients choosing to defer treatment until after the pandemic. Elective activity is recovering in many specialties however productivity remains lower than previous years due to restoring services safely in line with national and clinical infection control guidance which make each procedure take much longer. Maintaining social distancing and running safe services in line with current infection control and clinical guidance is a top priority. There is regional recognition of the challenging position of elective care performance in Dorset prior to COVID-19 and this has resulted in many patient waiting > 52 weeks for treatment. The growing number of 52 weeks is mainly due to lack of theatre / treatment capacity. This waiting list is clinically reviewed and prioritised to reduce any potential harm for those patients waiting longer than expected for their procedure.

The main focus is to increase activity by the following **High-Level Actions:**

- Restoration plans are focused on increasing additional elective capacity to undertake elective procedures including, National contract to use the Independent Sector, outsourcing services using other local NHS and private providers, insourcing services using Portland Clinical to provide additional theatre lists and running WLI sessions where possible. Note these plans will be hampered with wave 3 surge of the COVID-19 pandemic.

- Outpatient pathways play a lesser part in the drop of performance, the ambition to achieve 100% return to activity has not yet been achieved, current return of activity is less than 90% with further recovery limited due to social has been use of video and telephone consultations, the national ambition is for a minimum of 25% of all outpatient activity to be non-face to face, with 60% of all follow-up appointment activity being non-face to face. UHD has performed well achieving 39.4% of all outpatient activity being non-face to face which is a reduction from November of 43.1%. Note this plan to increase non face-to-face outpatient activity will be promoted further with wave 3 surge of the COVID-19 pandemic.

Key points for Board members:

DM01 (Diagnostics report)

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

December	Total Waiting List	< 6weeks	>6 weeks	Performance
UHD	6220	6052	168	2.7%

The DM01 standard has achieved 97.3% of all patients being seen within 6 weeks of referral, only 2.7% of diagnostic patients have waited > 6 weeks. This is a remarkable achievement and testament to all the previously reported plans delivering during Q3. Whilst this is a great position to be in at the end of December, the services are still planning further recovery to ensure sustainable improved performance during winter and whilst responding to COVID-19.

High level actions include:

- Continuation of additional temporary endoscopy capacity on the RBCH site and reviewing all endoscopy activity in the Dorset system to reduce waiting times.
- Working collaboratively across both sites to standardise and reduce waiting times for cardiology, ultrasound, MRI and CT
- Insourcing to provide additional capacity in radiology. A system of examination exchange is in progress to support a reduction in waits on both sites.
- Sharing capacity across sites to reduce the waiting times in endoscopy and echo cardiology.

Cancer Standards

	Measure	Target	Quarter 1 2020/21	Q2 20/21 FINAL	Oct 20 - FINAL	Nov 20 - FINAL
UHD	Cancer Two Week Wait	93%	96.7%	97.3%	N/A	N/A
	Cancer Plan 62 Day Standard (Tumour)	85%	79.3%	80.0%	77.9%	80.3%
	62 Day Screening Standard (Tumour)	90%	73.3%	73.3%	90.9%	100.0%
	31 Day First Treatment (Tumour)	96%	96.2%	94.4%	96.9%	95.6%
	Subsequent Treatment - Surgery	94%	89.4%	86.7%	94.3%	93.5%
	Subsequent Treatment - Radiotherapy	94%	98.8%	100.0%	97.4%	97.6%
	Subsequent Treatment - Anti Cancer Drugs	98%	100.0%	100.0%	100.0%	100.0%
	Faster Diagnosis	75%	76.3%	77.4%	76.6%	86.7%
	Over 104 days (treated in month)	N/A	18	23.5	11	

Performance

The Trust continues to be challenged by the number of fast track referrals currently, whilst trying to recover it position after the impact of COVID. This is particularly affecting head and neck, breast and gynaecology. Whilst performance remains below the standard for some of the KPI's the position is reflected Nationally.

Key points for Board members:

Factors impacting on standard.

Demand	• Referral numbers continue to exceed previous years putting additional pressure of several services at all stages of the pathway
Clinical Processing Capacity	• Patient choice continues to impact all pathways • Capacity not able to cope with current demand especially for some diagnostic tests impacting pathways • Specific challenges in some pathways- due to capacity to manage the increased demand- especially breast head and neck and gynaecology.

High Level Actions ongoing

- Clinical teams continue to explore opportunities to work across sites to maximise capacity and improve flexibility
- One stop opportunities at the start of the pathway to improve time to diagnosis.
- Exploring opportunities for robotic assistance at referral/triage stage to improve efficiency of current process and expedite the process
- Escalating any potential opportunities to improve pathway management across the care groups – especially for diagnostics
- Weekly backlog/backstop meeting to manage patients who have already breached 62 days to ensure appropriate actions and clinical safety
- Pursuing the opportunity to introduce LA template biopsies as part of Adapt and Adopt to improve efficacy of the pathway, this would decrease the use of TRUS biopsy (as per National guidance) and free up essential theatre space –moving GA to LA .
- Working with Primary care to improve quality of referral information

<u>Quality, Safety, & Patient Experience</u>

Infection Control

Following on from last month's report, the background level for cases of Covid-19 in the Bournemouth, Christchurch and Poole Council areas has continued to rise. This higher level of Covid-19 in the population has led to a significant increase in the numbers of patients being admitted to the hospital and critical care.

Within the trust and healthcare partners, procedures are in place to test patients for Covid-19 at a number of points in the hospital pathway in accordance with national guidance. This ensures that cases can be detected early with ongoing surveillance to identify healthcare associated infection. Throughout December however, there has been a rise in the number of asymptomatic patients attending who subsequently test positive on their second swab; these patients are classified as community acquired.

During December the Trust has declared a number of Covid-19 outbreaks on both sites with the most significant of these being in Surgery and Medicine on the Bournemouth site. Management of each outbreak has been robustly managed though the daily Outbreak Control Meetings chaired but the Director of Infection Prevention and Control (DIPC) or deputy and attended by representatives Public Health Dorset and Dorset CCG.

Key points for Board members:	Reports for the outbreaks that occurred in previous months are currently underway. Many of the outbreaks were as a result of and contributed to HCAI cases. The trust is continuing to follow strict infection prevention and control guidelines. The trust Infection and Prevention Control Team continue to work to implement and strengthen the response to COVID-19 including advising on the safe working practices, required to implement new national guidance. **Patient Safety: Pressure ulcers** Hospital acquired pressure ulcer incidence remains stable. Joint project initiated to develop a UHD offloading of heels pathway including the standardisation of devices. Pressure Ulcer eLearning modules on BEAT VLE revised for UHD in time for Poole launch. **Patient Safety: Falls** The number of moderate and above incidents remains in line with last year's trajectory. The ability to provide enhanced care observations for at risk patients remains a contributing factor. Covid related incidents are now collated and reported through the Nursing & Midwifery Group and Forum. **Patient Experience** Data collection for two of the National Surveys is in progress; the 2020 Urgent & Emergency Care Survey and 2020 Inpatient Survey. The national results for both surveys will be available autumn 2022. • Following the Friends and Family Test 'pause' in response to the COVID-19 pandemic, UHD has re-launched systems for feedback and is now receiving FFT feedback from over 2,100 patients per month. The national data submission and publication of the Friends and Family Test restarted for acute provider Trusts in December 2020. The first submission will be December's data, submitted in January, and this will be published in February 2021. The emphasis is moving away from measuring response rates to using the feedback to identify good practice and opportunities to improve. • From April 2020, the number of complaints received has steadily increased and is now similar to pre-COVID-19 numbers. The number of complaints responded to within the same time period has not kept up with this increase and during Q4, the teams will focus on dealing effectively with this backlog. This is not unique to UHD, but a national finding due to the NHSE recommended pause on dealing with complaints, to enable staff to focus on front-line care during the COVID-19 pandemic. • A small-scale modified PLACE assessment will take place at the RBH site in December and if successful, the same model rolled-out at PH during Q4.

Key points for Board members:

Workforce

12 month rolling rates to December 2020:

		20/21 YTD	19/20 YTD	Variance
Turnover		10.6%	12.2%	-1.6%
Vacancy Rate *20/21 only up to Oct 20*		0.9%	4.8%	-4.0%
Sickness Rate		4.3%	4.0%	0.3%
Appraisals	Values Based	42.1%	60.0%	-17.9%
	Medical & Dental	54.6%	82.1%	-27.5%
Statutory and Mandatory Training		86.7%	89.0%	-2.2%
Staff Friends & Family Test *Note: 19/20 Q1 & Q2 only*	Caring	N/A	87.4%	
	Work		72.7%	

Performance

Overall turnover continues to track lower than usual and vacancy rates are reporting very low due to a year where mobility is restricted and staff sourcing and recruitment is not typical.

Overall sickness levels remain steady; however we have seen a marked increase in Covid related absence due to positive cases and employees in self isolation.

Shielding has recommenced for our most clinically vulnerable staff although many are doing some form of work from home.

Statutory and Mandatory training compliance is looking strong and we have now launched BEAT on the Poole site which will strengthen this position even further.

Appraisal levels continue to track low due to operational pressures. We are promoting the importance of 1 to 1 discussions to check in on staff even if formal appraisals cannot be completed.

Significant pressures in temporary staffing continue due to escalating needs in key parts of the hospitals which may now be helped by repurposing of some staff.

Occupational Health, Learning and Education and Temporary staffing were very involved in the setting up and initial resourcing of the vaccine programme although this is now moving into a more sustainable operation.

While we continue to promote the flu campaign (currently reporting 64.4%), with peer vaccinators working hard to drive up uptake, interest from staff has significantly reduced with the roll-out of the Covid vaccination programme.

Factors impacting on standard.

Appraisals	Appraisals are lower than a normal year due to Covid but they are continuing with steady completion.

Key points for Board members*:*	**CPO Headlines:** • Employee Relations case work remains high. The consultation for part of the HR Operations team has now concluded and we are in the process of aligning our HR Business Partners to specific client areas, to ensure our leaders are adequately supported. This will be communicated shortly. • Progress is being made in aligning people practices and processes to enable consistency across the sites e.g. holiday payments. • The disciplinary, grievance, managing attendance and capability policies have now been ratified for UHD. Adverse Weather, Facilities Time for Trade Union Work and our Recruitment Policy and Procedure are due to be ratified on 20th January 2021. • We continue to work with OD, EU Networks and Staff Side to develop communications to EU staff on settled status requirements. • We are progressing integration of People teams for example we now have one dedicated UHD medical resourcing team and all rostering has now moved under Workforce systems. • We are moving forward with system alignment for example we are about to roll out ImageNow for the Poole site. • OD are making great progress with the UHD Values, Behavioural Framework linked to the new Appraisal process and the Building Healthy Working Lives Strategy. **Covid & Vaccination support:** • Since going into Tier 4, recommencing shielding and starting the vaccination programme, the enquiries into the HR Helpline have increased. We continue to provide significant support to managers. • We communicate regularly about the very wide and growing range of Health and Wellbeing interventions and support mechanisms available to our people. • Covid vaccination planning brought significant pressures to the teams and particularly the leaders over the Xmas/New Year period and we have been so proud of how everyone selflessly undertook all that was necessary to get this started. Particular thank you to Gemma Lynn whose clinical guidance and excellent organisation skills made this possible, to Lisa McManus including moving essential training to vacate space at very short notice, to Lisa Cain who worked to make sense of lists and systems and to Vicki Hill and Zandie Mpofu who were key to coordinating the urgent need for workforce. **Merger Integration:** • A significant amount of work driven by the Care Group Triumvurate leads has resulted in us being almost there for sign off of the main Tier 3 structures. • The Merger Integration Team continue to support this, working towards consultation for the main hospital structures to start at the appropriate date in February. • This includes ensuring job descriptions are completed, matched and consistency checked in preparation for the due consultation process. • Interim arrangements for operational cover are being reviewed to account for the delay from the original timeline – due to Covid 19. • We continue to balance the need to progress the reorganisation with the need to support our people facing unprecedented operational pressures.

Key points for Board members:	**Finance** On 1 October a new interim national financial framework came into effect with the Trust being allocated a fixed funding envelope. This new framework no longer provides for a retrospective true-up to achieve financial balance. Instead the Trust has submitted a financial plan for the period to 31 March 2021 forecasting a £5.6 million deficit, inclusive of ongoing COVID-19 costs, Phase 3 recovery, and winter preparedness. Against this plan, the Trust is currently reporting a favourable variance of £967,000, resulting from lower than planned expenditure in relation to ongoing COVID-19 costs and winter preparedness. However, costs are expected to rise considerably in January driven by the significant operational pressures associated with the current increase in COVID-19 admissions. This will be off-set in part by a reduction in expenditure linked to the recovery of elective services. This challenging position makes it very difficult to forecast the financial outturn of the Trust with any certainty. As such, an indicative forecast has been prepared based on a suite of assumptions which are reasonable, but likely to change as the pandemic evolves. This indicative forecast suggests a favourable variance of £1.5 million by the end of March. This will be kept under review and refined as the position unfolds. The current operational challenges are also having a material impact upon the Trusts capital programme. Many planned schemes are now unable to progress at the pace required due to access limitations within clinical areas. This means that the current slippage will not be recovered to the extent previously expected. The current favourable variance of £10.1 million is expected to grow to £13.7 million by the end of March. Again, this is an indicative forecast and further mitigations are being sought to progress schemes as far as possible or substitute these with capital expenditure planned post 31 March. Following consideration of these additional mitigations, a forecast outturn position will be agreed with the Dorset ICS and NHS Improvement prior to the end of January. Recurrent cost savings of £687,000 have been achieved to date being £124,000 below target. Plans are now in place to recover this shortfall recurrently over the next three months. The Trust is currently holding a consolidated cash balance of £118.7 million, however this includes the January contractual payments of £49.2 million received in advance. This cash advance is currently expected to be recovered in March.
Options and decisions required:	No decisions required
Recommendations:	**Members are asked to:** Note • the areas of the Board focus for discussion • The impact of wave 3 covid inpatients on the operational

Next steps:	Work will continue in addressing the actions raised as part of the escalation reports and through trust management Group.
Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	Continually improve the **quality of care** so that services are safe, compassionate, timely and responsive – achieving consistently good outcomes and an excellent patient experience. To be **a great place to work**, by creating a positive and open culture, and supporting and developing staff across the trust, so that they are able to realise their potential and give of their best. To **transform and improve our services** in line with the Dorset ICS Long term Plan, by separating emergency and planned care and integrating our services with those in the community.
BAF/Corporate Risk Register: (if applicable)	**UHD 1342** - The inability to provide the appropriate level of services for patients during the COVID-19 outbreak. **UHD 1383** - COVID -19 risk relating to HCAI **UHD** (risk ref tbc) – COVID -19 impact on staffing **UHD 1131** – inability to effectively place patients in the right bed at the right time (Flow) **UHD 1387** - Demand for acute inpatient beds will exceed bed capacity (Demand & Capacity) **Existing RBCH/Poole site risks (*1011, 801, 1332 – UHD ref no. awaited*)** re ED: *1) Performance; 2) Ambulance handovers; 3) Patient safety.* ***Existing RBCH/Poole site risks (1053 – UHD ref no. awaited)*** *re Long Length of Stay / Discharge to Assess* **RBCH – 808** Risks to regulatory performance compliance, patient delay and dissatisfaction if RTT related targets for 2019/20 are not met. **PHT - 1074** Risks associated with breaches of 18-week Referral to Treatment and 52 week wait standards
CQC Reference:	All 5 areas of the CQC framework

Committees/Meetings at which the paper has been submitted:	**Date**
Trust Board (Full report)	Jan 2020
Quality Committee (Quality)	Jan 2020
Finance & Performance Committee (Operational / Finance Performance)	Jan 2020
Trust Management Group	Jan 2020

University Hospitals Dorset
NHS Foundation Trust

INTEGRATED PERFORMANCE REPORT




December 2020

Created January 2020

Performance at a Glance - Key Performance Indicator Matrix

				standard	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	ytd	ytd var	trend
SAFE												
Quality	Presure Ulcers (Cat 3 & 4)				12	6	10	8	12	108	64	
	Inpatient Falls (Moderate +)				5	2	3	5	4	34	15	
	Medication Incidents (Moderate +)				1	2	5	4	9	24	-10	
	Patient Safety Incidents (NRLS only)				1379	1341	1654	1581	781	11,384	949	
	Hospital Acquired Infections		MRSA		0	0	0	0		0	0	
			MSSA		1	2	3	9		29	-2	
			C Diff		7	7	1	3		41	9	
			E. coli		3	12	4	8		45	27	
EFFECTIVE												
Mortality	HSMR	Latest	(Dec 20 - UHD)							90.7		
	Patient Deaths		YTD		207	185	265	244	249	1878	**150**	
	Death Reviews		Number		79	57	43	15	2	378	**N/A**	
	Deaths within 36hrs of Admission				30	35	40	36	49	326	**12**	
	Deaths within readmission spell				15	13	15	22	25	145	**-61**	
CARING												
	Complaints Received				57	48	51	56	62	413	143	
	Complaint Response in month				57	48	51	48	46	385	161	
	Section 42's				0	2	0	0	0	7	10	
	Friends & Family Test				90%	91%	91%	91%	91%	91%	-	
WELL LED												
Safety	Risks 12 and above on Register				36	38	39	31	32	32	-11	
	Red Flags Raised*				31	47	51	43	73	298	-183	
	*different criteria across RBCH & PHT											
	Overall CHPPD				9.5	8.8	9.0	9.4	9.4	10.5	2.5	
	Patient Safety Alerts Outstanding				0	0	0	0	0	0	0	
People	Turnover				10.40%	10.70%	10.40%	10.20%	10.00%	10.6%	-1.6%	
	Vacancy Rate				1.0%	0.7%	1.3%	-	-	0.9%	4.0%	
	Sickness Rate				4.2%	4.2%	4.2%	4.4%	4.5%	4.3%	0.3%	
	Appraisals		Values Based		41.6%	53.5%	57.3%	61.5%	63.9%	42.1%	17.9%	
			Medical & Dental		52.0%	45.9%	37.5%	29.9%	50.3%	54.6%	-27.5%	
	Statutory and Mandatory Training				86.52%	86.96%	88.37%	85.90%	85.80%	86.7%	-2.2%	

RESPONSIVE

Quality	Patient with 3+ Ward Moves (Non-Clinically Justified Only)			8	20	22	10	13	132	-36
	Patient Moves Out of Hours (Non-Clinically Justified Only)			58	64	84	106	103	720	-225
	ENA Risk Assessment	Falls		62%	61%	61%	61%	61%	58%	9%
	**infection eNA assessment*	Infection*		74%	73%	70%	64%	73%	61%	N/A
	went live at RBCH	MUST		64%	64%	63%	65%	61%	62%	10%
	during April 20	Waterlow		61%	61%	61%	61%	60%	58%	8%
RTT	18 week performance %		92%	49.0%	56.2%	60.4%	63.4%	64.8%		
	Waiting list size		42,587	41,172	43,123	44,320	44,349	44,117		
	Waiting List size variance compared to Mar 19 %		0%	-3%	1.3%	4.1%	4.1%	3.6%		
	No. patients waiting 26+ weeks			16,950	17,001	14,220	12,131	10,738		
	No. patients waiting 40+ weeks			6,395	6,921	7,197	7,799	8,031		
	No. patients waiting 52+ weeks		0	2,050	2,636	2,998	3,242	3,439		
	Average Wait weeks		8.5	20.8	20.6	19.5	18.3	18.6		
Theatre	Theatre utilisation - main		98%	67%	71%	71%	71%	73%		
	Theatre utilisation - DC		91%	70%	73%	59%	61%	63%		
	NOFs (Within 36hrs of being clinically fit - CCG)		95%	69%	10%	50%	74%	56%		
Outpatients	**Referral Rates**									
	GP Referral Rate year on year +/-		-0.5%	-45.8%	-37.8%	-34.4%	-32.0%	-28.2%		
	Total Referrals Rate year on year +/-		-0.5%	-45.3%	-37.1%	-32.2%	-28.7%	-24.5%		
	Outpatient metrics									
	Follow up backlog			13,652	13,941	13,722	13,099	13,941		
	Follow-Up Ratio		1.91	1.46	1.44	1.44	1.48	1.44		
	% DNA Rate		5%	5.7%	6.6%	7.0%	6.6%	6.0%		
	Patient cancellation rate			9.2%	9.9%	10.3%	9.5%	10.4%		
	30% reduction in face to face attendances									
	% telemedicine attendances		25%	52.9%	44.5%	42.0%	43.1%	39.4%		
DM 01	**Diagnostic Performance (DM01)**									
	% of <6 week performance		1%	19.5%	16.9%	9.8%	1.4%	2.7%		
Cancer	2 week wait (RBH not being monitored)			99.3%	95.4%	-	-			
	62 day standard		85%	76.6%	76.1%	80.3%	69.1%			
	28 day faster diagnosis standard		75%	80.3%	72.9%	86.7%	78.6%			
Emergency Dept	Arrival time to initial assessment		15	5.7	5.7	5.1	5.0	6.0		
	Clinician seen <60 mins			4065	4399	4664	4484	4385		
	PHT Mean time in ED		200	227	206	210	230	235		
	RBCH Mean Time in ED		200	211	217	226	219	259		
	Patients >12hrs from DTA to admission		0	0	0	0	7	8		
	Patients >6hrs in dept			1833	1454	1540	1488	2126		
	ED attendance Growth (YTD)			-26.0%	-23.2%	-15.7%	-21.2%	-21.8%		
SWAST SCAST	Ambulance handover growth (YTD)					-6.7%	-7.5%	-7.0%		
	Ambulance handover 30-60mins breaches			313	228	249	213	261		
	Ambulance handover >60mins breaches			56	52	48	57	103		
Patient Flow	Emergency admissions growth (YTD)			-11.9%	-10.5%	-12.1%	-15.4%	-16.4%		
	Bed Occupancy		85%		85.9%	86.0%	85.4%			
	Stranded patients:									
		Length of stay 7 days			380	394	385	311		
		Length of stay 14 days			197	214	219	155		
		Length of stay 21 days	108		108	126	132	86		
	Non-elective admissions				6089	6279	5673	6034		
	> 1 day non-elective admissions				3796	3932	3554	3686		
	Same Day Emergency Care (SDEC)				2291	2346	2118	2344		
	Conversion rate (admitted from ED)		30%		34.40%	36.10%	38.30%	36.90%		

Quality - SAFE

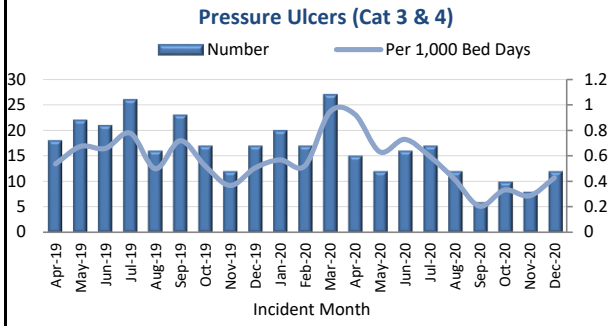
Commentary on high level board position

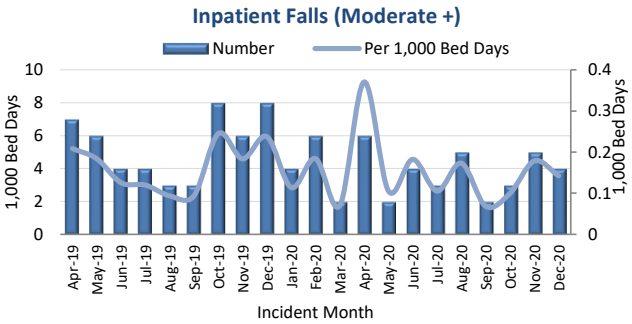
- One (1) new SI reported in month (Dec 2020). YTD figure slightly lower than 2019/20 trajectory.
- Pressure ulcers, work continues on aligning practice and equipment including standardised policies. Nasal cannula with ear protection introduced at RBH site as in Poole.
- Falls, IPC protocols continue to be a contributory factor for falls in those requiring enhanced observation.
- Stable position with key alert organisms - no MRSA bacteraemia or C.difficile outbreaks
- Healthcare associated COVID-19 has been identified and is robustly managed.

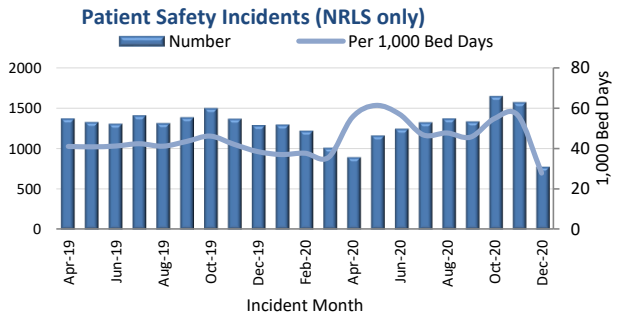
High level Board Performance Indicators

		20/21 YTD	19/20 YTD	Variance
Presure Ulcers (Cat 3 & 4)	Number	108	172	64
	Per 1,000 Bed Days	0.47	0.58	0.11
Inpatient Falls (Moderate +)	Number	34	49	15
	Per 1,000 Bed Days	0.15	0.17	0.02
Medication Incidents (Moderate +)	Number	24	14	-10
	Per 1,000 Bed Days	0.10	0.05	-0.06
Patient Safety Incidents (NRLS only)	Number	11,384	12,333	949
	Per 1,000 Bed Days	49.46	41.85	-7.60
Hospital Acquired Infections	MRSA	0	0	0
**IPC data not including*	MSSA	29	27	-2
December 2020	C Diff	41	50	9
	E. coli	45	72	27

High Level Trust Performance





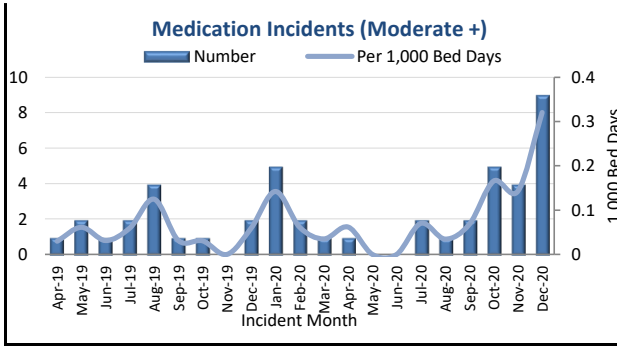


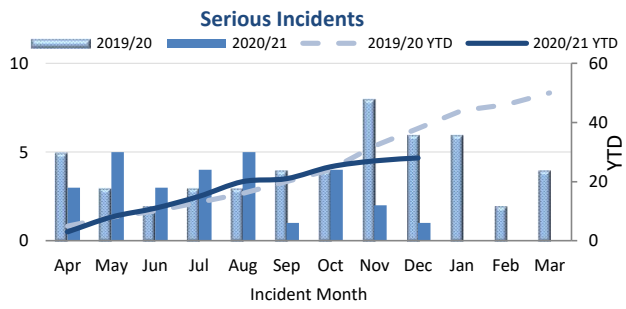
0 (Oct 20) | MRSA | 0 (Nov 20)

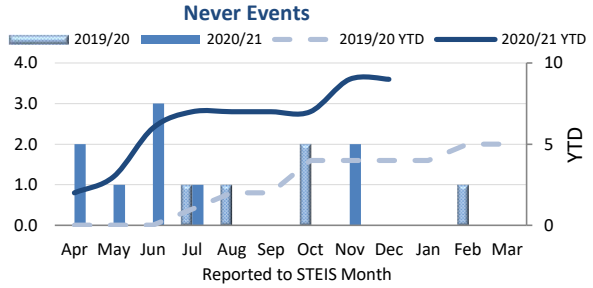
3 (Oct 20) | MSSA | 9 (Nov 20)

1 (Oct 20) | C Diff | 3 (Nov 20)

4 (Oct 20) | E. coli | 8 (Nov 20)







Quality - RESPONSIVE

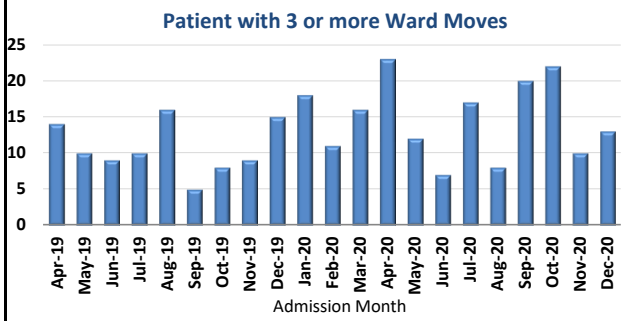
Commentary on high level board position

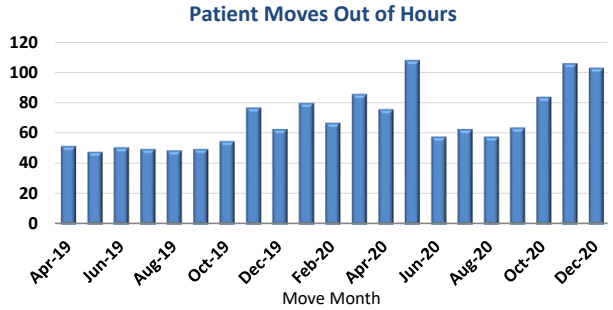
- ENA falls, MUST and Waterlow Assessment compliance has shown some improvement from April - December 2020 but remains an area of focus. Individual ward compliance scores are included in ward Quality dashboards at each site.
- The National Mixed Sex Accomnodation return has been suspended from April 2020. The Trust however, continues to manages same sex accomodation in the usual way.
- Ward moves out of hours have risen through Autumn and Winter as operational pressures related to the placement of patients with COVID 19 have increased.

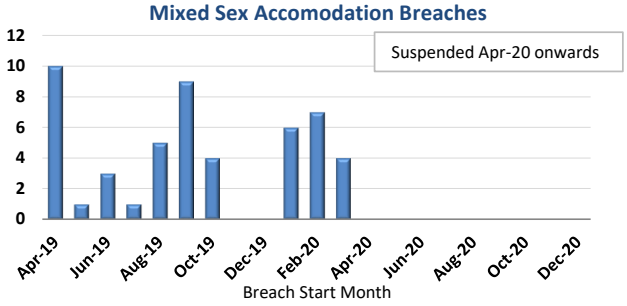
High level Board Performance Indicators

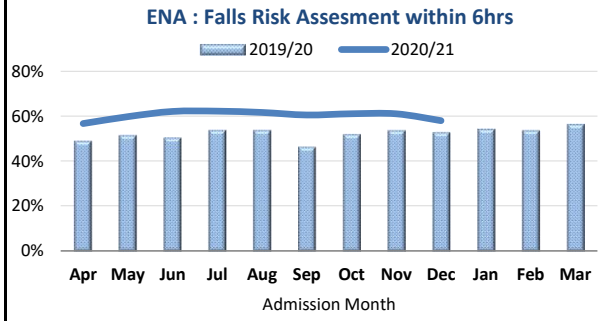
		20/21 YTD	19/20 YTD	Variance
Patient with 3+ Ward Moves (Non-Clinically Justified Only)		132	96	-36
Patient Moves Out of Hours (Non-Clinically Justified Only)		720	495	-225
Mixed Sex Acc. Breaches Suspended Apr-20 onwards due to Covid		0	33	N/A
ENA Risk Assessment				
**infection eNA assessme went live at RBCH during April 20*	Falls	61%	52%	9%
	Infection*	73%	15%	N/A
	MUST	64%	54%	10%
	Waterlow	60%	52%	8%

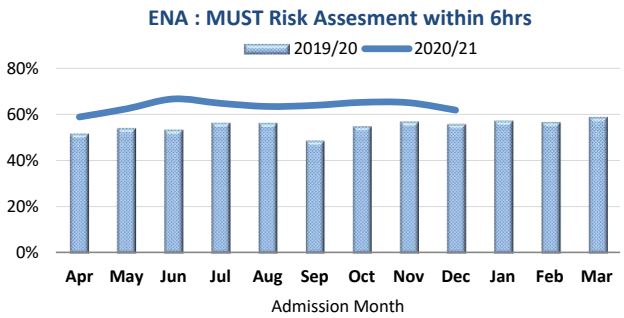
High Level Trust Performance

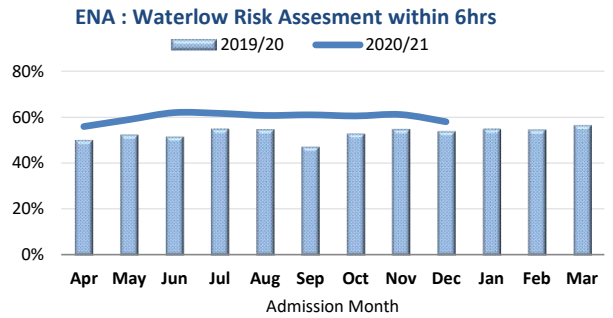












Quality - EFFECTIVE AND MORTALITY

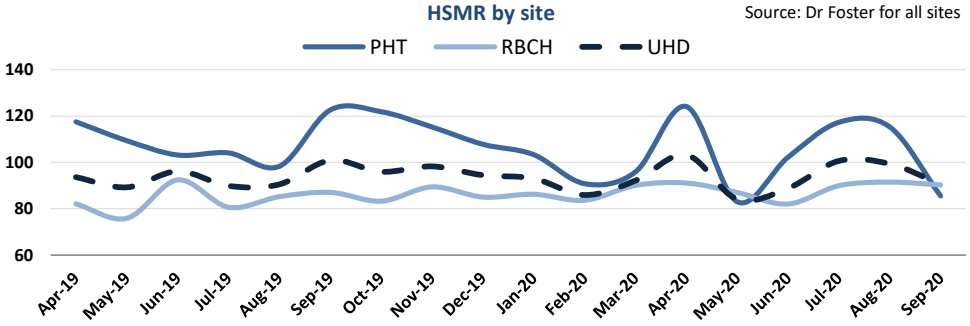
Commentary on high level board position

- The first UHD Dr Foster Mortality report was discussed at the Mortality Surveillancce Group on the 14/01/2021. HSMR for tthe 12 month period Oct19-Sept 20 was reported as **Trust** - 93.9, statistically significantly lower than expected, **RBH** - 80.1, statistically significantly lower than expected, **Poole** - 105.8, within the expected range. SHMI (August 2019 to July 2020) is 86.62, statistically significantly lower than expected using NHS Digital's control limits.
- A Joint UHD Learning from Deaths Policy has been agreed at the Quality Committe on the 21/12/2020. A UHD Medical Examiners policy has also been developed for approval at the QC on the 21/1/2021
- A thematic review of all covid deaths at Poole Hospital has been undertaken a SI panel meeting will be held on the 17/12/2020 to review the learning and reccomendations from the review. An action plan is currently being developed.

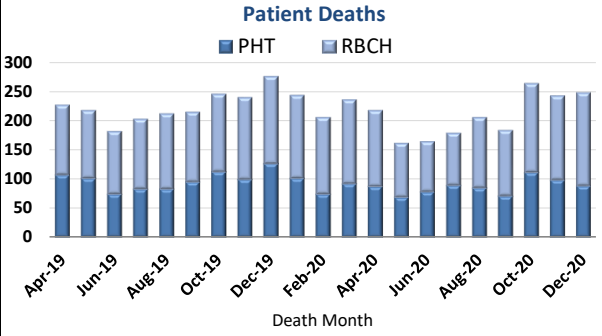
High level Board Performance Indicators

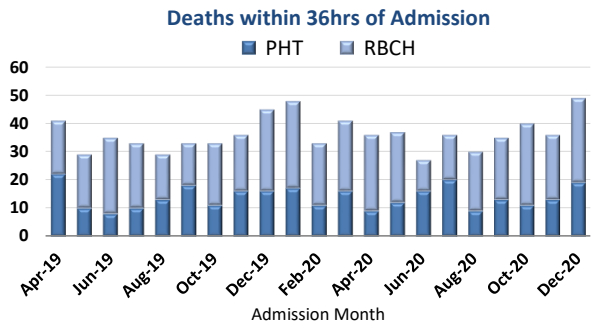
			20/21	19/20	Variance
HSMR (Source: Dr Foster for all sites)	Latest	(Sep 20 - UHD)	90.7	92.2	
Patient Deaths		YTD	1878	2028	**150**
Death Reviews		Number	378	810	**N/A**
Note: 3 month review turnaround target		Percentage	22%	50%	
Deaths within 36hrs of Admission			326	314	**12**
Deaths within readmission spell (Patient readmitted within 5 days)			145	206	**-61**

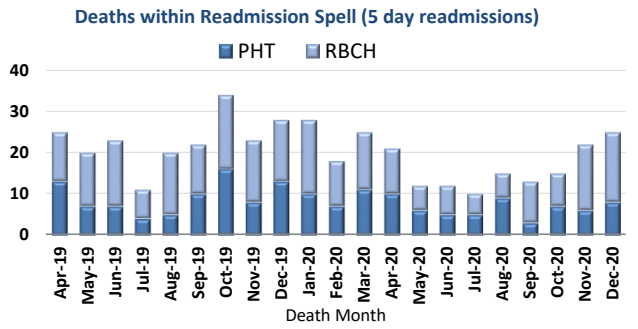
High Level Trust Performance



99.4 (Aug 20) HSMR 90.7 (Sep20) | 244 (Nov 20) Patient Deaths 249 (Dec 20) | 40% (Aug 20) Deaths Reviewed 31% (Sep 20)







Quality - CARING

Commentary on high level board position

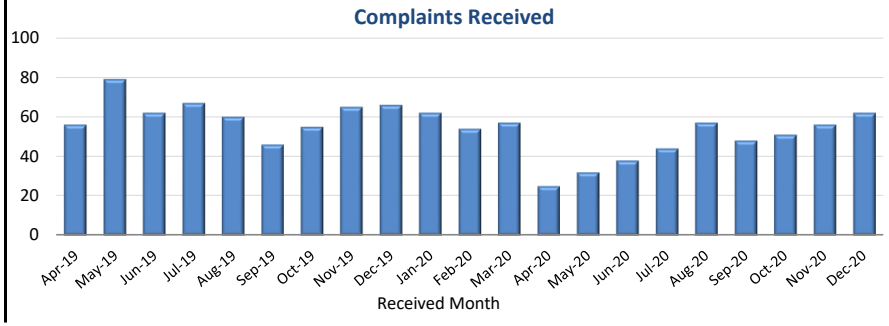
- The new Friends and Family test has been launched with national reporting expected to be published February 2021. Feedback from patients during the last quarter has been fairly consistent, with 91% of our patients reporting their experience as very good/good.
- Section 42's are lower this year due to the impact of reduced patient numbers in quarters 1 & 2 and a change in process within social care whereby only those for investigation come to the Trust.
- One PHSO investigation into a complaint response relating to care on the RBH site is nearing completion.
- The level of complaints received in December is slightly higher than November,but consistent with average monhtly levels pre-pandemic. As a % of complaints received, the response rate has reduced to 75%, reflecting delays due to additional pressures on clinical teams. The net effect of this is likely to be a growing backlog and longer complaint response times.

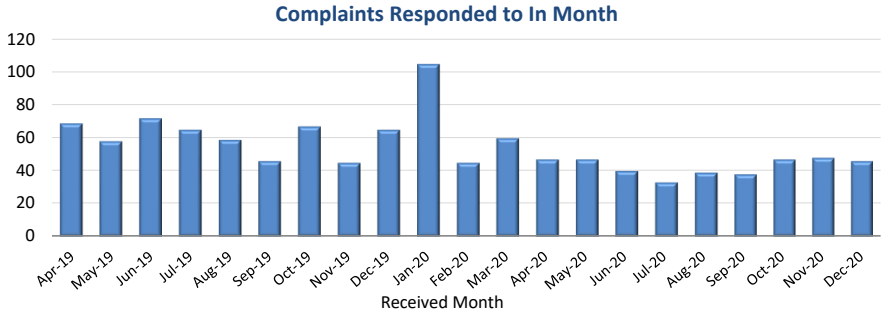
High level Board Performance Indicators

	20/21 YTD	19/20 YTD	Variance
Complaints Received	413	556	143
Complaint Response Compliance	TBC		
Complaint Response in month	385	546	161
Section 42's	7	28	21
Friends & Family Test	91%	N/A	-

Return changed 20/21

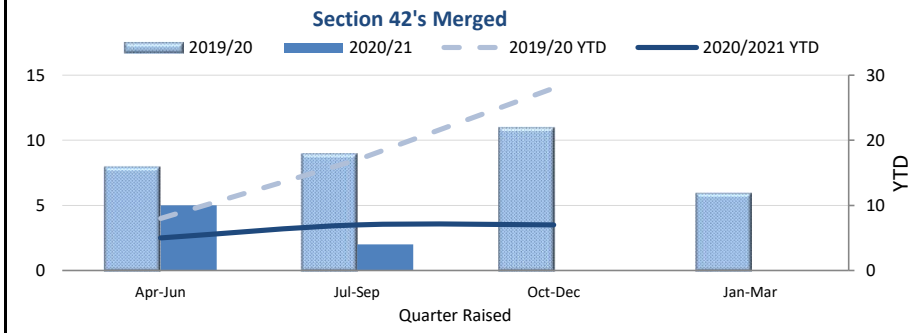
High Level Trust Performance

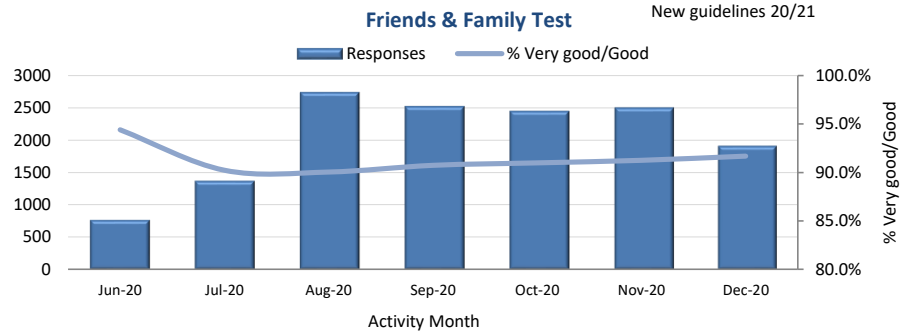




56 (Nov 20) | Complaints Received | 62 (Dec 20)

48 (Nov 20) | Complaint Responses | 46 (Dec 20)





Quality - WELL LED

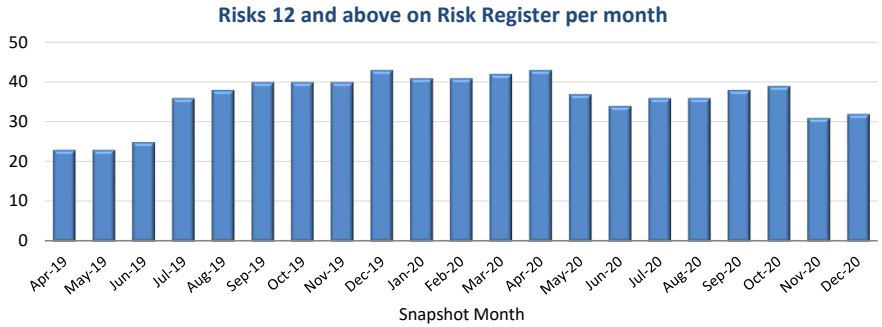
Commentary on high level board position

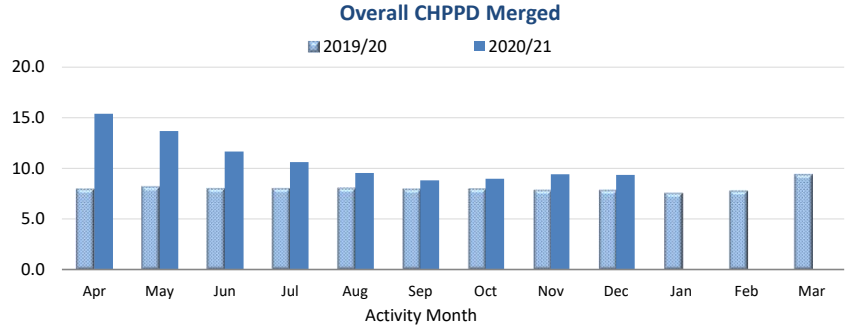
- Work continues to align the Risk registers for the Poole and RBCH sites. Care Group and Corporate Directorate leads are being supported by the Quality and Risk team to review and combine similar site risks into single UHD risks as appropriate. A deciison has been made to move all current risks over the Poole site Datix to maintina a single sytem. This work is in progress. All new risks are now entered onto the Poole Datix system only.
- A single UHD Board Assurance Framework has been produced with a quarterly update (Oct-Dec 20) provided to the Audi Committee and Quality Committee in January 2021
- There are no Patient Safety Alerts outstanding.

High level Board Performance Indicators

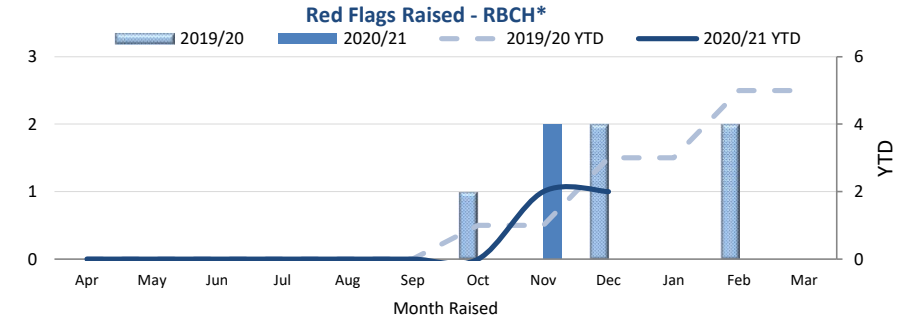
	20/21 YTD	19/20 YTD	Variance
Risks 12 and above on Register	32	43	-11
Red Flags Raised* *different criteria across RBCH & PHT	298	481	-183
Overall CHPPD	10.5	8.0	2.5
Patient Safety Alerts Outstanding	0	0	0

High Level Trust Performance

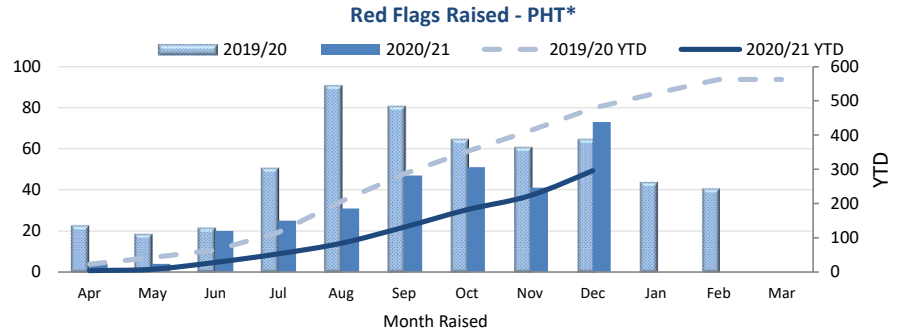




31 (Nov 20) Risks 12+ 32 (Dec 20)



9.4 (Nov 20) Overall CHPPD 9.4 (Dec 20)



Workforce

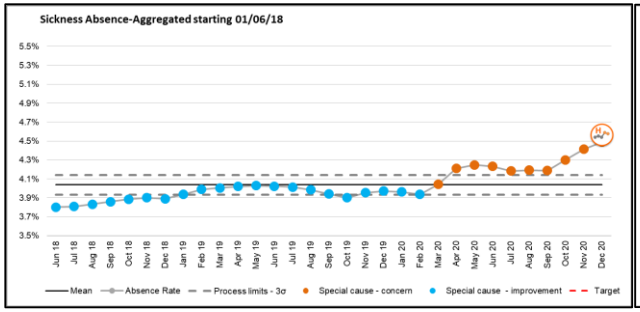
Commentary on high level board position

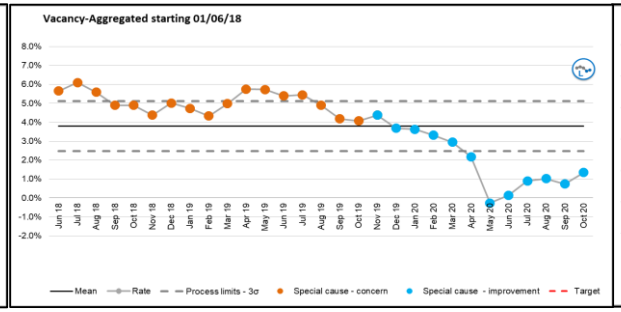
- Overall turnover continues to track lower than usual and vacancy rates are reporting very low due to a year where mobility is restricted and were staff sourcing and recruitment is not typical.
- Overall sickness levels remain steady, however we have seen a marked increase in Covid related absence due to positive cases and employees in self isolation.
- Shielding has restarted for our most clinically vulnerable staff although many are doing some form of work from home.
- Statutory and Mandatory training compliance is looking strong and we have now launched BEAT on the Poole site which will strengthen this position even further.
- Appraisal levels continue to track low due to operational pressures. We are promoting the importance of 1 to 1 discussions to check in on staff even if formal appraisals cannot be completed.
- There are significant pressures in temporary staffing due to escalating needs in key parts of the hospitals which may now also be helped by repurposing of some staff.
- Occupational Health, Learning and Education and Temporary staffing have also been very involved in the setting up and initial resourcing of the vaccine programme although this is now moving into a more sustainable operation.
- While we continue to promote the flu campaign (currently reporting 64.4%), with peer vaccinators working hard to drive up uptake, interest from staff has significantly reduced with the roll-out of the Covid vaccination programme.

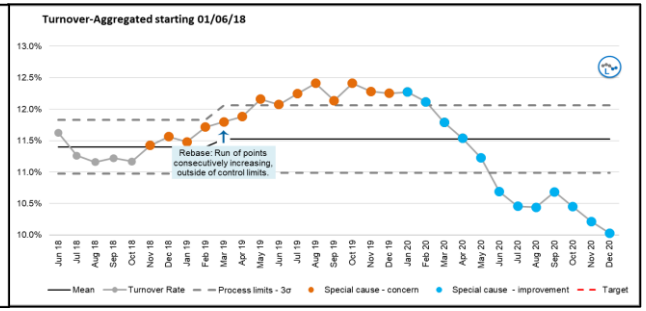
High level Board Performance Indicators

		20/21 YTD	19/20 YTD	Variance
Turnover		10.6%	12.2%	-1.6%
Vacancy Rate		0.9%	4.8%	-4.0%
20/21 only up to Oct 20				
Sickness Rate		4.3%	4.0%	0.3%
Appraisals	Values Based	42.1%	60.0%	-17.9%
	Medical & Dental	54.6%	82.1%	-27.5%
Statutory and Mandatory Training		86.7%	89.0%	-2.2%
Staff Friends & Family Test	Caring	N/A	87.4%	
Note: 19/20 Q1 & Q2 only	Work		72.7%	

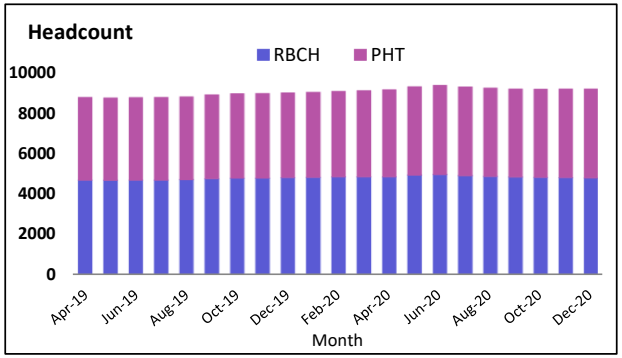
High Level Trust Performance

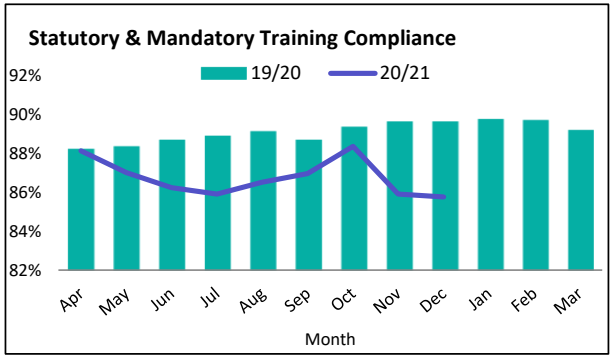


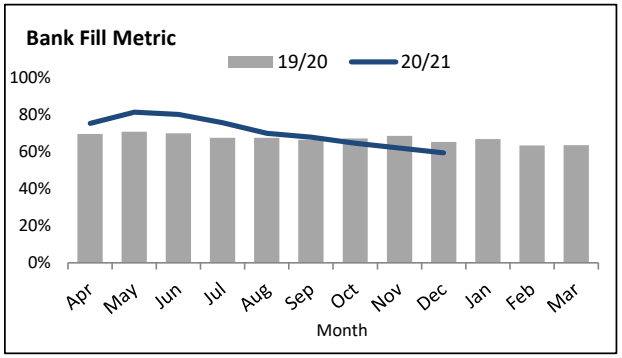




29.9% (Nov 20) | Appraisals (Medical) | 50.3% (Dec 20) | 61.5% (Nov 20) | Appraisals (Values) | 63.9% (Dec 20) | 10.7% (Nov 20) | Turnover | 10.0% (Dec 20) | 4.2% (Nov 20) | Sickness | 4.5% (Dec 20)







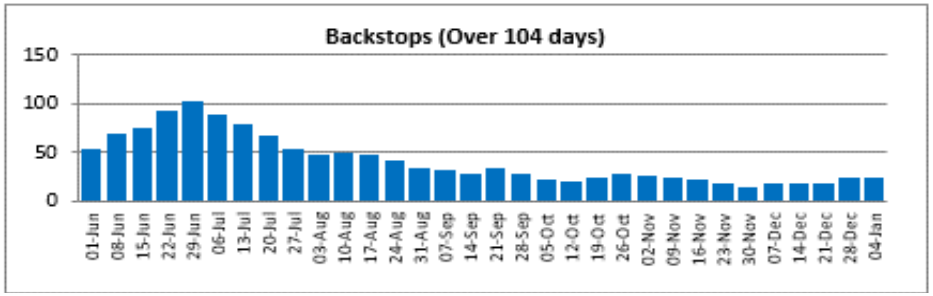
Cancer - Actual November 2020 and Forecast December 2020

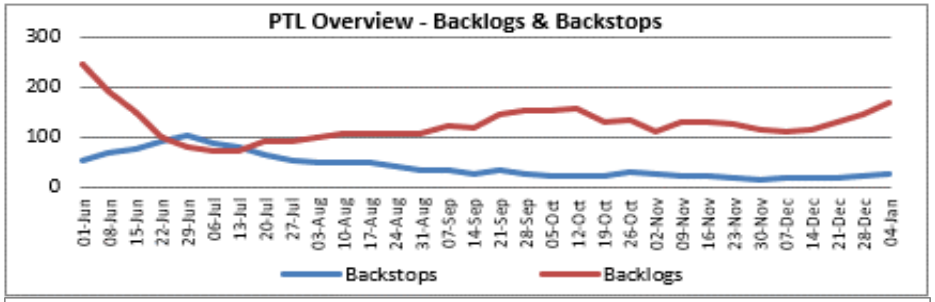
Commentary on high level board position

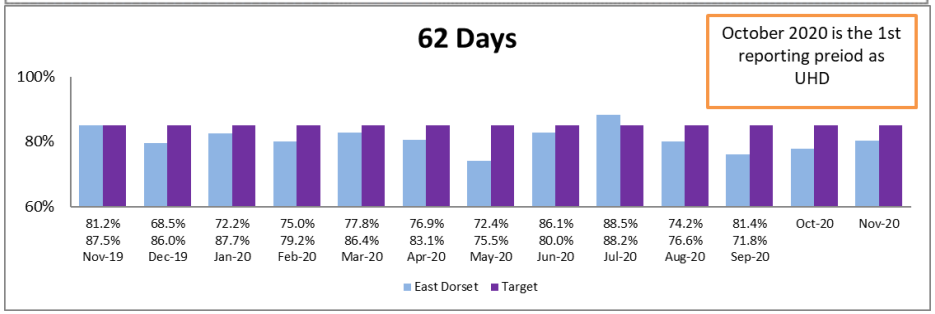
The Trust continues to have challenges managing the volume of 2 week wait referrals- especially in head and neck, (PHT site) Gynae and breast (RBH site) , with several teams having to provide additional capacity to cope. Even with this pressure the Trust has managed to sustain 28 day FDS target.
62 day performance continues to also be challenged however there is an improved position for 31 days (achieving in Oct 96.9% and only just failing in Nove at 95.6%
The position for patietns exceeding the 62 threshold remains reatively static, and all clinical teams are aware of patients at risk of exceeding 104 days

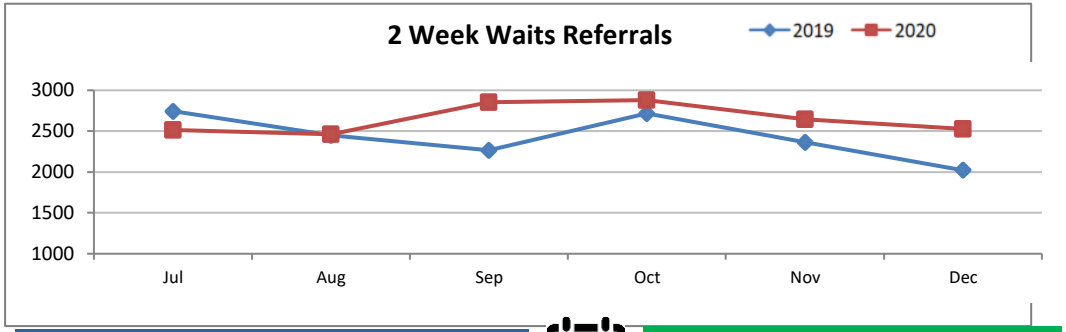
High level Board Performance Indicators & Benchmarking

Cancer Standards	Standard	UHD Nov-20	Predicted Dec-20
31 day standard	96%	95.6%	96.4%
62 day standard	85%	80.3%	69.1%
28 day faster diagnosis standard	75%	86.7%	77.7%

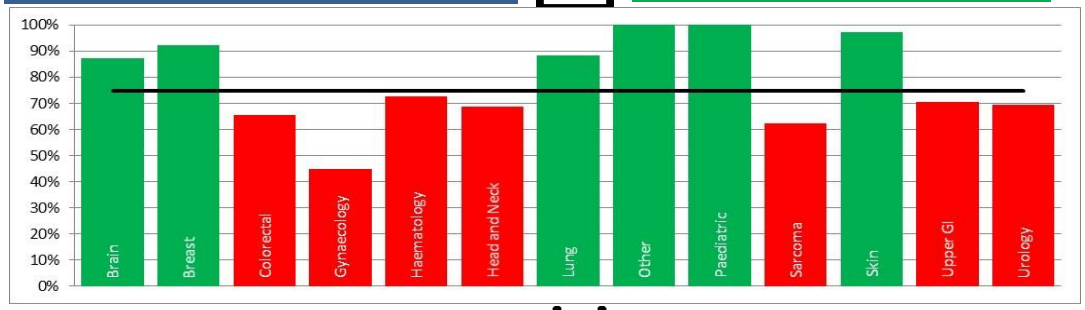




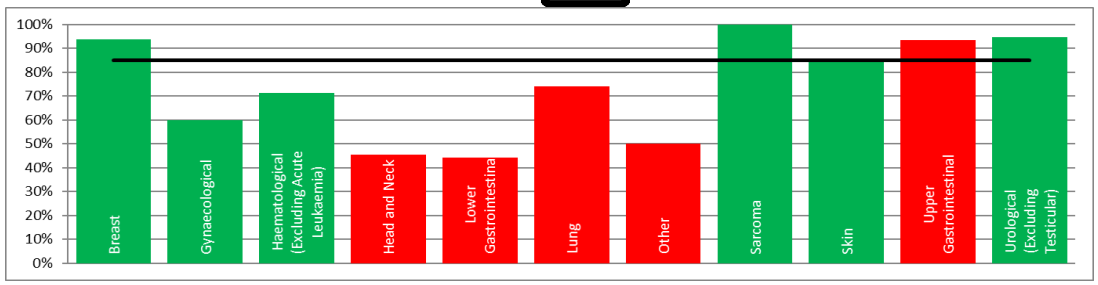




Target 75% | **28** | **UHD: Nov 2020: 86.7%**



Target 85% | **62** | **UHD: Nov2020: 80.3%**



Emergency

Commentary on high level board position

Both Emergency Departments continue to experience reduced overall attendances, with 2917 less patients presenting in December 2020 than did in December 2019. Emergency admissions remain significantly lower than last year, with 977 fewer patients admitted in when compared to the same period last year, with reductions predominantly in the Poole site. Despite reduced ED attendances and admissions overall ED performance has been challenging, with wave 2 COVID significantly impacting on department capacity for suspected Covid patients and flow at both sites. This has resulted in capacity challenges and delays to offloading ambulances as well as in admissions from the department. Regrettably there were 8 reported breaches of the 12 hour DTA standard in month recorded at the Poole site.

Ambulance conveyances increased in month, with almost 250 more than November, but remain 7% lower than the same period last year. For December the Trust has achieved the trajectory for recovery of handovers in excess of 30 minutes, but did not achieve the zero tollerance of 60 minute breaches.

As previously reported our Bournemouth site has moved to the pilot metrics, piloted at the Poole site since May 2019. There is currently a national open consultation on the revised approach moving to System focused emergency and urgent care metrics, due to close in Feb

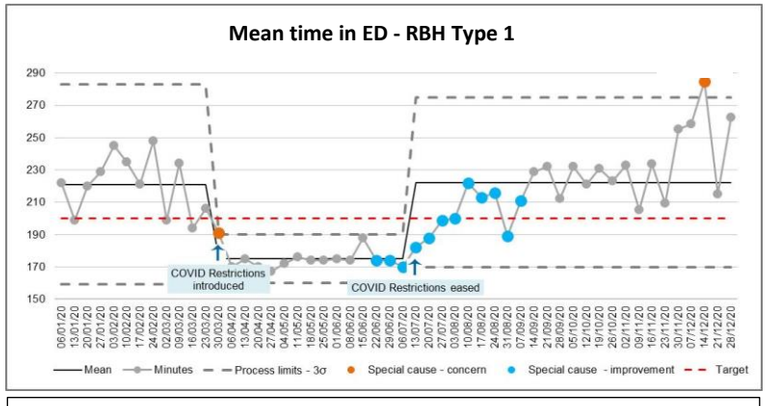
High level Board Performance Indicators

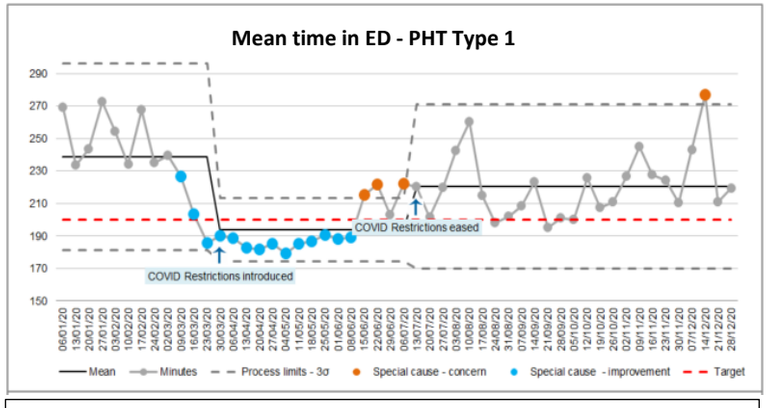
Type 1 ED	Standard	Merged Trust
Emergency Dept		
Arrival time to initial assessment	15	6
Clinician seen <60 mins		4385
PHT Mean time in ED	200	235
RBCH Mean Time in ED	200	259
Patients >12hrs from DTA to admission	0	8
Patients >6hrs in dept		2126
ED attendance Growth (YTD)		-21.8%
Ambulance Handover		
Ambulance handover growth (YTD)		-7.0%
Ambulance handover 30-60mins breaches		261
Ambulance handover >60mins breaches		103
Emergency Admissions		
Emergency admissions growth (YTD, all types)		-16.4%

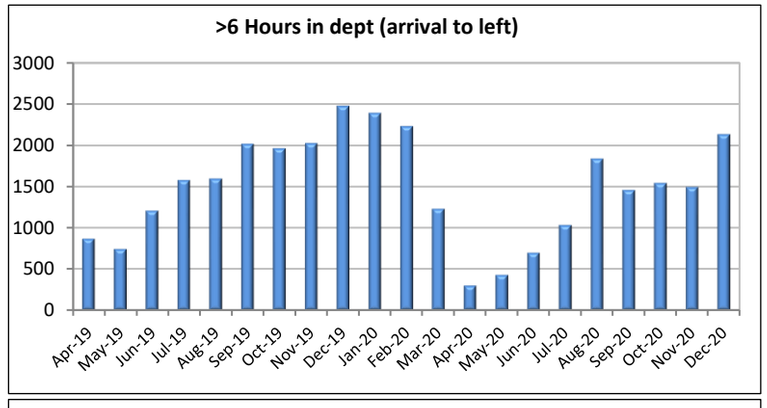
5 mins Nov-20 | Mean time to initial assessment | 6 mins Dec-20

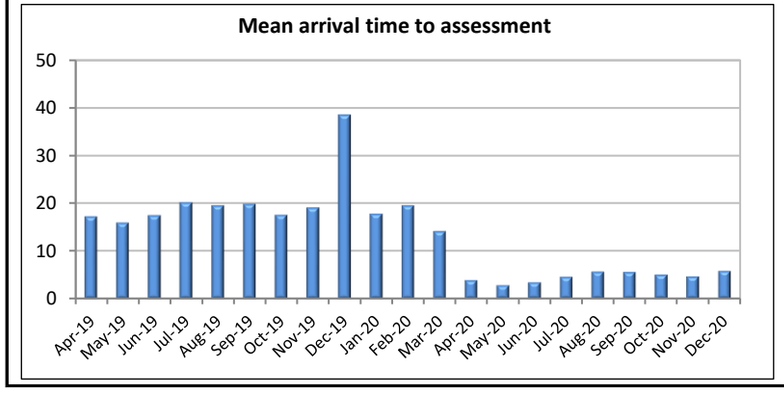
248 mins Nov-20 | Mean time in Dept RBH & PHT | 224 mins Dec-20

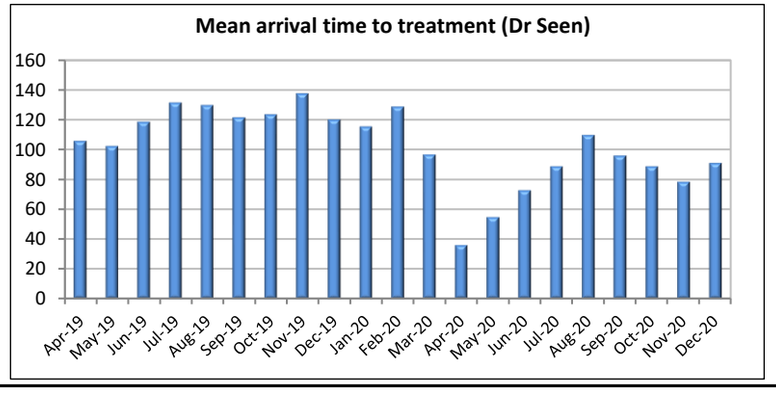
High Level Trust Performance

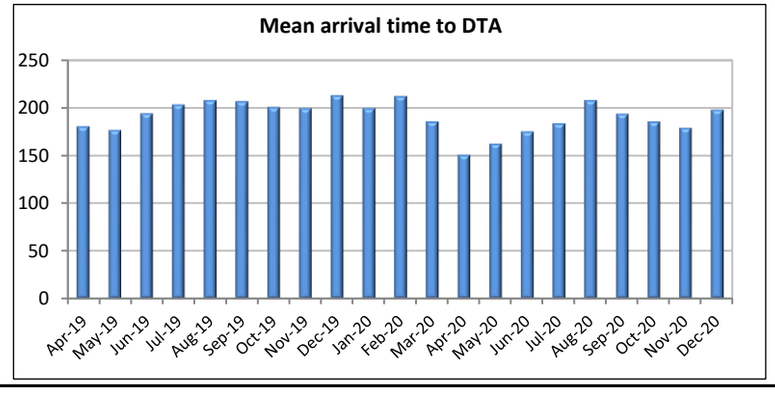












Elective & Theatres

Commentary on high level board position

18 Weeks Referral to Treatment

- The Trust's 18 week RTT performance is 64.8% against the 92% standard. This is due to cancelation of elective work in line with national guidance., constrained capacity due to COVID and the impact of infection control guidance which has reduced efficiency.
- The >78 and >52 week backlog waiting list has increased since last month.
- The Trust number of incomplete pathways is above the March 2019 target.(3.6%).
- Specialty level recovery plans have been developed and discussed jointly with a focus on system wide working in relation to 52 week waiters. This will not deliver the RTT standard in the short to medium term due to reduced capacity as a result of efficiency and utilisation limitations. Additional capacity plans have been proposed via the Adopt and Adapt initiative (and bids)
- At the end of December 2020 the Trust reported 3,439 52 week breaches. Dorset wide leads are progressing joint plans in 5 key specialties: Endoscopy, Ophthalmology, Orthopaedics and ENT/Oral Surgery. Focus for improvement is to reduce the number of 52 week breaches on the non admitted pathway. The number of 52 week waiters increased during December but continuing to drop in > 26 ww indicating an improvement prior to January and further COVID related pressures.

Theatre utilisation

- The current theatre utilisation rates are low as they do not include activity undertaken within the Independent Sector and therefore is not a true reflection of the position. The activity undertaken at the acute trusts will be focused on cancer and emergency cases which can also impact adversely on utilisation rates.

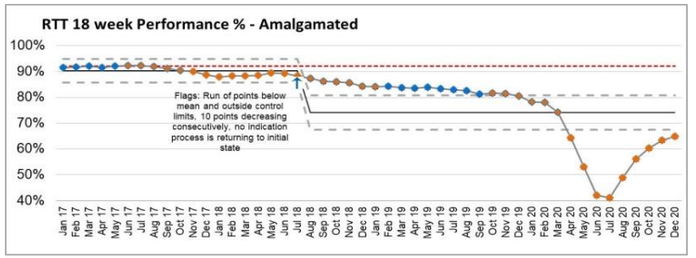
Trauma

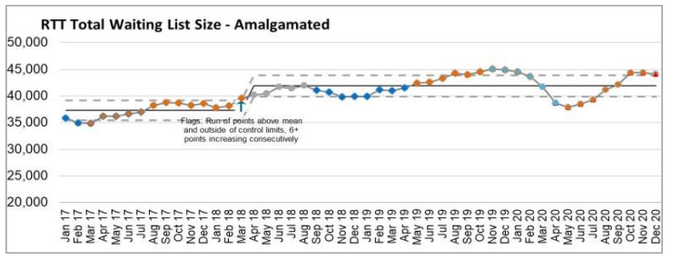
- Hip fractures within 36 hours of being clinically fit for surgery (CCG 95% standard) is currently 56.4% (74%.last month)

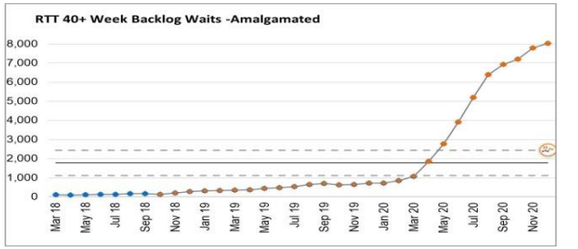
High level Board Performance Indicators & Benchmarking

	Standard	Merged Trust
Referral To Treatment		
18 week performance %	92%	64.8%
Waiting list size	42,587	44,117
Waiting List size variance compared to Mar 19 %	0%	3.6%
No. patients waiting 26+ weeks		10,738
No. patients waiting 40+ weeks		8,031
No. patients waiting 52+ weeks (and % of waiting list)	7.8%	3,439
No. patients waiting 78+ weeks		291
Average Wait weeks	8.5	18.6
Theatre metrics		
Theatre utilisation - main	80%	73%
Theatre utilisation - DC	85%	63%
NOFs (Within 36hrs of being clinically fit - CCG)	95%	56%

High Level Trust Performance

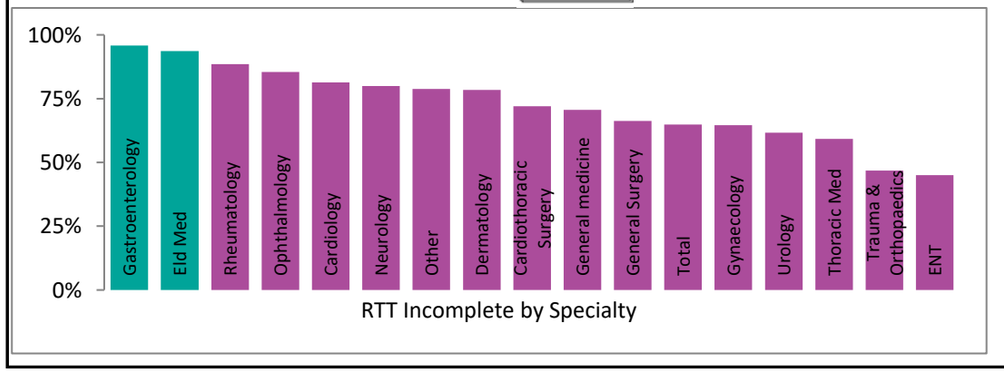


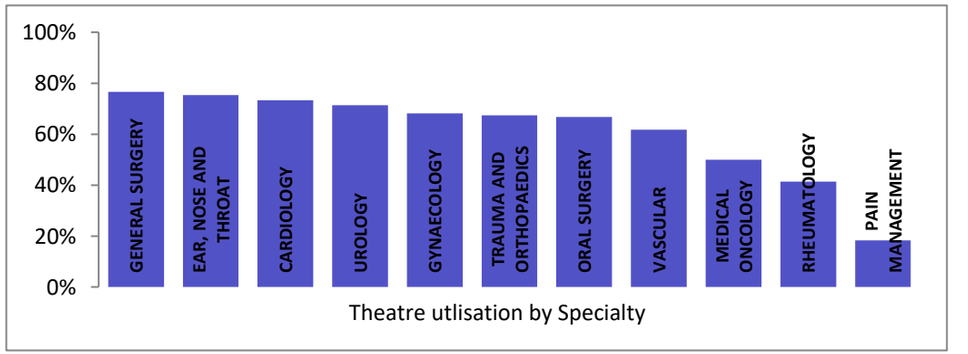




RTT Incomplete 64.8% <18weeks 18 WEEKS (Last month 63%) Target 92%

Theatre Utilisation 72% (Last month 69%)





Referral to Treatment (RTT)

What is driving under performance?	What actions have been taken to improve performance ?

92% of all patient should be seen and treated within 18 weeks of referral.
Performance **64.8%** of all patients were seen and treated within 18 weeks at the close of December 2020.
The overall waiting list (denominator) was **44,117** which is lower than November but aove the March 19 waiting list of 42,587.

At the end of December 2020, 3,439 patient pathways were reported as having exceeded 52 weeks.

December 2020

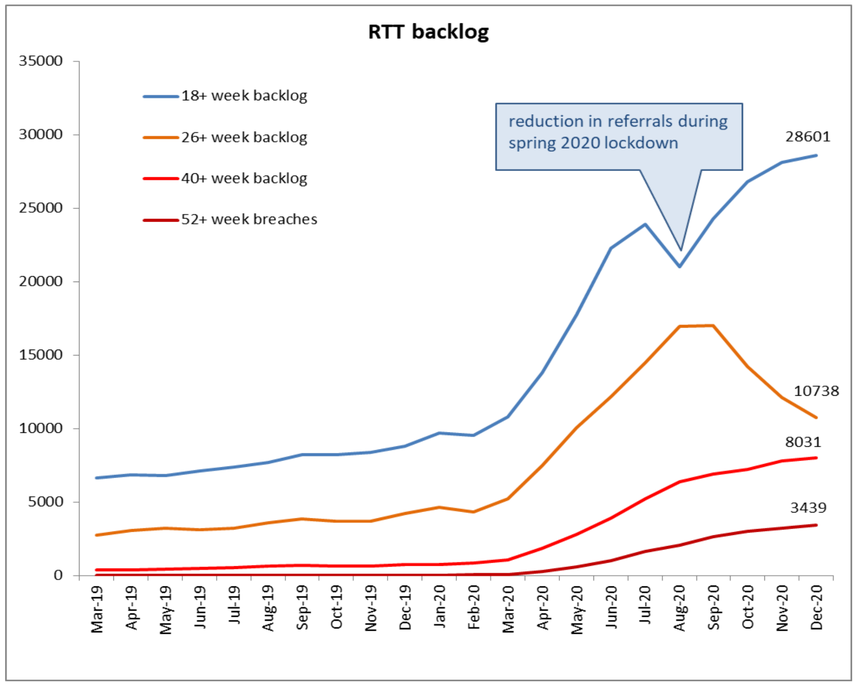
28,601 increase > 18 weeks
10,738 decrease > 26 weeks
8,031 increase > 40 weeks
3,439 increase > 52weeks

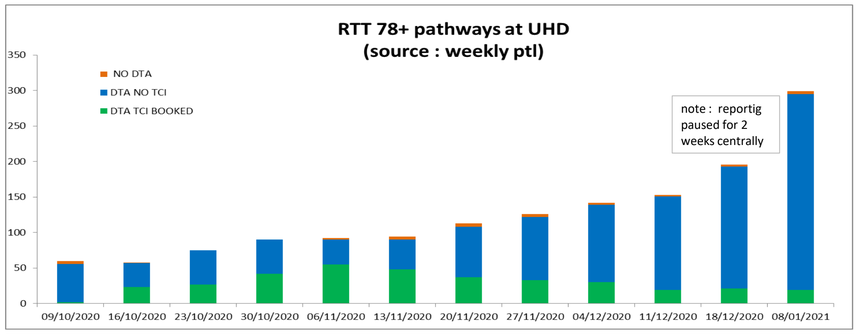
From October all trusts are required to provide patient level exception reports for all patients waiting > 78 weeks, this was paused for 2 weeks centrally over Christmas/New Year.

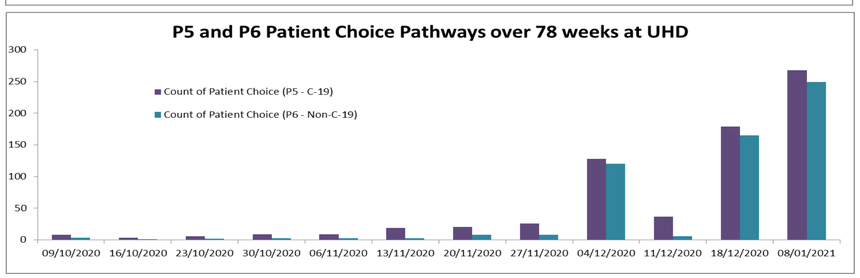
During the first wave of the Covid-19 pandemic the priority was to undertake essential emergency/urgent services whilst adhering to national guidelines on social/physical distancing, shielding and self isolation. This led to a significant reduction in elective activity including out patient appointments which were managed as digital non face to face, whilst this continues the specialties are also recovering by seeing patients face to face where necessary.

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

- Royal College guidelines on the numbers of patients that can be safely seen during Covid leading to many patients being deferred for both outpatients and elective surgery
- Patients chosing not to attend hospital due to concerns about Covid, this number is increasing as prevalence of COVID-19 in the community has increased.
- National requirements regarding testing, PPE and infection control processes restrict a full recovery of activity over the coming months.
-Clinical prioritisation of cancer pathways during period of reduced capaciy / activity







Additional theatre and treatment capacity contiues to be provided by the Indpendent Sector. Close working with colleagues in the Independent Sector continues as it is essential that this capacity is fully utilised.

Endoscopy remains a key priroity with all urgent and Fast Track patients across both Bournemouth and Poole booked first and existing capacity across both sites is being used optimally. The use of the Independent Sector and insourcing has created additional capacity and the use of day theatres on the Royal Bournemouth site is also contributing to an increase in activity levels.

An Operational Performance, Assurance and Delivery programme was launched in October to oversee improvements in performance, activity and reducign patients with a long wiaign time for treatment.

All patients on an admitted pathway have been cliinically reviewed and prioritised in accordance with the national protocol.

Waiting lists are being merged into one to enable easier management of treating our longest waiting patients in order.

Health Inequalities
Actions have commenced to reflect performance linked to health inequalities in future IPRs. The phase 3 planning letter linked health inequalities to Trusts' performance on recovery of referral rates and activity levels; reducing variation in access across geographies in the system, regionally or nationally; and the use of digitally enabled pathways e.g. attend anywhere. These form part of the Trusts regular monitoring of urgent and elective care through the Operational Performance Group. We are exploring with the Dorset System and the Region opportunities to link population health and primary care data to our secondary care data which would allow us to link health inequalities with patients waiting list information. The CCG have been asked to support a conversation between the Trusts and the Population Health Implementation Team. The Trust will also be taking part in a SW Regional session on 14 December on Health Inequalities & Elective Care Recovery to look at best practice in this area.

Wave 3 Surge COVID 19
Plans will be reassessed to recover elective care performance with a particular focus on long waiters noting that many routine elective patients were canceleld towards end of December and into January in repsonse to emergency operational pressures.

Escalation Report

Dec-20

Trauma Orthopaedics -55% compliance achieved against fractured neck of femur target of 95% of clinically appropriate patients to surgery within 36hrs.

Activity | Response

Definition of Trauma Quality Targets & Compliance Achieved

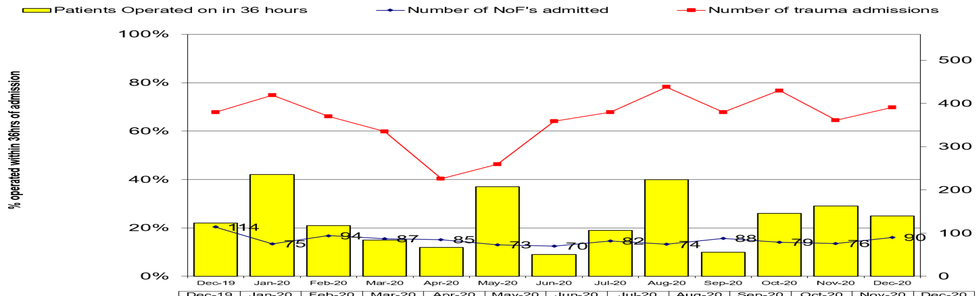
NHFD Best Practice Tariff Target: 85% of fractured neck of femur (NOF) patients to be operated on within 36 hours of admission
December 2020 Compliance: 25%

CCG 2018-19 Quality Target: 95% of fractured neck of femur (NOF) patients to be operated on within 36 hours of admission or of being clinically appropriate for surgery, increasing to 95% by March 2019 (internal target remains at 95% on a monthly basis)
December 2020 Compliance: 55%
Internal Target: 95% of other trauma patients to theatre within 48 hours of admission or being deemed fit for surgery.
December 2020 Compliance: 83%

Breakdown of Breach Reasons and Waiting Times

NoF Breach Reasons	No. of pts
Patients not fit pre-op & needed optimising	16
Patients on anti coagulants	9
Other NoF patients prioritised	30
Awaiting specialist Blood	0
Awaiting x-ray/scan availability	2
Required medical review pre-op	3
Awaiting specialist surgeon	1
Total breached NoFs	61

Demand on Trauma Directorate during December 2020



	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Patients Operated on in 36 hours	22%	42%	21%	15%	12%	37%	9%	19%	40%	10%	26%	29%	25%
Number of NoF's admitted	114	75	94	87	85	73	70	82	74	88	79	76	90
Number of trauma admissions	380	419	370	335	226	259	359	380	438	380	430	361	391

Escalation Activity in December

The service admitted 391trauma patients in December which includes 90 patients with # NOF, operating on 85 as 3 died pre op, 1 went to DCH due to renal problems and 1 patient refused treatment.
31 # NoF patients breached their 36 hour target due to other trauma cases being clinically prioritised, # NoF patients who had been admitted prior to them, and the number of # NoF's admitted in a 24 hour period also impacts on our ability in achieving our 36 hour target, on several occasions in December we had 4 or more admitted in a day, and 5 admitted Boxing day when we are trying to catch up from only 1 all day theatre list on Christmas day. X-ray provision has also been an issue due to staffing challenges within radiology, as yet we do not regularly have the same provision we had pre Covid.. The number of patients requiring surgery fluctuated widely throughout December, starting the month in Stage 1, up to stage 3 by the 14th and out of escalation by Christmas Eve. We finished the month in stage 2 of escalation with 43 patients outstanding 10 of who were # NoF waiting for surgery which impacts on the New Year.
We lost 9 theatre sessions over the Christmas period, hence the increase in numer of patients waiting by the New Year. The third list running at the weekend remains helpful and gives us greater access for patients waiting at home.

Mitigations and Reset

Application of national clinical guidelines: Major trauma, #NOF, Spinal, discharge, flow.
Front door support: 7 day SHO front door cover with mid grade support
Theatre efficiency: as a result of following national guidelines = max 3 cases per session
Fracture clinic capacity increased to 550 per week, all patients are reviewed and receive telephone consultations where appropriate
VFC capacity increased to provide same day access.
RTT Performance 92%. Complete PTL validation and clinical review complete
Bed base, reduction in core capacity to provide critical care capacity, purple and green
Medical cover: continued ward SHO and support of medical SHO cover, established shadow consultant on call rota with escalation plan to include fellows and senior registrars.
SHO recruitment successful with all SHO positions now in post.

No decrease in the average daily NOF admissions leading to backlog of patients awaiting surgery
"other" trauma admissions initially reduced by 70% now on the increase
Conservative treatment options considered before operative intervention, Eg application of bone stimulators with 100% success rate.
Availability of timely fracture clinic reviews, both F2F and telephone
Direct support for front door teams reducing admissions.
Business case for 2 additional conultant posts approved at september HEG, interviews planned for beginning of December.

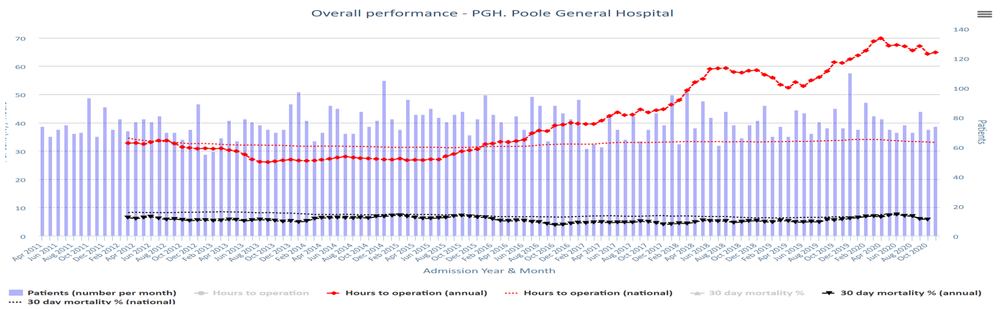
Complexity of Case Load

Soft Tissue	No. of pts
Patients requiring returns to theatre	20
Additional theatre slots required	20
Complex Surgery	**No. of pts**
Total Hip Replacements for NoFs	3
Revisions carried out	0

The service carried out 3 THR's in December for patients with a # NOF. There were 20 patients requiring 2 or more trips to theatre, equating to an additional 20 theatre visits, which is approximately 7 theatre sessions (of multiple trips to theatre) if 3 soft tissue cases are done on a session.

At the time of writing RBH continue to take some of our more suitable patients, which continues to be a support to us and reduces our numbers waiting.

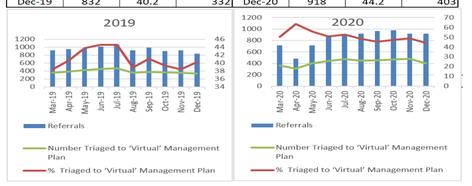
Neck of Femur QSPC Focus



Name	Code	Number of cases submitted	Surgery on day of, or day after, admission	Surgery supervised by consultant surgeon and anaesthetist	General anaesthetic	General anaesthetic and nerve block (of all GA)	Spinal anaesthetic	Spinal anaesthetic and nerve block (of all SA)	Proportion of arthroplasties which are cemented	Eligible displaced intracapsular fractures treated with THR	Intertrochanteric fractures (excl. reverse oblique) treated with SHS	Subtrochanteric fractures treated with an IM nail
Poole General Hospital	PGH	952	24.3	15.8	90.2	47.6	9.4	18.4	97.1	32.9	55.0	92.6
Royal Victoria Hospital	RVB	931	9.5	99.7	18.7	8.9	81.0	0.3	100.0	33.9	45.8	80.0
Leicester Royal Infirmary	LER	906	69.9	61.4	52.1	83.7	48.4	57.4	100.0	17.1	86.3	90.9

December Update on virtual fracture clinic

2019 Month	Referrals	% Triaged to 'Virtual' Management Plan	Number Triaged to 'Virtual' Management Plan	2020 Month	Referrals	% Triaged to 'Virtual' Management Plan	Number Triaged to 'Virtual' Management Plan
Mar-19	924	38.4	355	Mar-20	716	50.4	361
Apr-19	953	40.6	387	Apr-20	484	63.6	308
May-19	972	43.7	425	May-20	716	55.9	400
Jun-19	1012	44.6	451	Jun-20	861	50.8	438
Jul-19	1064	44.6	467	Jul-20	908	52.6	473
Aug-19	926	38.9	352	Aug-20	922	48.6	448
Sep-19	988	41.1	375	Sep-20	964	45.2	452
Oct-19	899	39.4	365	Oct-20	978	47.2	467
Nov-19	924	38.4	355	Nov-20	922	48.8	478
Dec-19	832	40.2	332	Dec-20	918	44.2	403



In comparison to 2019 activity we have seen an increase in patients managed virtually, with up to 64% of all referrals managed as such. over the comparable months there has been an over all increase to 55% Vs 40% in 2019. this has undoubtably helped to mitigate demands on F2F fracture clinics and remains a huge succsess.

Author John West

Patient Flow

Commentary on high level board position

Patient Flow

The number of discharges versus the number of admissions have broadly been in balance for the last 2 months (favourable net loss of 10 residing patients)

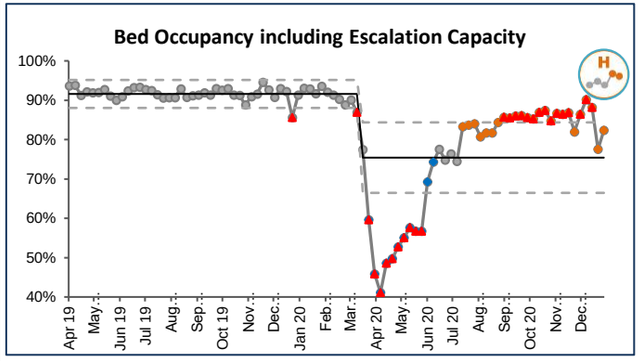
The number of beds consumed by patients with a length of stay greater than 7 days in December was a similar level to those observed in November. An average of 379 beds a day were consumed in December compared to 385 in November (and compared to 450 in December 2019). Bed consumption by patients with a length of stay of over 21 days has decreasaed in December when compared to November. An average of 118 beds a day were consumed In December compared to 132 in November (and compared to 158 in December 2019). This is also significantly less than the the pre-covid winter peak in the first 2 months of the 2020 calendar year (average 186 a day, -37%)

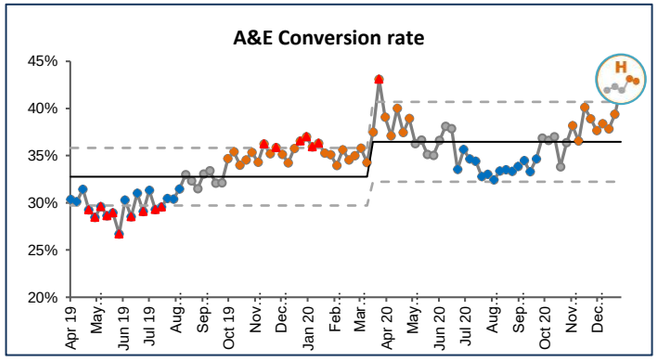
The stabilsied discharge to admission ratio and length of stay metrics is reflected in a favourable occupancy rate of 85.2% in December (85.4% in November), and this remains below the 90.5% observed in December last year. However, lost beds due to infection control protocols, together with acuity (also reflected in A&E conversion rates) presents a challenge to occupancy and flow.

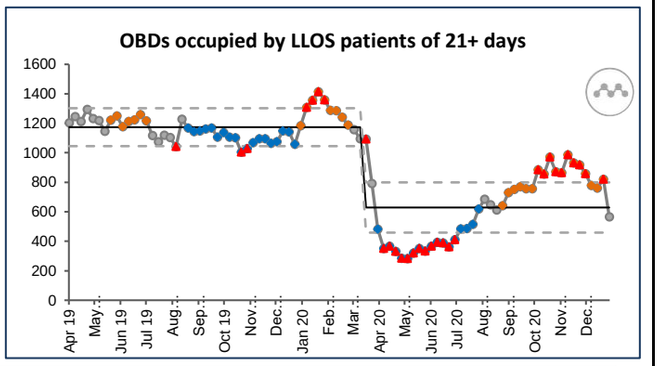
High level Board Performance Indicators & Benchmarking

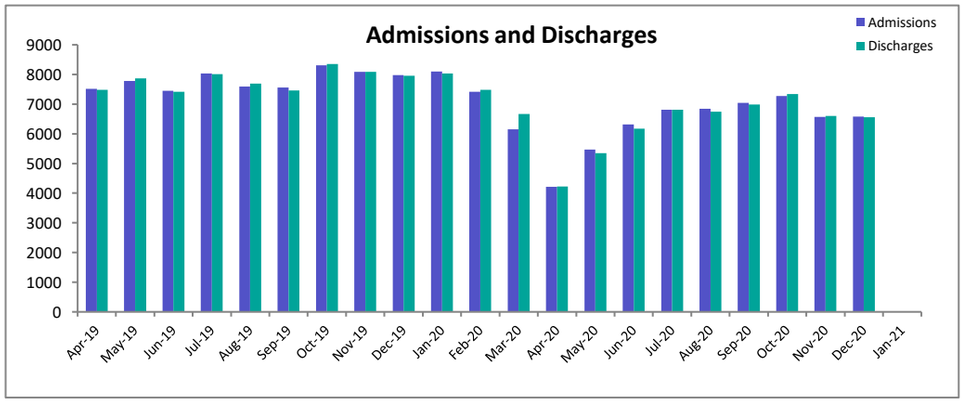
December 2020	Standard		Merged Trust
Patient Flow			
Bed Occupancy	85%		85.2%
Stranded patients:			
Length of stay 7 days		*42%*	379
Length of stay 14 days		*21%*	206
Length of stay 21 days	108	*12%*	118
Non-elective admissions			5,822
> 1 day non-elective admissions			3,685
Same Day Emergency Care (SDEC)			2,133
Conversion rate (admitted from ED)	30%		38.8%

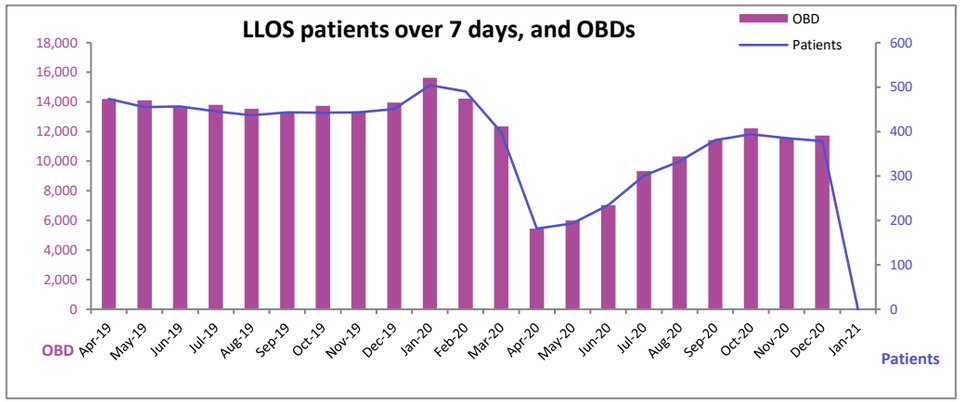
High Level Trust Performance (weekly)











Exception Report

October 20

OCCUPANCY

What is driving occupancy?

The number of beds consumed by patients with a length of stay greater than 7 days in December was a similar level to those observed in November. An average of 379 beds a day were consumed in December compared to 385 in November (and compared to 450 in December 2019). Bed consumption by patients with a length of stay of over 21 days has decreasaed in December when compared to November. An average of 118 beds a day were consumed In December compared to 132 in November (and compared to 158 in December 2019). This is also a signifincantly less than the the pre-covid winter peak in the first 2 months of the 2020 calendar year (average 186 a day, -37%)

The stabilsied discharge to admission ratio and length of stay metrics is reflected in a favourable occupancy rate of 85.2% in December (85.4% in November), and this remains below the 90.5% observed in December last year.

Challenges

- Despite new guidance underpinning regarding discharge to care homes for COVID+ patients outside of isolation preiod, the sector remains extremely anxious regarding accepting clients from hospital setting. The admission rate per home is limited to 2 per day.
- Circa 100 care home COVID suspensions across the BCP conurbation which is further impacting outflow from acute and community beds.
- Community beds continued to experience outbreaks through December, however Dorset Healthcare are planning for additional bed capacity to come online early in the new year.
- Very limited designated care homes bed capacity for covid positive patients with only one care home across Dorset (10 beds) being accredited by CQC.
- Community beds have in turn a dependancy on the availability of care homes, domicliary care hours etc, increasing the occupancy across the bed base which in turn is impacting outlflow from acute beds.
- Domicilary Care providers are struggling to meet demand including support to COVID+ patients and their families, who remain within acute and community beds. This challenge meant admitting patients into community beds who would otherwise be cared for at home.
- The number of care hours needed to support patients post COVID is significantly higher than non COVID patients due to the infection control measures needing to be in place.
- End of Life pathways are challenged by a lack of capacity. Marie Curie was commissioned to provide additonal support from December, however this will no longer be available until February 2021.
- Large care packages are difficult to source. Mitigation is to discharge to interim bed however this is limited by the challenges described regarding the care home sector.

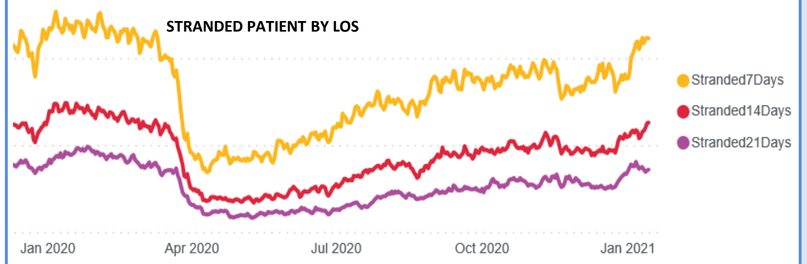
Governance

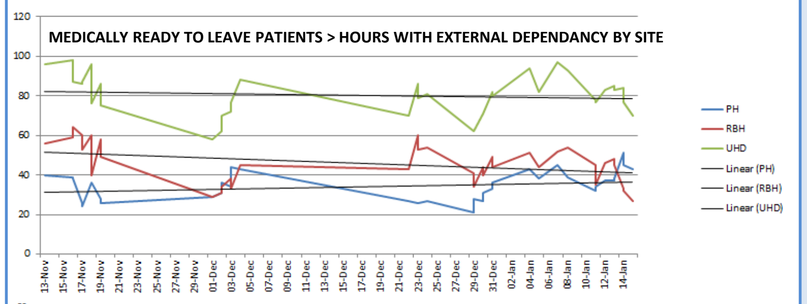
- Home First Board with Executive sponsorship and leadership continues to oversee the implementation of the D2A model.
- Bronze system command in place reporting to Silver system command structure overseeing systemwide action plan to reduce occupancy across bed base.

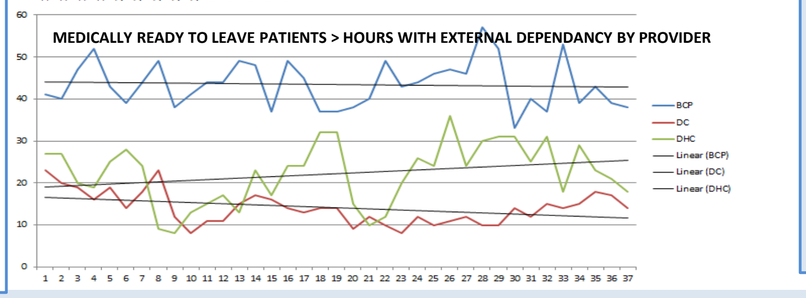
Delivery

D2A A delivery group reporting to the board has been established to design and implement the future D2A model and trouble shoot the current operational challenge.

System wide Bronze team assembled in repsonse to winter pressures charged with the delivery of a system wide plan to reduce bed occupancy with oversight from SIlver Comman.







Improvement Actions - winter

Dorset wide action plan in place to reduce occupancy across acute and commubnity beds, with Executive oversight by Silver Command.

D2A 'Home First' Model

- Complete review of all processes identified several bottlenecks. Action taken to reduce the number of patients being referred through an MDT process and to brokerage.
- Weekend cover in place across UHD to support
- Care homes now accepting weekend admissions to increase
- Dorset Healthcare have now implemented System 1 to track and report patients being discharged through the Single POint of Access (SPOA).
- Daily metrics reported to partners to ensure visbility of improvement or decline, thus prompting remedial action.
- QI approach supporting the ready to leave data to priortise the improvements required for the D2A process.
- ECIST supporting UHD with a hospital flow programme including D2A; board rounds; critieria to reside and critieria led discharge. Planning meetings with the ECIST team hasve commenced.

System Support

- Silver have agree d to a number of measures for managing a "third wave" and abilty to rapidly discharge medically ready patients via community services from early January. This includes block booking of additonal care home capacity and domicialary care hours. The challenge is that a proportion of this commisioned capacity is merely offset
ting lost capacity therefore not increasing rate of discharges needed to reduce occupancy.
- Operational group in place to oversee the reduction of the number of patients who no longer meet the critieria to reside within an acute Trust through a "process review exercise."
- ECIST are supporting the Dorset system in the implementation of the new model. This includes some specific work with acute trusts around Critieria to Reside and 'Same Day Emergency Care,' (SDEC).
- Dorset Healthcare with LA support focussed on decanting patients from commuity setting to support step down from acutes.
- Request submitted to the System regarding a proposal for CHS to support brokerage with care home placement and home with care agency support for medically ready to leave patients. This is under consideration.

Lead Director Mark Mould

Outpatients & Diagnostics

Commentary on high level board position

Outpatients

- DNA rates increasing, some feedback that patients are more cautious about attending face to face appointments again, also increase in DNA of telephone appointments believed to be caused by new hospital telephone number and patients not recognising it.
- Communications have gone out, but some patients do not answer unidentified numbers.
- Increasing Covid Tier restrictions and lockdown in December has resulted in increased DNAs and patients not wanting to attend for F2F OPAs and Diagnostics

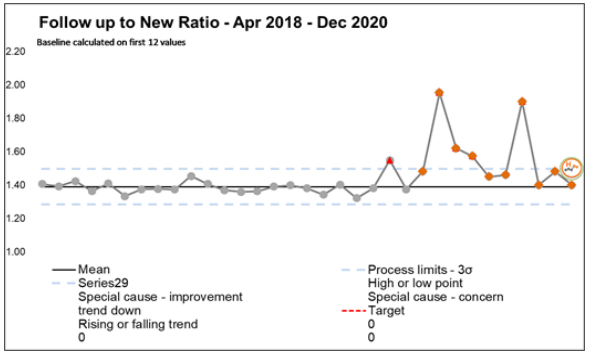
Diagnostics

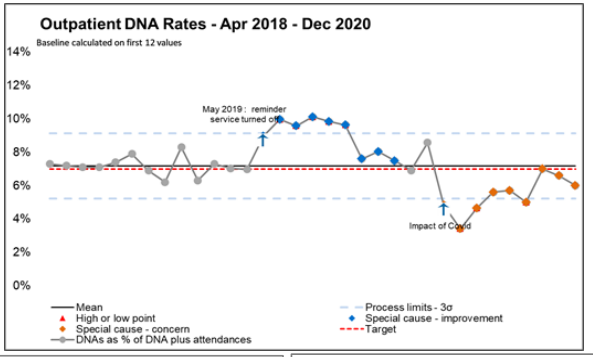
- 97.3% of all diagnostics tests were achieved within the required 6 weeks, of which Radiology achieved 99.5%
- Endoscopy and imaging capacity constrained by Infection Control requirements . Endoscopy 91.3% within 6 weeks, with all elements achieving 90%+ with the exception of Cystoscopy which is slightly behnd at 88.6%.
- Consolidation of Endoscopy IT systems begun - moving to single waiting list
- Cardiac echo recovery plan constrained by availability of insourcing solution, and process of transfer to PH from RBH. Currently achieving 88.5% within 6 weeks in the DM01 99% standard, a drop from 94.6% last month.
- IS assisting with MRI, CT and Plain Film. Additional WLIs and weekends planned.
- Loss of activity due to bank holidays has impacted on DM01

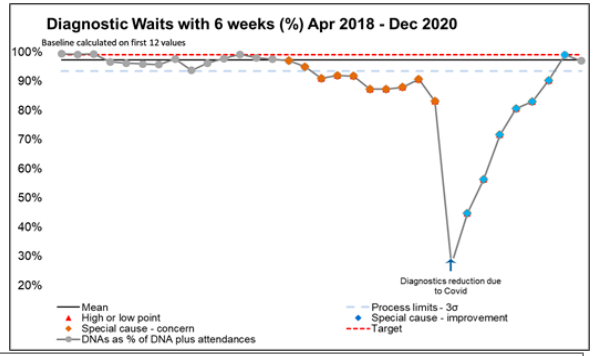
High level Board Performance Indicators & Benchmarking

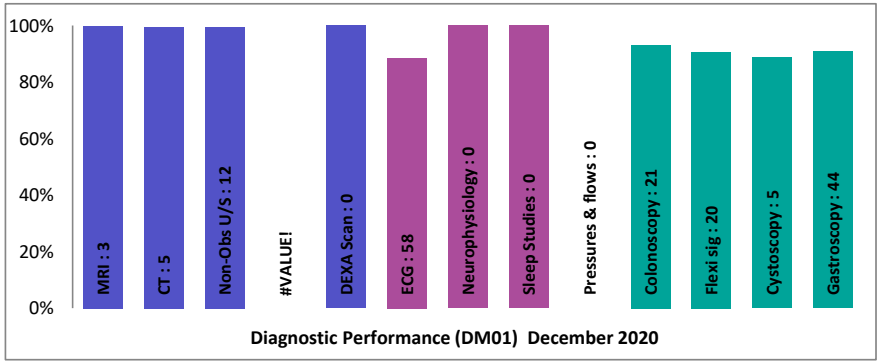
		Standard	Values	Merged Trust
Referral Rates				
GP Referral Rate year on year	*(values 19/20 v 20/21)*	-0.5%	96925 / 69551	-28.2%
Total Referrals Rate year on year +/-		-0.5%	168153 / 126951	-24.5%
Outpatient metrics				
Follow up backlog				13,941
Follow-Up Ratio		1.91		1.44
% DNA Rate	*(New & Flup Atts / Total DNAs)*	5%	29875 / 1892	6.0%
Patient cancellation rate	*(New & Flup Atts / Total Pat Canx)*		29875 / 3458	10.4%
reduction in face to face attendances				
% telemed/video attendances	*(Total Atts / Total Non F-F)*		29875 / 11760	39.4%
Diagnostic Performance (DM01)				
% of <6 week performance	*(Total / 6+ Weeks)*	1%	6220 / 168	2.7%

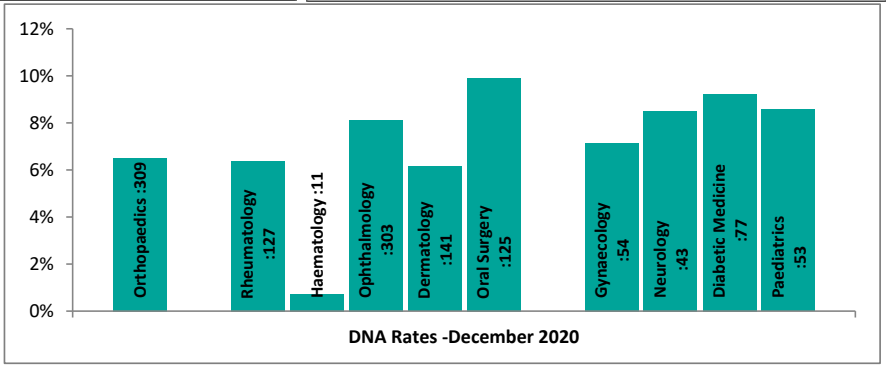
High Level Trust Performance











FINANCE

Commentary

Consistent with the national interim financial framework the Trust has set a planned deficit of £5.6 million for the period to 31 March 2021, inclusive of ongoing COVID-19 costs, recovery of elective services and winter preparedness.

Against this plan, the Trust is currently reporting a favourable variance of £967,000, resulting from lower than planned expenditure in relation to ongoing COVID-19 costs and winter preparedness. However, costs are expected to rise considerably in January driven by the significant operational pressures associated with the current increase in COVID-19 admissions. This will be off-set in part by a reduction in expenditure linked to the recovery of elective services.

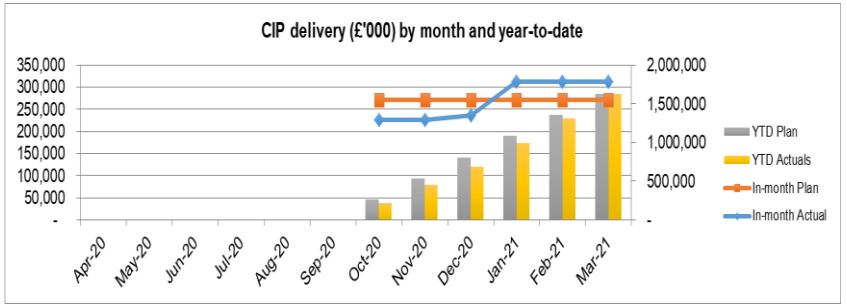
This challenging position makes it very difficult to forecast the financial outturn of the Trust with any certainty. As such, an indicative forecast has been prepared based on a suite of assumptions which are reasonable, but likely to change as the pandemic evolves. This indicative forecast suggests a favourable variance of £1.5 million by the end of March which will be kept under review.

The current operational challenges are also having a material impact upon the Trusts capital programme. Many planned schemes are now unable to progress at the pace required due to access limitations within clinical areas. This means that the current slippage will not be recovered to the extent previously expected. The current favourable variance of £10.1 million is expected to grow to £13.7 million by the end of March. Again, this is an indicative forecast and further mitigations are being sought to progress schemes as far as possible or substitute these with capital expenditure planned post 31 March. Following consideration of these additional mitigations, a forecast outturn position will be agreed with the Dorset ICS and NHS Improvement prior to the end of January.

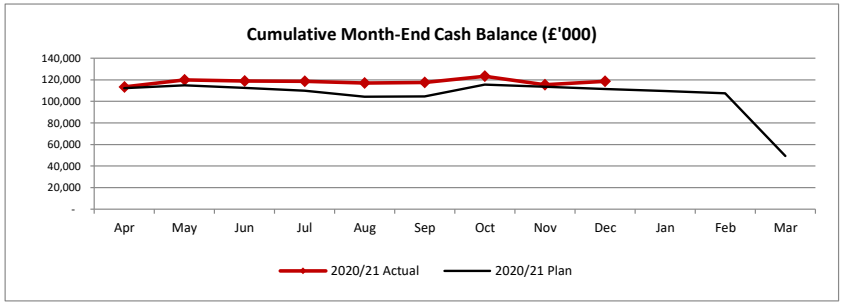
Recurrent cost savings of £687,000 have been achieved to date being £124,000 below target. Plans are now in place to recover this shortfall recurrently over the next three months.

The Trust is currently holding a consolidated cash balance of £118.7 million, however this includes the January contractual payments of £49.2 million received in advance. This cash advance is currently expected to be recovered in March.

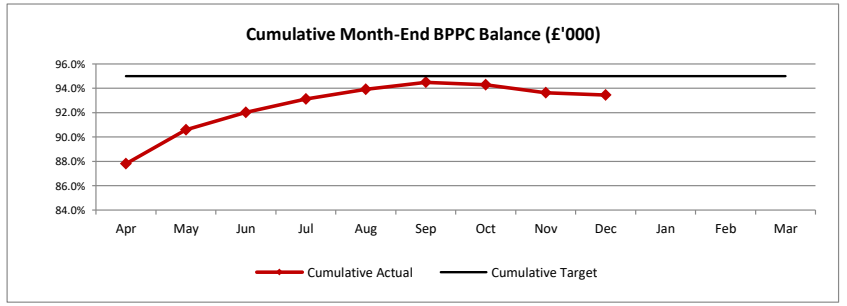
FINANCIAL INDICATORS	Year to date			Forecast
	Budget £'000	Actual £'000	Variance £'000	Variance £'000
Control Total Surplus/ (Deficit)	(2,645)	(1,678)	967	1,498
Capital Programme	34,468	24,346	10,122	13,740
Closing Cash Balance	111,451	118,662	7,211	0
Public Sector Payment Policy	95%	93%	-2%	0



REVENUE	Year to date			Forecast
	Budget £'000	Actual £'000	Variance £'000	Variance £'000
Surgical	(33,745)	(34,031)	(286)	(442)
Medical	(44,253)	(44,604)	(351)	(543)
Specialties	(38,614)	(38,242)	371	229
Operations	(5,625)	(5,482)	144	272
Corporate	(16,192)	(15,983)	209	837
Trust-wide	135,568	136,231	664	1,145
Surplus/ (Deficit)	(2,861)	(2,111)	750	1,498
Consolidated Entities	0	164	164	0
Surplus/ (Deficit) after consolidation	(2,861)	(1,947)	914	1,498
Other Adjustments	216	270	54	0
Control Total Surplus/ (Deficit)	(2,645)	(1,678)	967	1,498



CAPITAL	Year to date			Forecast
	Budget £'000	Actual £'000	Variance £'000	Variance £'000
Estates	2,841	1,756	1,085	5,616
IT	6,135	6,449	(314)	1,500
Medical Equipment	4,410	2,839	1,571	(1,285)
Covid-19	1,375	1,425	(50)	(40)
Strategic Capital	19,706	11,877	7,829	7,949
Total	34,468	24,346	10,122	13,740



University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 27 January 2021

Agenda item: 8.3

Subject:	The Ockenden report (self -assessment tool and action plan)

Prepared by:	Lorraine Tonge Director of Midwifery And Alex Taylor Clinical Director
Presented by:	Lorraine Tonge Group Director of Midwifery

Purpose of paper:	• To share UHD position in relation to the NHSE Self- assessment tool following the Ockenden report issued on the 14th of December 2020. • To give the board assurance of an action plan to address the gaps identified. • To provide assurance for trusty board sign off before submission to the Regional Chief Midwife and NHSE/NHSI

Background:	• An independent maternity review into The Shrewsbury and Telford NHS Trust' and the maternity service, was commissioned by Jeremy Hunt in 2017 when he was then the Secretary of State for Health and Social Care. Concerns were raised by the two couples whose babies died shortly after birth in 2009 and 2016.
	• The initial review was of 23 cases however further families presented and there are now currently a total 1,862 cases for review.
	• A first report has been published on the 10th of December by Donna Ockenden, (Chair of the Independent Maternity Review). This report has been presented to the Health Select Committee at The Houses of Parliament. A second report is expected in December 2021
	• The report highlighted several failings:
	  • Lack of leadership
	  • Poor processes for Quality and Governance from ward to the board
	  • Not listening to families concerns.

Background:	• All Trusts were then asked to implement 12 immediate clinical priorities in December and report back to the national team. UHD had completed 10 of these standards with the further 2 in progress. • All Trust where also required to do a deeper analysis of 7 key immediate and essential actions using the NHSE maternity assessment tool. • This has also been completed with the maternity safety champions, the non-executive and executive leads for maternity and the LMS to establish a long-term plan for improving maternity quality and safety. • The Maternity Voices Partnership (MVP) also contributed to section 2 Listening to families. • Further work has commenced through the Local maternity system in establishing maternity safety reporting and UHD maternity team are fully engaged in this new governance structures. • Regional and National reporting of Quality and Governance mechanisms are also underway. • Boards have been asked to review their own processes to be confident that they know that mothers and babies are really safe.
Key points for members:	The 7 Immediate and essential actions are: 1. Enhanced safety 2. Listening to Women and families 3. Staff training and working together 4. Managing complex pregnancy 5. Risk Assessment throughout pregnancy 6. Monitoring fetal wellbeing 7. Informed Consent Many of the elements we have been making progress on improving maternity safety over the last 4 years following the better births recommendations. 60 - 70% of each of the standards are fully achieved by UHD. An action plan to address the gaps has commenced. Some of the actions are: ▪ Providing evidence from audits and actions taken from women's feedback needs to be improved. ▪ Developing the role of a senior independent advocate. ▪ Developing specialist clinics and Consultant ward rounds at night. ▪ Providing IT access in the community to record risk assessments. ▪ Developing the fetal wellbeing roles

Key points for members:	▪ Providing an up-to-date website for families to access for information on informed consent. ▪ Working with the LMS and regional team on developing the assurance framework for reporting and benchmarking our safety measure. ▪ Developing both the Clinical workforce and maternity team to provide a sustainable workforce for the future. To achieve all the standards this will require further investment into maternity services and business cases will be submitted to support any additional roles. The report trust board awareness of quality and governance ensuring that their maternity unit is safe.

Options and decisions required:	To sign off the maternity assessment tool and action plan for submission to the Regional Chief Midwife
Recommendations	There are no recommendations made.
Next steps:	After board sign off this report needs to be signed off by the LMS chair and submitted to the Regional Chief Midwife by the 15th of February. Maternity safety Champions to commence the action plan and report progress to the board. Maternity workforce to complete birthrate plus (the date given was the 31st of January) UHD are in the queue for this to occur.

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register.	
Strategic Objective:	**AF1** To provide assurance to the trust board of the continual work of the maternity safety champions in promoting safety within the maternity unit
BAF/Corporate Risk Register: (if applicable)	
CQC Reference:	**Safe**: Patients are protected from abuse and avoidable harm.

Committees/Meetings at which the paper has been submitted:	**Date**
Discussed at Maternity safety champions meeting with non-executive Caroline Tapster	11/1/2021
Care group board meeting postponed due to Covid so brought to Care group Director and Medical Director by exception	15/1/2021

University Hospitals Dorset
NHS Foundation Trust

Ockenden Report
December 2020
Assurance assessment

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Purpose

The purpose of this paper is to provide the Quality committee with the position of UHD maternity services in relation to the Ockenden report assurance framework for safety.

The first stage was reported to the board in December in relation to the 12 immediate clinical priorities assessment. This evidence was submitted on the 21st of December to the Regional Chief Midwife Helen Williams.

The second stage is a further assessment of our maternity services by completing the Ockenden NHS maternity services assessment tool.

This gap analysis will support our individual maternity safety action plans, which will need to be implemented in 2021.

The Trust board and the LMS chair must approve this paper.

The action plan and assurance of safety must be then submitted to the Regional Chief Midwife by the 15th of February 2021.

In addition to the above requirements, the analysis of our maternity unit and our safety action plan must be presented to the next Public Trust Board meeting to provide pubic assurance of safety.

This paper has been prepared by Lorraine Tonge Director of Midwifery and Alex Taylor Clinical Director in conjunction with the LMS and Patient safety and quality lead in the CCG.

The paper has also had oversight of the Care Group Director Care Group Medical Director and Non-executive maternity safety board member Caroline Tapster.

Background

An independent maternity review into The Shrewsbury and Telford NHS Trust' and the maternity service, was commissioned by Jeremy Hunt in 2017 when he was then the Secretary of State for Health and Social Care. Concerns were raised by the two couples whose babies died shortly after birth in 2009 and 2016.

The initial review was of 23 cases however further families presented and there is now currently a total 1,862 cases for review.

A first report has been published on the 10th of December by Donna Ockenden, (Chair of the Independent Maternity Review). This report has been presented to the Health Select Committee at The Houses of Parliament.

This report identified failings on the Shrewsbury and Telford NHS Trust in particular to its leadership and assurance framework of quality and safety.

Some of the themes where:

- Lack of compassion and kindness by staff to families,
- Recognition of the importance of close working relationships between Midwives and Obstetricians,
- Lack of continual risk assessment by clinicians in relation to Consultant and Midwifery care and the intended place of birth,
- Management of complex women,
- Escalation of concerns by staff,
- Poor Fetal monitoring training and interpretation training,
- Poor bereavement care, and failure to identify a deteriorating woman and give appropriate care.

There also was a lack of understanding that Obstetric anaesthetists and neonatologist are an integral part of the maternity team.

The report highlights Immediate and Essential Actions (IEA's) which all trusts must undertake which are intended to bring forward lasting improvements in maternity care. These IEA's will form the Trusts individual safety action plan following our gap analysis.

Maternity services assessment and assurance tool - gap analysis

Section 1

Action 1

Immediate and Essential Action 1: Enhanced Safety

Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

1. Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.

2. External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.

3. All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months

Link to Maternity Safety actions:

Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Yes we are using the National Perinatal Mortality Review Tool as a Pan Dorset MDT meeting monthly.
Dates scheduled for 2021.

Action 2: Are you submitting data to the Maternity Services Dataset to the required standard?

Yes we are submitting our data however we had a system upgrade in November to meet all the all MSDS submissions.
Our December submission will meet all the standards however the scorecard will be available from NHSI in March as this Scorecard is reported by NHSI in retrospect.

Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?

Yes we have reported all qualifying cases to HSIB and NHS Resolutions Early Notification scheme.

Link to urgent clinical priorities:

(a) A plan to implement the Perinatal Clinical Quality Surveillance Model

UHD fully supports the guidance released to implement the Perinatal Clinical Surveillance Model on the 18/12/20.

Principle 1-Strengthening trust level oversight of quality.

As Poole and RBCH trust merged on the 1st of October a new governance structure was put in place for UHD which meets the standard required. Reporting of Quality occurs to the board on a monthly basis. Non-Executive Director Caroline Tapster works alongside the safety champions.

The maternity safety champions will work with the LMS and the Regional Chief Midwife to strengthen quality surveillance.

LMS Maternity safety meetings commenced on the 7th of January and terms of reference discussed which will strengthen learning and quality assurance through the LMS.

Principle 2- Strengthening LMS and ICS role in quality oversight.

UHD maternity works closely with the LMS and will support quality surveillance through the ICS this will be strengthened through our LMS maternity safety meetings.

Principle 3 –Regional oversight and Principle 4-National oversight
Are both in development and UHD will be committed to support this change process?

(b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

All SI's and HSIB are reviewed at Maternity Governance and Trust Governance meetings and are reported formally through the Quality Committee each month. SI reports are presented by the Medical Director each month at Trust Board.

Maternity presents at the quality surveillance group throughout the year (on an invite basis) on maternity risk and quality however a more formal assurance framework is being agreed through the LMS for reporting and sharing learning for SI's .
The first LMS maternity safety meeting was on the 7th of January with terms of reference drafted.

What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?	RAG rating
Action 1 :Enhanced Safety 1.Dashboard UHD and Dorset LMS have the maternity Dashboard on each LMS partnership meeting and discussed.	Specific areas for improvement are identified at LMS partnership and at Trust Board. Further exploration of the data and the root cause enables the development of an action plan which is then presented to the LMS for agreement.	To evaluate if changes had occurred we re-audited in December 2020 as per action plan. Effective changes were demonstrated as Apgar <7 at 5 minutes are now 0.86% which	Update on local dashboard to meet national dashboard requirements. Dorset to be included in the Regional Dashboard data collection to enable regional	LMS Principal project lead to work with Daniel Webster LMS Consultant Obstetrician and UHD DOM and HOM at DCH to improve local and national dashboard. LMS maternity project lead to	LMS Principal Project leads time. Lead Clinicians time. CCG, IT technical help to implement national dashboard as it is developed.	LMS Principal Lead to agree with Regional chief midwife sharing of dashboard if regional chief Midwife not at LMS partnership until new dashboard is in place until escalation systems are in place.	

	An example of this mechanism for UHD would be through our NPMA data which showed that we were an outlier for Apgar <7 at 5 minutes and above the National mean in the year March 2016 to April 2017 at 1.7% The report was shared at the LMS partnership meeting by Consultant midwife Lisa Relton and An agreed action plan Implemented. Improvements have been seen and shared with the Trust Board.	shows a significant improvement This audit results was reported as a quality improvement to the LMS and outcomes of this improvement will be shared at next LMS partnership meeting.	comparisons and benchmarking. Improving the sharing of success and improvements at LMS partnership meetings	work with Regional Chief Midwife to include Dorset data in regional dashboard. Formalise sharing of quality improvements through standard item at LMS partnership giving assurance to the LMS Maternity Quality safety meeting of improvements or concerns Timeframe 6 months			

2.<u>External clinical specialist opinion</u>. All cases are reviewed through PMRT which is Pan Dorset MDT meeting which happens monthly. Findings from PMRT are shared through our governance structures Maternity risk meeting and Quality meeting	The PMRT generates actions to be taken which are shared with the maternity teams. An action plan is made from each PMRT case and thematic areas for improvements are noted. The overall themes feed into the maternity action plan tracker. The action plan tracker is reviewed quarterly to ensure there is a continuous drive for improvements and that changes have taken place.	Completion of the action and auditing changes to demonstrate change in care.	Improvements in our auditing schedule.	Consultant Obstetrician and Consultant Midwife Lisa Relton to lead on improving auditing schedule Timeframe 6 -12 months	This process will require an audit midwife to manage the auditing schedule and therefore this post will need to be through a job matching process and recruitment.	UHD DOM and Midwifery risk manager to review action tracker and highlight improvements and report through maternity safety champions and quality committee.	

<u>3. A summary and key findings from HSIB and Si's are sent to the trust board and LMS each quarter.</u> All SI's and HSIB are reviewed at Maternity Governance and Trust Governance meetings and are reported formally through the Quality Committee each month. SI reports are presented by the Medical Director each month at Trust Board. SI's are currently reported the LMS on completion and a panel review with feedback is given to the Trust on the SI. Maternity presents at the LMS quality surveillance group throughout the year of risk and quality however a more formal assurance framework has been agreed through the LMS for reporting and sharing learning for SI's . The first LMS maternity safety meeting was on the 7th of January with terms of reference agreed.	There is an On - going Pan Dorset action plan for shared learning across Dorset.	Completion of action plan.	No further action required as LMS maternity safety meetings agreed for sharing of SI's and HSIB learning.	LMS lead for quality and patient safety and UHD DOM to implement sharing. Timeframe 3 months	Clinical time to write up report and present cases.	As terms of reference agreed for LMS maternity safety meetings no further mitigation required.	

Summary of HSIB cases have been presented at LMS partnership for shared learning but these will now be reviewed at the LMS maternity safety meeting.	This demonstrates shared learning. Shared learning enables Trusts to look at their systems and processes to prevent the events from reoccurring.						

Action 2

Immediate and essential action 2: Listening to Women and Families

Maternity services must ensure that women and their families are listened to with their voices heard.

1. Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.

   We do not currently have an independent senior advocate role in our Trust. This role needs developing with job role, grading and recruitment process which the national team will be advising trust on this role.

2. The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.
   UHD supports the concept and will move to implementing this recommendation.

3. Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.
   Executive Board Safety Champion, Chief nursing officer, Paula Shobbrook and Non –Executive maternity Safety Champion, Caroline Tapster Is aware of their roles and responsibilities as board safety champions.

Link to Maternity Safety actions:
Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Yes we always request women's feedback through the PMRT process and this is followed up with a letter and a stamped addressed envelope for responses.

Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?

Service user feedback is given through a variety of sources.

Maternity Voices Partnership – A maternity voices partnership (MVP) for the east of Dorset is employed through LMS funding 30 paid hours per month.

The model is that the MVP collects family's feedback through different mechanisms including local community groups, social media platforms such as Face book and direct contact with families.

A report of themes and findings is reported through the LMS partnership meeting and actions taken. The MVP escalates and immediate concerns which require urgent attention by the Director of Midwifery. A telephone call is made directly to the DOM and immediate action is taken.

The MVP's also complete family surveys with parents and presents their findings through partnership meetings.

This intelligence guides changes within the maternity unit. Evidence of this was through Covid parents felt that they did not have enough information communicated to them. Social media our website and our text service were used to give up to date information.

Themes from the MVP reports are presented to the trust quality committee.

The MVP also co-produces the Maternity Services information leaflets ensuing that they can be understood by the audience of readers.

Friends and family feedback is another mechanism for service user feedback. This is provided on a monthly basis and positive and negative feedback is received. This feedback had been paused temporarily under Covid. As a trust UHD has re-instated Friends and family feedback

Complaints from patients are reviewed through our governances meetings. Themes and leaning are discussed and disseminated to staff.

Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Yes Trust safety champions meet bi-monthly - dates for 2021 set.

Link to urgent clinical priorities:

(a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.

(Evidence as above action 7)

(b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.

What do we have in place currently to meet all requirements of IEA 2?	How will we evidence that we are meeting the requirements?	How do we know that these roles are effective?	What further action do we need to take?	Who and by when?	What resource or support do we need	How will we mitigate risk in the short term?	RAG rating
1/ 2. <u>Independent senior advocate role</u> We do not currently have an independent senior advocate role in our Trust. This role needs developing with job role, grading and recruitment process	Unable to evidence until independent advocate employed and supporting women.	N/A	This role needs to be developed.	Midwifery risk and governance manager to support the process of development and implementation. Timeframe within 6 months	More information with expectation of this role, grading, job description, resourcing of role.	PMA to support the woman at the feedback appointment until an independent advocate is in post	

3.Board safety Champions. Executive Board Safety Champion- Chief Nursing Officer, Paula Shobbrook Non-Executive Safety Champion – Caroline Tapster	Minutes from safety meeting.	Supportive challenges to safety champions to improve care.	None	N/A	N/A		

Action 3

Immediate and essential action 3: Staff Training and Working Together

Staff who work together must train together

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.

  Prompt MDT training is happening throughout the year and continued during the Covid period online. We record the training after completion through ESR and aware of the % completion of each maternity team. This is one of our performance indicators. Currently this is not validated externally through the LMS. This will become part of our reporting mechanisms in 2021 through our LMS partnership and LMS maternity safety meeting by exception.

- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.

  Yes consultant led ward rounds happen twice daily over 24hours and 7 days per week. However adjustments to timings needs to be implemented.

- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

  The Chief Finance Officer confirms that external funding allocated for the training of maternity staff is ring fenced for this purpose only

Link to Maternity Safety actions:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Current Position

Monday to Friday 8am to 6pm, Consultant Obstetrician with a Registrar and SHO,
Monday to Thursday 6-9pm Consultant Obstetrician acts down as a registrar, On call Consultant Obstetrician available from home
Monday to Thursday 9pm to 8am Registrar and SHO, Consultant Obstetrician on-call from home
Saturday and Sunday am to 12pm, Consultant Obstetrician with a Registrar and SHO, then Consultant available from home

There will be planned changes from April the 1st 2021

The proposed changes will give more continuity of care & resilience, however they will leave a deficit of 7 Consultant programmed activities required to deliver Consultant led labour ward rounds twice a day, 7 days per week night & day.
The department has agreed a move to "hot weeks" in gynaecology to support the changes.

The workforce in Obstetrics & Gynaecology is interwoven.

It also should be recognised that similar sized units (Southampton & Portsmouth), circa 5000 deliveries, University Status have second tier of Registrars eg a Senior Registrar grade. This is the standard nationally. As a University hospital we are an outlier. It should therefore be our aspiration to work towards a second tier. This would then open up the additional allocation for ST trainees from HEE Wessex

Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?
No this is an area which needs improving but also has been impacted by Covid.

Link to urgent clinical priorities:

(a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week day and night
Current positions see above.

We currently meet the above standard for 4 days a week and daily consultant led labour ward wards rounds 7 days a week.
In addition there are telephone board rounds delivered Friday, Saturday & Sunday.
The programmed activity gap for Consultants to deliver this new standard

(b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place
Yes an MDT training programme is in place and dates set for 2021.

What do we have in place currently to meet all requirements of IEA 3?	What are our monitoring mechanisms?	Where will compliance with these requirements be reported?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?	RAG rating
UHD currently has monthly PROMPT training to meet the requirement of MDT training. All midwifery, support staff, obstetric and anaesthetic staff are required to attend on an annual basis and the faculty is MDT. Consultant led	Evaluation of each session to guide faculty on development of sessions Attendance is logged onto ESR and compliance followed up by practice education team This is currently	Training compliance will reported at the through our Care Group boards for performance by Consultant midwife. LW forum - the	Admin support to formally schedule the Obstetric team and the anaesthetic team onto prompt training. Changes in job plans required to allocate this training. Validation by the LMS Job plans to be	DOM/ Consultant Midwife to feedback to LMS partnership Obstetric Clinical	Admin support to formally schedule the Obstetric team and the anaesthetic team onto prompt training. Changes in job plans required to allocate this training Training compliance to be added to LMS partnership board agenda Support with Job	Obstetric and Anaesthetic staff currently booking themselves onto PROMPT dates Night time	

ward rounds happen twice daily and over 24hours and 7 days per week. Consultant is on site until 9pm 4 days a week. (Monday – Thursday). Therefore morning and evening rounds. Therefore 3 days a week ward rounds are only during the day hours.	documented in the CDS diary and attendance.	audit detailed in guidance is to review attendance in one ward round per month from CDS diary- this will form basis of feedback at LW forum. This will need to be reported through our audit programme.	updated to facilitate change in ward round times at weekend and nights 7 days a week. Business plan for further consultants posts to enable this service.	Lead to submit business case.	plans, and recruitment of Obstetric Consultants.	registrar completes 'board round' via telephone with consultant following obstetric and anaesthetic ward round-	

Action 4

Immediate and essential action 4: Managing Complex Pregnancy

There must be robust pathways in place for managing women with complex pregnancies

Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

- Women with complex pregnancies must have a named consultant lead
  Yes women with complex pregnancies have a named Consultant
- Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team
  Yes which is audited and on our audit plan.

Link to Maternity Safety Actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.
b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.

What do we have in place currently to meet all requirements of IEA 4?	What are our monitoring mechanisms?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?	RAG rating
All women have a named Consultant Women are risk assessed to low risk (midwifery led care) or high risk (Obstetric led	Audit 5074 has been updated to review correct allocation to consultant care following risk assessment as high	This audit has not routinely been reported but will be reported through maternity risk and governance	Improving auditing schedule	Consultant Obstetrician and Consultant Midwife Lisa Relton to lead on improving auditing schedule	This process will require an audit midwife to manage the auditing schedule and therefore this post will need to	Consultant Midwife will report on audit until an audit midwife in post.	

care) at booking Once a complex pregnancy is identified they are allocate to the appropriate Consultant. We currently have one Sup- speciality trained fetal medicine Consultant and 2 Fetal medicine Consultants with ATSMs. In addition we run high risk maternal medicine clinics in Diabetes, and maternal medicine clinics to plan care for high risk mothers with Cardiac, endocrine and haematogical conditions. We have recently appointed a LTFT	risk	meetings and locally at clinical governance and exceptions will be reported to trust board quality committee.	Further development of maternal medicine clinics require further adjustment to job planning to and additional Consultant time to facilitate this development. Also on-going support for additional clinic For example extra clinic space. This will also require additional USS scanning time and USS machines. We also need to improve triaging in	Timeframe 6 -12 months Clinical Director to map of requirements for additional specialist clinics. DoM to map out midwifery support for these clinics (PNMH business case already submitted.) Business plans to be submitted to develop the maternal medicine service.	be through a job matching process and recruitment as UHD does not have an audit midwife in post Consultant time in terms of job planning of any new additions to the obstetric Consultant team.	These women would currently be seen in general obstetric team with support from either local maternal medicine consultant or support from UHS obstetric physician.	

Consultant colleague to add resilience and have funding in place to advertise for a new fetal medicine colleague to help meet the standards required eg for multiple pregnancy. UHD supports the Maternal Medicine Centre in Southampton. MDT representation (midwifery, obstetric (Maternal medicine specialist) and anaesthetic representation are in place at the local maternal medicine clinical network. By utilising the proposed hub and spoke model, University			our ANDA and perinatal mental health services. As the maternal medicine specialist centres are developing in Southampton it is currently unknown whether the Trust will be expected to contribute to funding streams going forward.				

Hospitals Southampton is the hub that we can refer complex cases but the care will still be provided at UHD by local clinicians with support from the Obstetric Physician at UHS. We have a named consultant that links with the maternal medicine network primarily (RJS) and ensures learning and information is cascaded to the maternal medicine consultants and senior midwifery team for dissemination and to ensure guidance reflects the work put forward in the maternal medicine network. Consultant midwife teaches							

on the maternal medicine midwifery training days with the Obstetric Physician for Wessex Maternity Academy. Topics covered -The midwives role in understanding complex pregnancies secondary to pre-existing disorders. We have commenced joint specialist clinics with haematology, cardiology, and diabetes and have plans to roll this out to neurology which will also support work from other national reports. .							

Action 5

Immediate and essential action 5: Risk Assessment Throughout Pregnancy
Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.

- All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional.
  Yes all women are assessed at every contact.

Risk assessment must include on-going review of the intended place of birth, based on the developing clinical picture

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.

What do we have in place currently to meet all requirements of IEA 5?	What are our monitoring mechanisms and where are they reported?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?	RAG rating
All women are risk assessed at each contact and place of delivery discussed. This has been implemented by paper documentation if IT is not available in the community. .	Risk assess Audit has been added to our audit plan and will be audited monthly	This will be reported through our maternity risk meeting to care group governance by exception.	Audit of risk assessments. IT equipment for Community midwives. Development of the Personalised care Plan through the LMS pan	IT midwife to provide DOM with a Gap analysis of IT equipment in Community. Interim IT equipment to be purchased. Audits once audit midwife in post.	Audit midwife to support assurance framework IT equipment in Community	Paper audit in 3 months by Consultant midwife.	

Action 6- we have continued to engage and submit the quarterly reports to the local clinical network for Saving Babies Lives v2 Compliance Examples of our progression to achieve compliance are : Element one: NRT to partners to help reduce number of women smoking in pregnancy (including systems level work with Mat-Neo SIP) Element two: update to the GROW policy including UA Doppler's(Poole site) Element 3: text messages to all	We have a monthly SBL meeting and actions and minutes are recorded centrally- this is then included in the update to the safety champions. This is monitored through MIS safety meeting, And reported to Quality Committee.	Safety champions, and quality committee	Dorset digital project. Audits of improvements to demonstrate effective change.		Audit midwife	We will continually submit quarterly returns to the region.	

women on importance of fetal movements , Element five: development of the preterm birth clinic including a SOP to support this. PReCePT lead midwife and obstetrician lead work for region as part of Mat-Neo SIP with 100% administration of MGSO4 to those requiring MGSo4 prior to 30/40 .							

Action 6
Immediate and essential action 6: Monitoring Fetal Wellbeing All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring. The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: - • Improving the practice of monitoring fetal wellbeing – • Consolidating existing knowledge of monitoring fetal wellbeing – • Keeping abreast of developments in the field – • Raising the profile of fetal wellbeing monitoring – • Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported – • Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. • The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. • They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. • • The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.
Link to Maternity Safety actions: **Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?** **Yes** **Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?**
Link to urgent clinical priorities: a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

What do we have in place currently to meet all requirements of IEA 6?	How will we evidence that our leads are undertaking the role in full?	What outcomes will we use to demonstrate that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?	RAG rating
A Fetal Monitoring Lead Midwife 0.4wte was appointed in January 2020.This role has been funded until December 2021 by LMS transformation. The Lead Obstetrician for Labour Ward is informally recognised as he Lead Obstetrician for Fetal Monitoring. We will need to recognise this role formally	Our audit programme includes fresh eyes on CTG's and assurance that we are adhering to our guidance.	Reduction in admission to NICU with HIE secondary to poor interpretation of CTG's.	Increase Fetal monitoring midwife time to achieve extended targets of the role. Lead Obstetrician Job planning, and time to fulfil this role. Which will require further Consultants in post	Business case submitted by DOM to increase fetal monitoring midwife from 0.4wte to 0.8wte. Business case to be submitted by Clinical Director.	Increase Fetal monitoring role HR and business manager support to submit business case .	Support from intra-partum Matron and consultant midwife. Informal arrangement to continue.	

Action 7
Immediate and essential action 7: Informed Consent All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery. **The Dorset Maternity Matters website is comprehensive with information about all aspects of pregnancy, labour, birth and afterwards.** All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care We use the website Dorset maternity matters to support this process which also has links to national guidance Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care **We strive to enable women to be involved in their decision making and enabling informed choice**. Women's choices following a shared and informed decision-making process must be respected.
Link to Maternity Safety actions: **Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?** **We work closely with our MVP's .UHD MVP link is Rachel Filmer who assisted us in the co-production of our web site and read many documents to insure we are meeting women's needs.**
Link to urgent clinical priorities: a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.

What do we have in place currently to meet all requirements of IEA 7?	Where and how often do we report this?	How do we know that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?	RAG rating
We direct women to Dorset Maternity Matters webpage for information which also links to national sites. We also have local patient information leaflets which our MVP is also involved in any updated leaflets or changes. Additional time and support is given to women who wish to birth or have care outside our guidelines or national recommendations. A Consultant midwife will see them to provide the additional time to discuss their	We do not have any reporting mechanism for the webpage.	Positive feedback from women	Review of current website and update Information.	Resources to be identified once understanding of requirements	Clinical time to support the LMS with this update	Initial review of website by LMS team.	

wishes and all decisions are respected.							

Section 2

MATERNITY WORKFORCE PLANNING

Link to Maternity safety standards:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard
Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?
Yes

We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st January 2020 and to confirm timescales for implementation.
We do continual workforce midwifery gap analysis and report through our non- clinical workforce group which reports to UHD quality committee.

What process have we undertaken?	How have we assured that our plans are robust and realistic?	How will ensure oversight of progress against our plans going forwards?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?	RAG rating
Midwifery workforce is analysed daily by the operational Matrons at the maternity safety huddle to ensure safe staffing over the 24 hour period and forward	We are reassured by our reviews of our red flags and any gaps in our day to day are managed effectively. There is full support for	Continue with our maternity workforce reviews and reporting to Trust Board.	Birth-rate plus to be completed as a merged organisation.	DoM to plan this work	Clinical time to support the assessment	Continue to have monthly recruitment and rolling advert to appoint staff.	

planning for any gaps developing. Monthly workforce review is analysed by the DoM and Matrons Six monthly quality reports is submitted to the non-clinical workforce group and escalated to the Quality committee As we have now merged we have requested a review of Birth-rate plus as a merged organisation. Birth-rate plus has been contacted and awaiting a date for this work to commence.	maternity recruitment. There is commitment to Birth rate plus.						

MIDWIFERY LEADERSHIP

Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care

UHD became a merged organisation in October 2020.
The Midwifery leadership structure was based on "Strengthening midwifery leadership: a manifesto for better maternity care.
There is a Director of Midwifery who is accountable to the chief nursing officer.

NICE GUIDANCE RELATED TO MATERNITY

We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.

What process do we have in place currently?	Where and how often do we report this?	What assurance do we have that all of our guidelines are clinically appropriate?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?	RAG rating
New NICE guidance is reviewed by Consultant Obstetrician and Consultant Midwife. Current guidelines are reviewed monthly be Consultant midwife to	At present there is no direct reporting mechanism.	All guidelines are MDT reviewed in line with NICE guidance. .	We need to align RBH and Poole guidance now we are UHD, although work commenced on this previously there are still guidelines due for review or required variation due to care delivery on each site.	Consultant Midwife and risk lead at RBH with support from Obstetric lead for guidelines. By 6 months	Protected time to complete this task IT support for update of guidance available to staff	To add Nice guidelines to maternity risk governance agenda and report maternity quality and safety report to Care group governance and by exception to Quality Committee.	

allocate a timely review for those which are coming up for review Changes are made to current maternity guidelines as appropriate. The guidelines are then ratified through our governance procedures. Also if the guidance includes medication this is reviewed at the Trust Drug and Therapeutics Committee. Final ratification and sign off is at Trust Clinical Policies and Procedures group.			We also need to have a reporting mechanism through governance for guidelines.				

Fully meets standard	Partially meets standard >60%	Majority of standard not met

Ockenden Report Action Plan

Maternity safety champions are responsible for the overall action plan oversight:					
Action Ref	**Action description**	**Action Owner**	**Target date**	**Resources required**	**Evidence and assurance** **Status (and closure date, when closed)**
IEA 1 Enhanced Safety **Dashboard**	Update on the local dashboard to meet national standards. UHD to be included in the Regional and National dashboard to enable comparable comparisons and benchmarking Formalise sharing of quality improvements successes from the dashboard through the LMS and Trust Board.	Consultant Obstetrician /Care Group Medical Director Daniel Webster, LMS-Principal Project lead Hannah Nettle Director of Midwifery Lorraine Tonge	September2021	Lead Clinicians time Principal Project leads time CCG, IT help to implement National dashboard as it is developed.	**LT- 11/1/21 Sharing of example of national dashboard from national team.**

IEA 1 Enhanced Safety **PMRT**	To demonstrate and provide assurance to the board of the learning from PMRT an auditing programme from completion of the actions needs to be implemented.	Maternity risk and governance Midwifery Manager Emma Barton	July 2021	Business case for auditing Midwife. Job description and recruitment. Commence further audits	
IEA 1 Enhanced Safety **SI and HSIB**	Sharing of SI's and HSIB key findings and learning to be presented at the LMS - maternity safety meeting bi-monthly. Exceptions to be raised at QSG	LMS-Principal Project lead Hannah Nettle Director of Midwifery Lorraine Tonge	March 2021	Clinical time to write up reports and present cases.	**LT-11/1/2021 Draft LMS safety meeting terms of reference at first safety meeting on the 7/1/2021**
IEA 2 Listening to Women and their Families	We do not have an independent advocate role in our Trust. This is a new role and the national team will be providing the standards for this role with Job description and expectations of the role.	Director of Midwifery Lorraine Tonge	September 2021	Business case for independent senior advocate post and recruitment once post is defined.	
IEA 2 Listening to Women and their families	We collect and receive feedback from women in many formats but need to demonstrate how we use this feed-back to make improvements. To do this we need to collate and evidence and the changes we make.	Maternity risk and governance Midwifery Manager Emma Barton	July 2021	Business case for a midwife to manage women's feedback, themes, and evidence improvements.	
IEA 3 Staff Training and Working Together	Prompt training occurs but % completion is not currently reported through the LMS or Trust Board % completion of MDT prompt training to be reported through maternity governance, care group governance, quality committee and trust board by exception. % completion of MDT prompt training to be	Director of Midwifery Lorraine Tonge Clinical Director Alex Taylor	July 2021	Escalation Framework from Region Admin support to schedule medical team onto prompt training.	

	reported to LMS maternity safety and LMS QSG by exception which twill then report to Region.				
IEA 3 Staff Training and Working Together	Twice daily Consultant ward rounds both day and night. Map out requirements, Job planning, Business case Recruit new Consultants	Clinical Director Alex Taylor	July 2021	Business case for Consultants and recruitment process – assistance from business manager Georgina Floyd.	
IEA 4 Managing complex pregnancy	Maternal medicine clinics and Maternal Medicine Centre Additional specialist clinics required. We need to map out the requirement and resources required to support these clinics for example USS Sonographers, equipment and time clinics space. Obstetric Consultants and Gynaecology Consultants are interwoven so any additional requirements for Gynaecology would be needed to support Obstetric changes. Maternal medicine centre unknown what resources may be required for UHD to support	Clinical Director Alex Taylor	April 2021 September 2021	Mapping out the requirements, Business case for Consultants. Recruitment process – assistance from business manager Georgina Floyd to support this process.	
IEA 5 Risk assessment throughout pregnancy	All women to be risk assessed at each AN visit and place of birth discussed. Evidence that this is occurring by audit. Ability to Risk assess in the community currently on paper but needs to be digitally recorded.	Maternity risk and governance Midwifery Manager Emma Barton	July 2021	(As above in IEA 1) Business case for auditing Midwife. Job description and recruitment. IT equipment required to enable midwives to	

				record digitally.	
IEA 6 Monitoring Fetal wellbeing	Requirement fetal monitoring midwife And fetal monitoring Obstetric Consultant.	Director of Midwifery Lorraine Tonge Clinical Director Alex Taylor	July 2021	Business case for fetal monitoring additional hours submitted Business case for Consultant fetal monitoring lead to be submitted.	**LT-Fetal monitoring midwife for 0.4 of the role until December 2021.**
IEA 7 Informed Consent	Improving our informed consent information on Maternity matters website. Understanding the requirement from leaflets to website information.	LMS-Principal Project lead Hannah Nettle	September 2021	Clinical time to support this Pan Dorset work through LMS. Support from Regional chief midwife to understand the requirement fully.	
Midwifery Staffing	Complete Birth-rate Plus and timescales for completion	Director of Midwifery Lorraine Tonge	Plan by end of January and completion 6 months from commencing process	Clinical time from Digital midwife to support this review.	**LT 11/1/2021 BR plus quoate for work received ,** **Awaiting date from BR plus to commence work.**
Nice guideline related to maternity.	Review of all NICE guidelines to keep policies updated	Maternity risk and governance Midwifery Manager Emma Barton	July 2021	Midwifery and Obstetric time to review policies	
	<u>Summary</u> This action plan requires significant extra midwifery and Obstetric Consultant posts and there is a risk of not being able to fulfil these due				

	to the national demand. Action plan to be reviewed monthly by Clinical Director Alex Taylor and Director of Midwifery Lorraine Tonge and to report back progress to Executive maternity safety champion Paula Shobbrook and Non -Executive Caroline Tapster at maternity safety champion bi-monthly meetings.				

Completed action	Making good progress	Work to commence

Summary

UHD had been working on of many of these priorities prior to the Ockenden report. Merging our Trusts in October has enabled a full review of our governance structures and reporting mechanisms of Safety and quality to the Trusts board.

The gap analysis shows good evidence of maternity safety is in place at UHD. Further work is needed with the regional and national team to develop the assurance framework.

To meet some of the safety recommendations further workforce investments are required.

UHD maternity safety champions will fully engage in Regional and national quality and safety improvements planned for 2021.

The Trust confirms the clear mandate from NHSE/I in the letter sent 15th December that the trust must ringfence the CNST maternity incentive scheme value for investment in maternity quality. The Chief Financial Officer is in discussion with the Regional Finance Director on the impact of the allocation of funding in respect of the impact on the UHD quality and safety prioritisation process.

Work will continue on these priorities and action plan and reviewed each quarter by the maternity safety champions. The progress of the action plan will be reported to the maternity safety non-executive and Executive champions and any challenges in achieving the outcomes will be highlighted.

Next Steps Key Deadlines

Following this initial submission of 12 clinical priorities implemented, Trusts are required to complete the following:

1. The assurance framework and the safety action plan the to be approved by the Trust board and the LMS chair .The action plan and assurance of safety must be submitted to the Regional Chief Midwife by the 15th of February 2021.

2. In addition to the above requirements, the analysis of the Trust maternity unit and our safety action plan must be presented to the next Public Trust Board meeting to provide public assurance of safety.

3. The action plan to commence and the maternity safety champions to report back to trust Board quarterly on it progress.

4. Evidence to support the Trust Assessment will be requested and submitted through a NHS portal which should be in place by March 2021.

5. Further Ockenden reports are expected to be presented in December 2021 as the investigation continues.

Supporting guidance documentation


Ockenden Letter CEO Chairs final 14.1


Assessment and assurance tool.docx


Implementing a revised perinatal qual


A core competency framework.pdf


Provider Board level measures - minimum


Transforming perinatal safety.pdf


Annex - Role of the non-exec board safet

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 27th January 2021

Agenda item: 8.4

Subject:	Quality Impact Assessment

Prepared by:	Helen Rushforth, Head of Productivity and Efficiency
Presented by:	Paula Shobbrook, Chief Nursing Officer

Purpose of paper:	For noting
Background:	Following a sustained period of efficiency requirements CIP is increasingly challenging to identify and deliver and tends to be more transformational (and therefore impactful) than previously. As such a robust approach to Quality Impact Assessments ensuring that decisions are considered for their risk to quality individually and collectively is increasingly important. All CIP schemes should be considered for their impact and where necessary a review by the Chief Medical Officer, Chief Nursing Officer and Associate Director, Quality Governance and Risk undertaken. This is undertaken in line with the UHD QIA policy.
Key points for members:	c. £4.1m schemes have been fully agreed or agreed in principle. The £2.4m schemes not ready are being reviewed in light of changing operational approaches and may be discontinued or taken forward for review.
Options and decisions required:	N/A
Recommendations:	The QIA is reviewed at the Finance and Performance Committee and Quality Committee, from the QIA reviews to date, there are no exceptions which impact negatively on safety or quality to report to the Board.
Next steps:	Nil to escalate to the Board

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

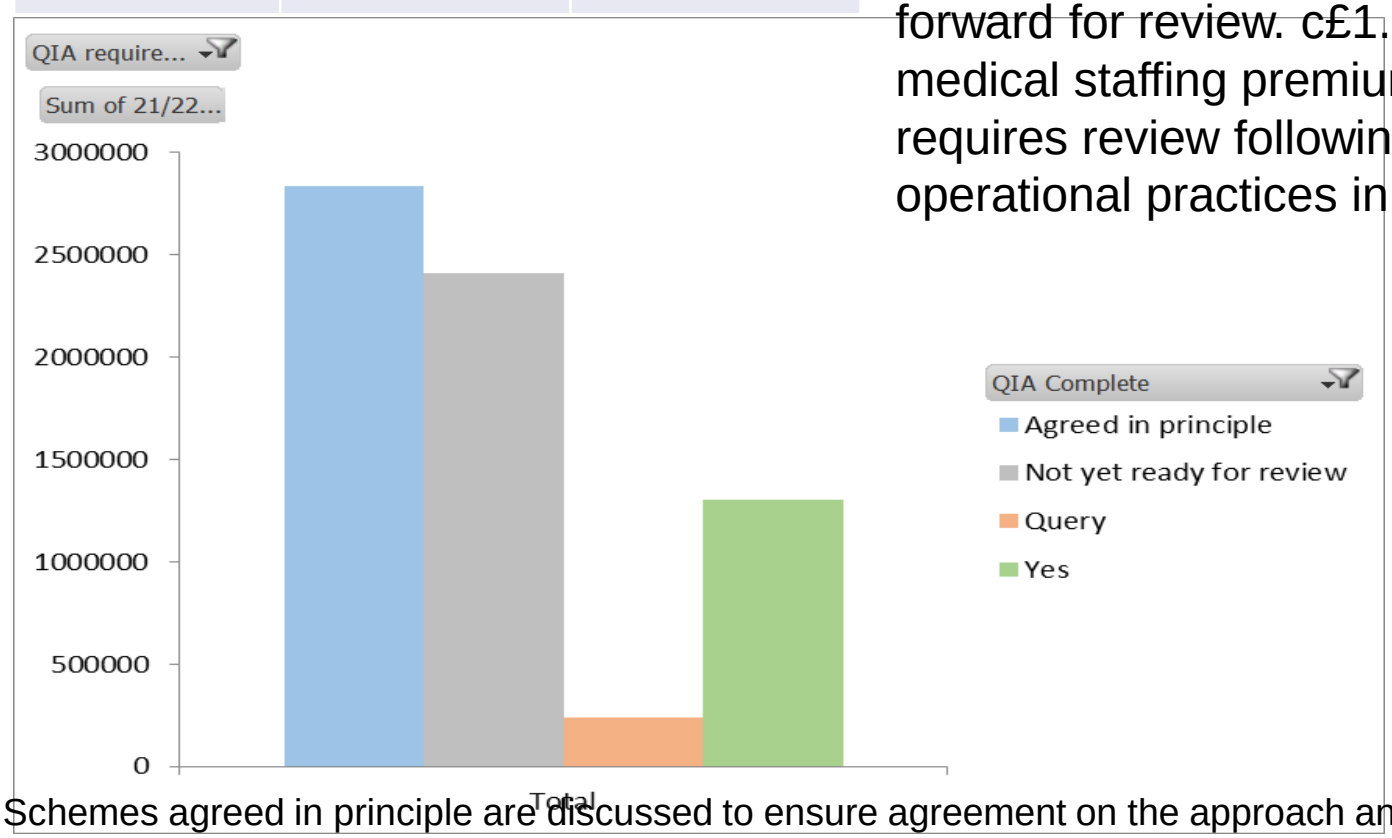
Committees/Meetings at which the paper has been submitted:	**Date**

Quality Impact Assessment Update

University Hospitals Dorset NHS Foundation Trust

Requiring QIA?	Total No of Schemes	FYE £000's
Y	106	£12,321
N	84	£3,643

c. £4.1m schemes have been fully agreed or agreed in principle. The £2.4m schemes not ready are being reviewed in light of changing operational approaches and may be discontinued or taken forward for review. c£1.1m relate to medical staffing premium spend that requires review following the change to operational practices in light of COVID.



Schemes agreed in principle are discussed to ensure agreement on the approach and likely impacts to enable projects to move ahead. Final approval is still required

£000's	Income (Patient Care Activities)	Income (Other)	Non-Pay (Clinical)	Non-Pay (Non-clinical)	Drugs	Pay (Premium spend)	Pay (Skill Mix)	Pay (WTE)
Surgical	25	0	63	10	0	782	27	0
Medical	274	0	263	5	0	1,001	0	189
Specialist	41	18	181	7	0	24	142	81
Corporate	78	24	159	638	0	2,861	97	1,420
Grand Total	**418**	**42**	**666**	**660**	**0**	**4,668**	**265**	**1,690**

Pay (WTE) includes vacancy factor savings which do not reflect permanent reductions in establishment but vacancies that are not currently filled (£1,112k)

Corporate Premium Spend includes plans for a Trust-wide approach to managing premium pay that will be spread across the Care Groups as the work is developed

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 27 January 2021

Agenda item: 8.5

Subject:	Six Month Safe Staffing Review (Q1 & Q2) 2020

Prepared by:	Fiona Hoskins, Deputy Chief Nursing Officer Sue Reed, Care Group Director of Nursing Medicine Kate Horsefield, Care Group Director of Nursing Surgery Claire Rogers, Care Group Director of Nursing Specialities
Presented by:	Paula Shobbrook, Chief Nursing Officer.

Purpose of paper:	This slide deck is presented to provide the committee with assurance around the management of safe nurse staff levels across the Trust.
Background:	Trusts are required to report to Board every six months on the topic of safe staffing. Historically this has been done in the form of a formal paper. With the current pandemic however, ward templates and reporting procedures have changed to a degree that the usual format would not provide assurance.
Key points for members:	To note the challenges to reporting on safe staffing during the pandemic. In particular: • The adjustment to templates to support social distancing and infection control management. • The complexities of managing safe staffing during a pandemic. • The reconfiguration of the Stroke Pathway • The complexity of critical care staffing in wave 1.
Options and decisions required:	Item is for information only.
Recommendations:	Item is for information only
Next steps:	N/A

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	Valuing Staff
BAF/Corporate Risk Register: (if applicable)	N/A
CQC Reference:	Safe, Effective, Caring and Well led

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

University Hospitals Dorset
NHS Foundation Trust

Review April – October 2020

Q1/2

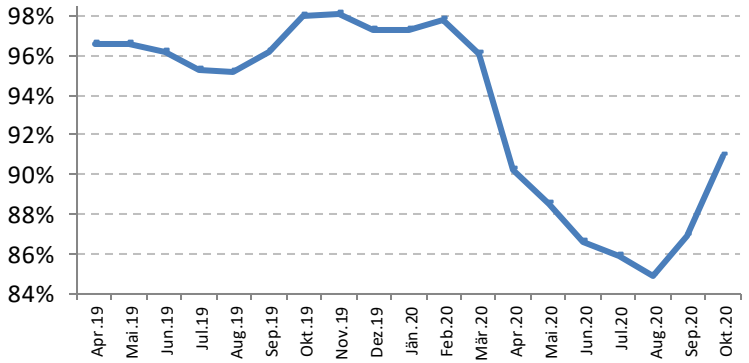
Replaces the standard 6 month safe staffing paper

Corporate Safe Staffing

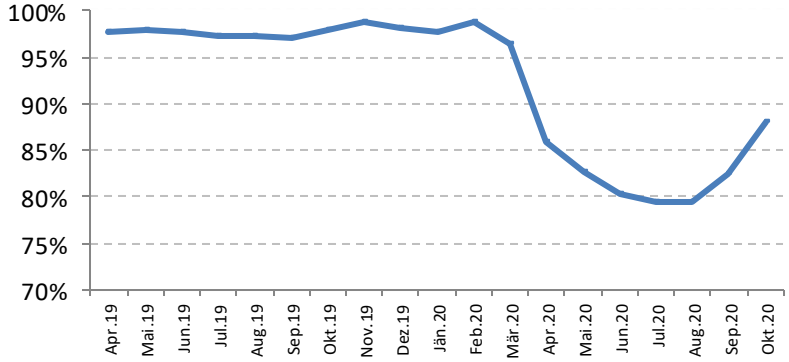
University Hospitals Dorset
NHS Foundation Trust

Corporate Safe Staffing

- Safe Staffing data is now included in the monthly Quality metrics for the Trust Integrated Performance Report. The metric for Care Hours Per Patient Day for registered nurses by day and night is set out opposite. The full report includes Care Staff and red flag data. The drop in CHPPD between April and August 2020 reflects the redeployment of staff to critical care and the front door during the first wave of the pandemic.
- During Quarter one the national Unify data submission was placed on hold. This was restarted for quarter two, however with the significant changes to templates, due to the pandemic, it is not a reliable reference tool for identifying safety concerns. During the pandemic the use of professional judgement and red flag data has been key to this. These reviews have been undertaken the through daily safe staffing meetings.
- At the beginning of the pandemic a large scoping exercise identifying staffs clinical competencies was undertaken and a data base built to support staff repositioning.
- The Trust education team supported the repositioning of Trust staff by putting on additional training for staff. This included Fit Testing and respiratory training.
- During the pandemic the Trust welcomed additional support from Aspirant Nurses (3rd year student nurses) and Returning Nurses (recently retired). These nurses were deployed to areas where they felt able to work and enabled the release of Trust nurses into critical care or to the front door.
- Following on from the Aspirant nurses. The newly qualified registered nurse in take for September 2020 has gone ahead as planned with many nurses already in post.
- International recruitment was paused during lockdown 1 and recommenced in July 2020.
- Whilst staffing during the pandemic has been challenging there were no red flags that went un-mitigated.



Registered Nurses' & Midwives staffing fill rate. Day shifts

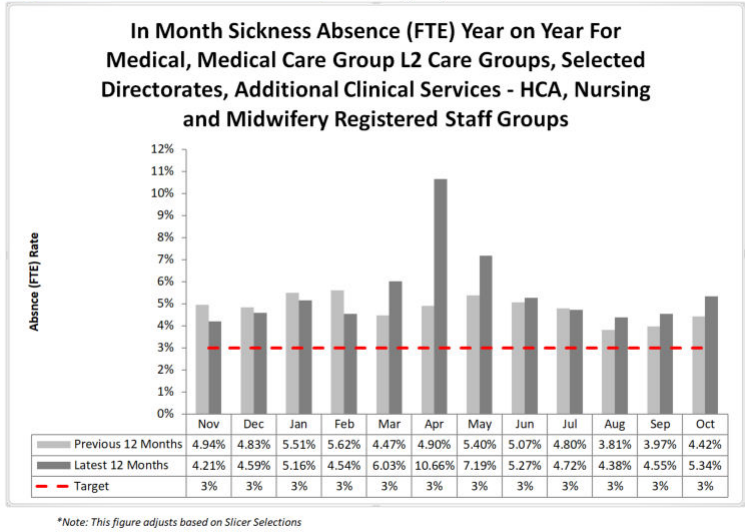


Registered Nurses' & Midwives' , staffing fill rate. Night shifts.

Medical Care Group
RBCH Site

University Hospitals Dorset
NHS Foundation Trust

- Ward reviews continued to happen with the Head of Nursing and Quality in the medical care group, to ensure robust governance and planning.
- AMU in wave one operated a split assessment unit to achieve blue and green pathways whilst everyone embraced this it was coupled with significant challenges. In June with IPC guidance we went back to one AMU.
- Social distancing beds in AMU has allowed for adaptions to the AMU template supporting the opening of the frailty pathway 24/7 on wards 25 and 26.
- Older Persons Assessment Unit launched in September 2020 24/7 with investment from COVID-19 monies to support this initiative. This also aligns with the Poole site model. OPS has been through several ward moves to start the pathway work incorporating the short stay model. This is a work in progress but something that we are proud to have achieved for our patients and staff during the pandemic.
- During the pandemic wards 24,25,26,22,14 have all been COVID-19 receiving wards the pace of change has been well adopted but has caused frustration among staff. A review of all wards is part of good governance and financial management.
- CCU permanently relocated to Ward 23 during the pandemic and following a recognition of patient benefits has stayed in place, this has required a staff consultation due to the loss of beds on Ward 23. This work has been through formal sign off with the CNO to ensure governance and financial alignment.
- ED is operating with a co-located minors causing logistical and workforce challenges. During wave one ED was supported by repurposed staff this has been pulled back and meant ED is now requiring 35% Bank & agency usage average. ED has had indicative sign off of its new template and authorisation to commence substantive recruitment. A joint Virtual recruitment day is planned for UHD. The ED template has been benchmarked against the recent RCN standards for Safer EDs. A joint template review for good governance and financial sign off is planned for early December.
- As a care group we continue to look for new and active ways to recruitment and have participated in HCA trust open days, and overseas recruitment.



	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Previous 12 Months	4.94%	4.83%	5.51%	5.62%	4.47%	4.90%	5.40%	5.07%	4.80%	3.81%	3.97%	4.42%
Latest 12 Months	4.21%	4.59%	5.16%	4.54%	6.03%	10.66%	7.19%	5.27%	4.72%	4.38%	4.55%	5.34%
Target	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%

*Note: This figure adjusts based on Slicer Selections

COVID-19 Pandemic started in April 2020, the graph above shows the steep climb in sickness figures. The added complexity of COVID-19 has contributed to this presenting an additional workforce challenge in the medical care group. The workforce was supported by specialist nurses, aspirant nurses and other areas due to stopping of all electives in Wave one. The start of wave two has been challenged as electives are encouraged to continuing adding a complexity to the workforce.

Medical Care Group
PH Site

University Hospitals Dorset
NHS Foundation Trust

- Stroke acute pathway reconfigured and opened September 2020. Reconfiguration saw the cessation of acute stroke admissions at PHFT and centralising on the RBCH site. This approach improved Hyper acute care for some 1300 patients per year and improved the parity of service by consolidating RCP recommendations at RBCH The move saw new TIAs managed predominantly at the Poole site. Full staff consultation implemented.
- AMU has seen an improvement in recruitment with a current B5 gap = 1.5 WTE however skill mix is a current issue with a high number of junior B6 staff which is under review. HCA reports low turn over in the unit.
- ED resus split into blue & green pathways with an introduction of Pit stop. Additional unfunded increase in establishment. Indicative sign off of the new template.
- DME unfunded summer escalation beds remained open which was in response to the Covid 19 pandemic however staff morale was impacted due to sickness and vacancy gaps.. Supportive and proactive senior management oversight was undertaken.
- Establishment template reviews undertaken in August/September using the Shelford Safer Staffing Tool. Additional work being led by the Group Director of Nursing to align establishment reviews across the medical care group
- Strong leadership demonstrated in Endoscopy with regards to reducing the increased patient waits, due to Covid 19.
- RACE unit celebrated its 10th anniversary on 21.06.20, on Teams. Allowing all staff to feel proud about the success of the unit.
- Particular recruitment challenges in Neurology enabled development of Advanced Practice role in MS & spasticity and a desire for better referral management. As a care group we continue to look for new and active ways to recruitment and have participated in HCA trust open days, and overseas recruitmentt.

Directorate	Organisation	12m Rolling	2019/2020 Q3	2019/2020 Q4	2020/2021 Q1	2020/2021 Q2
Care Group Total		3.52%	3.57%	3.35%	3.26%	3.43%

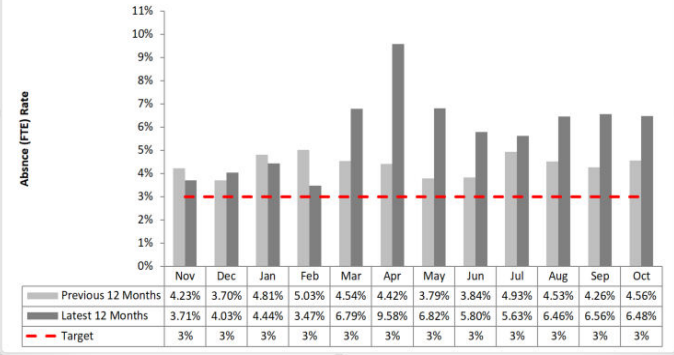
Despite the COVID-19 Pandemic affecting the organisation in March 2020 the chart above shows an improving picture of overall sickness incidences. There were still areas that had seen increased sickness in the early stages of wave one such as ED, Medicine and DME and these were in the admission areas of either positive/suspected Covid 19 patients.

Surgical Care Group
(RBCH and PH Sites)

University Hospitals Dorset
NHS Foundation Trust

- The majority of Ward template review's have been completed on the Bournemouth site up until October 2020.
- The Surgical templates for the Poole site have been reviewed by the Interim Head of Nursing and are planned to be submitted for formal template review in April 2021 but it is anticipated that these will require further analysis and benchmarking in advance of the formal reviews to ensure that proposed templates are safe and within the financial envelope.
- The Bournemouth site ITU template has been reviewed against Poole and other ITUs in the SW regional network, in addition to standardising the shift patterns for consistency with the Ward shift patterns for long days. This has necessitated an increase in the template so as to support an additional RN at night and the standardisation of shifts which will be submitted for sign off at budget setting.
- During the first wave of Covid 19 staff from all over the Trust were redeployed into ITU to support surge capacity. The majority of the redeployed staff were specialist nurses and theatre staff. All redeployed staff underwent a bespoke training programme to support them during their allocation to the unit.
- During the summer of 2020 and following on from the first wave of Covid 19 the Surgical Directorate took the opportunity to execute a plan to merge Wards 15 and 16 into a new 50 bedded Enhanced Surgical Care Unit otherwise known as ESCU. Two of the bays have been reduced to 4 beds from 6 beds but have maintained the same nursing template to provide acuity bays with a higher nursing ratio to support high acuity patients or patients stepped down from ITU. Wards 15 and 16 staffing templates have been merged to support the ESCU with some slight adjustments to increase night template
- The vacancy rate for nursing and Healthcare assistants has reduced from 4.21% in November 2019 to 3.16% in October 2020. The turnover rate is also in a downward trend from 7.39% in November 2019 to 4.71% in October 2020
- We continue to actively recruit both HCAs and Registered practitioners and are expecting 6 overseas nurses to join the Care Group between now and February 2021
- Vacancies in Theatres on both the Bournemouth and Poole Sites have reduced marginally with the appointment of newly qualified ODPs in September. There is a higher vacancy rate in the Poole theatres following an establishment review against increased activity.
- We continue so support ITU with Theatre staff during the second wave of Covid 19 as staff previously redeployed from wards are no longer available given that the Trust has remained fully operational.

In Month Sickness Absence (FTE) Year on Year For Surgical, Surgical Care Group L2 Care Groups, Selected Directorates, Additional Clinical Services - HCA, Nursing and Midwifery Registered Staff Groups



	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Previous 12 Months	4.23%	3.70%	4.81%	5.03%	4.54%	4.42%	3.79%	3.84%	4.93%	4.53%	4.26%	4.56%
Latest 12 Months	3.71%	4.03%	4.44%	3.47%	6.79%	9.58%	6.82%	5.80%	5.63%	6.46%	6.56%	6.48%
Target	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%

*Note: This figure adjusts based on Slicer Selections

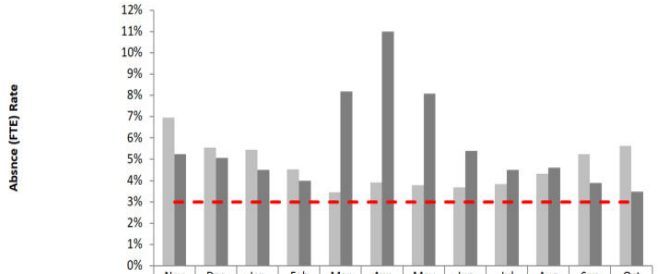
Overall sickness rates for the Surgical Care Group are consistently higher than 2019 reaching a peak of 9.58% during the first phase of the Covid pandemic. This did reduce slightly over the summer months but has seen a slight increase again during the second surge which is expected to increase further. There has been a significant impact on staff health and well being particularly amongst staff redeployed to ITU during the pandemic. Clinical leads are working hard to ensure that the appropriate psychological support mechanisms are available to all staff affected

Specialities Care Group

NHS
University Hospitals Dorset
NHS Foundation Trust

- Roster template reviews continue with Directorate teams and Head of Nursing and Quality within in Care Group, to ensure robust roster governance and facilitate planning for template review with DON and budget setting.
- Roster reviews now include non-ward based areas (Radiology- all modalities Dermatology, DOSH).
- To support triangulation of data (experience, safety and quality) and ensure templates reflects the workforce required each area has developed a specific set of quality metrics that are reviewed and evaluated at the meeting alongside the background roster metrics.
- Full Electronic rostering for Radiology (all modalities) was challenging as the software was unable to cope with the complexities of shifts . Therefore Workforce team have been working with the Directorate to trial the new software " planner" . This has been working well and had stopped the need for a dual system of recording (electronic and paper spread sheets).
- The Care Group has supported the Trust Covid staffing response by sending staff with previous critical care and emergency experience, to ITU and ED. Due to the reduction in outpatient face to face work in a number of areas clinical staff also participated in the wrap around teams work. The Lead Research Nurse led the implementation and management of the swabbing team and staff from research , DOSH and Orthodontic working in the service and supporting fit testing.
- Based at the Derwent staff from within the Care Group and orthopaedic teams implemented and managed the Trust antibody testing service and tested over 4500 staff in a two week period.
- Macmillan Team temporarily moved from Christchurch to the Derwent in preparation for expected increase of patients requiring palliative care increasing from 16 to 28 beds. Extra staffing resource was provided by displaced Derwent staff working in partnership with the Palliative Care Team.
- Ward 11 required extra beds to manage an increased volume of haematology patients. This was provided by utilising the BPC facility with some of the BPC staff supporting the team. (social distancing requirements already in place on Ward 11).
- The Care Group continue to look for new and active ways to recruitment and have participated in HCA trust open days, and overseas recruitment and invested in some new posts to support deficits in trained chemo nurses (national shortage) which have been exacerbated by increased service needs.

In Month Sickness Absence (FTE) Year on Year For Specialties, Women, Children's & Oncology Care Group L2 Care Groups, Selected Directorates, Additional Clinical Services - HCA, Nursing and Midwifery Registered Staff Groups



	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Previous 12 Months	6.96%	5.56%	5.45%	4.52%	3.46%	3.92%	3.79%	3.68%	3.84%	4.31%	5.25%	5.61%
Latest 12 Months	5.24%	5.06%	4.51%	3.98%	8.17%	11.00%	8.08%	5.39%	4.50%	4.60%	3.88%	3.47%
Target	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%

*Note: This figure adjusts based on Slicer Selections

Similarly to the other Care Groups a steep climb in sickness is noted at the end of March beginning April . This is in relation to COVID-19 Pandemic with staff being off with symptoms and need to isolate. Guidance at this time was also around pregnant staff needing to shield which created extra workforce pressures. The workforce was supported by specialist nurses, and practice educators who also took on some of the Covid related precautions for the most vulnerable patients. Utilisation of Shielding staff was optimised during this time to support alternative ways of working (video calls, extra telephone checks) .were utilised aspirant nurses and other areas due to stopping of all electives in Wave one. This has been more challenging during second covid wave as research nursing team have been tasked with covid research in relation to patient treatments and vaccines in line with the national agenda

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 27th January 2021

Agenda item: 9.2

Subject:	National Zero Carbon Strategy

Prepared by:	Richard Renaut, Chief of Strategy and Transformation
Presented by:	Richard Renaut, Chief of Strategy and Transformation

Purpose of paper:	To update the Board on the national strategy, ahead of developing the local plan
Background:	Both predecessor Trusts have successfully reduced carbon emissions against the 1990 baseline, but there remains more work to do. The Board seminar on this topic occurred in November 2020.
Key points for Board members:	• 80% reduction by 2030 requires a fundamental review of every aspect of the Trusts' services and models of care. • There are significant opportunities to improve care and reduce carbon, and use new technology and evidence. • Climate emergency is also a health emergency, with heatwaves, air quality, flooding and infectious diseases all related.
Options and decisions required:	A sustainability strategy, known as the "Green Plan" will be developed in draft for the Board in March 2021 for approval as part of the Annual Plan by April 2021. A decision to approve will then be required.
Recommendations:	To note the national strategy and NHS commitment to net zero carbon, and prepare the local Trust strategy.
Next steps:	For the Sustainability Committee of the Board to oversee the production of UHD zero carbon strategy.

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

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

Delivering a 'Net Zero' National Health Service

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Foreword by Sir Simon Stevens

In late January we launched the campaign *For a Greener NHS* and I invited Dr Nick Watts and an expert panel to set out a practical, evidence-based and quantified path to a 'net zero' NHS.[1]

Less than a week later, WHO declared COVID-19 a global health emergency. Since then, 2020 has been dominated by this virus. Alongside tragedy and suffering, the pandemic has seen NHS staff recognised for their rapid, professional and selfless response – caring for COVID-19 patients and sustaining the wider work of the NHS.

The burden of coronavirus has been exacerbated and amplified by wider, deep-seated social, economic and health concerns. The right response is therefore not to duck or defer action on these longer-term challenges even as we continue to respond to immediate pressures. It is to confront them head on.

One of the most significant is the climate emergency, which is also a health emergency.[2] Unabated it will disrupt care, and affect patients and the public at every stage of our lives. With poor environmental health contributing to major diseases, including cardiac problems, asthma and cancer, our efforts must be accelerated.

We therefore make no apologies for pushing for progress in this area while still continuing to confront coronavirus.[3]

This report sets out the considerable advances that the NHS has already made in improving our carbon footprint and reducing the environmental impact of our services. But as the largest employer in Britain, responsible for around 4% of the nation's carbon emissions, if this country is to succeed in its overarching climate goals the NHS has to be a major part of the solution.

It is for this reason that we are committing to tackle climate change by reducing our emissions to ‘net zero’. In doing so, our aim is to be the world’s first 'net zero' national health service. This report provides a clear plan with credible milestones to get there. It covers both the care we provide (the NHS Carbon Footprint) and the entire scope of our emissions (the NHS Carbon Footprint Plus).

Our thanks go to the expert panel, to all those who responded to the international call for evidence and to the many staff across the NHS who have helped shape this plan. Everyone will need to continue to play their part – including our partners, our suppliers and our staff. Of course in a fast moving field where urgency is increasing, it represents an important milestone rather than the final word. Our commitment is therefore to continuing engagement and dialogue, further building support for both practical action and deepening ambition.

Simon Stevens
NHS Chief Executive

October 2020

Summary

The NHS aims to provide health and high quality care for all, now and for future generations. This requires a resilient NHS, currently responding to the health emergency that COVID-19 brings, protecting patients, our staff and the public. The NHS also needs to respond to the health emergency that climate change brings, which will need to be embedded into everything we do now and in the future.

More intense storms and floods, more frequent heatwaves and the spread of infectious disease from climate change threaten to undermine years of health gains. Action on climate change will affect this, and it will also bring direct improvements for public health and health equity. Reaching our country's ambitions under the Paris Climate Change Agreement[4] could see over 5,700 lives saved every year from improved air quality, 38,000 lives saved every year from a more physically active population and over 100,000 lives saved every year from healthier diets.

The NHS embarked on a process to identify the most credible, ambitious date that the health service could reach net zero emissions. This work comprised an international call for evidence, with nearly 600 submissions provided in support of further commitments on climate change; a robust analytical process described throughout this report; and the guidance of a newly formed NHS Net Zero Expert Panel.

This report provides a detailed account of the NHS' modelling and analytics underpinning the latest NHS carbon footprint, trajectories to net zero and the interventions required to achieve that ambition. It lays out the direction, scale and pace of change. It describes an iterative and adaptive approach, which will periodically review progress and aims to increase the level of ambition over time.

With the UK government hosting the UN climate change negotiations in 2021, we will launch an engagement process with patients, our staff and the public over the coming months, to identify further opportunities and resource to help decarbonise our health service.

Two clear and feasible targets emerge for the NHS net zero commitment, based on the scale of the challenge posed by climate change, current knowledge, and the interventions and assumptions that underpin this analysis:

- for the emissions we control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032
- for the emissions we can influence (our NHS Carbon Footprint Plus), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

An overview of the interventions required to meet these targets is provided in the sections below, accompanied by analysis of the expected carbon reductions and any risks, and opportunities for an accelerated timeline.

A number of early steps will be taken to decarbonise:

1. **Our care:** By developing a framework to evaluate carbon reduction associated with new models of care being considered and implemented as part of the NHS Long Term Plan.
2. **Our medicines and supply chain:** By working with our suppliers to ensure that all of them meet or exceed our commitment on net zero emissions before the end of the decade.
3. **Our transport and travel:** By working towards road-testing for what would be the world's first zero-emission ambulance by 2022, with a shift to zero-emission vehicles by 2032 feasible for the rest of the fleet.
4. **Our innovation:** By ensuring the digital transformation agenda aligns with our ambition to be a net zero health service, and implementing a net zero horizon scanning function to identify future pipeline innovations.
5. **Our hospitals:** By supporting the construction of 40 new 'net zero hospitals' as part of the government's Health Infrastructure Plan with a new Net Zero Carbon Hospital Standard.
6. **Our heating and lighting:** By completing a £50 million LED lighting replacement programme, which, expanded across the entire NHS, would improve patient comfort and save over £3 billion during the coming three decades.
7. **Our adaptation efforts:** By building resilience and adaptation into the heart of our net zero agenda, and vice versa, with the third Health and Social Care Sector Climate Change Adaptation Report in the coming months.

8. **Our values and our governance:** By supporting an update to the NHS Constitution to include the response to climate change, launching a new national programme For a greener NHS, and ensuring that every NHS organisation has a board-level net zero lead, making it clear that this is a key responsibility for all our staff.

Meeting this commitment will only be achievable if every part of the NHS – more than 1.3 million of us – are working together. Whether it is a physiotherapist keeping their patients active with sustainable mobility aids, a mental health nurse providing high quality care via telemedicine or a hospital chef sourcing their ingredients from the local community, we all have a role in delivering a net zero NHS, providing health and high quality care for all, now and for future generations.

1. Introduction

The climate emergency is a health emergency.[5] Climate change threatens the foundations of good health, with direct and immediate consequences for our patients, the public and the NHS.[6,7] The situation is getting worse, with nine out of the 10 hottest years on record occurring in the last decade and almost 900 people killed by heatwaves in England in 2019.[8] Without accelerated action there will be increases in the intensity of heatwaves, more frequent storms and flooding, and increased spread of infectious diseases such as tick-borne encephalitis and vibriosis.[9,10]

Over the last 10 years, the NHS has taken notable steps to reduce its impact on climate change.[11] As the biggest employer in this country,[12] there is more that the NHS can do. Action must not only cut NHS emissions, currently equivalent to 4% of England's total carbon footprint,[13–15] but also build adaptive capacity and resilience into the way care is provided. This action will lead to direct benefit for patients, with research suggesting that up to one-third of new asthma cases might be avoided as a result of efforts to cut emissions.[16] This is because the drivers of climate change are also the drivers of ill health and health inequalities. For example, the combustion of fossil fuels is the primary contributor to deaths in the UK from air pollution,[17] disproportionately affecting deprived and vulnerable communities.[18]

In January 2020, the campaign For a greener NHS was launched to mobilise our more than 1.3 million staff and set an ambitious, evidence-based route map and date for the NHS to reach net zero. This report sets out the initial results of this work, reaching net zero emissions for the care we provide (the NHS Carbon Footprint) by 2040, and zero emissions across the entire scope of our emissions (the NHS Carbon Footprint Plus) by 2045. These dates, and the activities that will help deliver them, have been informed by our staff, an international call for evidence and the NHS Net Zero Expert Panel (see **Annex 1**).

The current global COVID-19 pandemic has further reinforced the connection between global public health and healthcare systems and populations across the world, described in **Box 1**. The NHS' response to the pandemic has demonstrated an impressive capacity to adapt and respond in an emergency. It also highlights the importance of preparedness for future pandemics, and the wider health implications

of climate change.[19] The forthcoming third Health and Social Care Sector Climate Change Adaptation Report will cover these topics, and the alignment between adaptation and mitigation in greater detail.

Box 1: COVID-19 and the NHS

COVID-19 is having a profound impact on the world, every health sector including the NHS and, in turn, the work outlined in this report.

There is an interrelationship between the pandemic and the environment,[20,21] which reinforces the need to minimise our impact on the environment and be prepared for climate change. A host of infectious diseases, ranging from dengue fever to swine flu (H1N1), are in part affected by changes in land use as a result of environmental degradation.[22]

The NHS has introduced rapid changes to the way services are delivered to minimise risks of transmission and ensure continued access to timely treatment for those who need it. COVID-19 remains a priority for the NHS, and alongside this, the NHS is also continuing to provide non-COVID-19 services and preparing for winter demand pressures, in the context of minimising the risks of further outbreaks. It is clear therefore that COVID-19 will continue to impact on the way the NHS delivers care, and the emissions from that care.

Key learnings from this response may be evaluated and retained for the long-term, with future carbon reduction benefits. This includes the roll out of digitised care in primary and secondary care settings, which could represent a significant step forward in accelerating NHS Long Term Plan commitments.

Conversely, some elements of the response to COVID-19 have the potential to increase our impact on the environment, including increased need for personal protective equipment (PPE), cleaning products, ventilators and other associated equipment, single-use plastics and changes to patterns of prescribing and clinical interventions.

2. A net zero NHS

Since 2008, the NHS has tracked and reported its carbon footprint, regularly improving its methods and monitoring our progress in meeting the commitments of the Climate Change Act (2008)[23,24] This report provides an update on the progress the NHS has made in reducing carbon emissions as well as an overview of the targets and trajectories for reaching net zero. **Box 2** describes the analytical approach taken to inform these trajectories.

Box 2: A net zero NHS – the analytical approach

A number of inputs have been used to inform the targets and trajectories for net zero. An initial call for evidence received almost 650 responses from a wide variety of stakeholders across the system. Analysis was conducted by NHS England and NHS Improvement, with the NHS Net Zero Expert Panel meeting regularly in 2020 to provide guidance on the scale of ambition and the scope of change required.

A four-step analytical process, described in full in **Annex 2**, was followed to establish these trajectories:

1. **Baseline:** A complete update of the NHS carbon footprint was conducted to provide an estimate of present-day emissions against a 1990 baseline (see Section 2.1). This made use of a hybrid approach, combining 'top-down' modelling (drawing on financial activity data and an environmentally extended input–output model) with 'bottom-up' validation (drawing on a range of inputs from NHS organisations, including local travel, buildings and medicines data).
2. **Projections:** A number of scenarios were then modelled to understand the emissions from the NHS over the long-term, including a 'do nothing' scenario and a 'committed policies' scenario.
3. **Carbon reductions available across the system:** Available reductions for each of the key sources of carbon were then estimated, which informed the system-wide targets for net zero.

4. **Net zero interventions:** Drawing on the call for evidence and external technical input, an extended set of interventions and carbon reductions were modelled, to give confidence in the credibility and ambition of the trajectories.

A full summary of the responses from the call for evidence can be found in **Annex 3**, and the full methodology for the NHS' carbon footprint will be independently published to support other healthcare systems across the world.

2.1. The carbon footprint of the NHS

In 2008 the Climate Change Act set national targets for the reduction of carbon emissions in England, against a 1990 baseline. Since then, the NHS has been working to deliver on these targets, most closely approximated by the **NHS Carbon Footprint** (see **Table 1**).

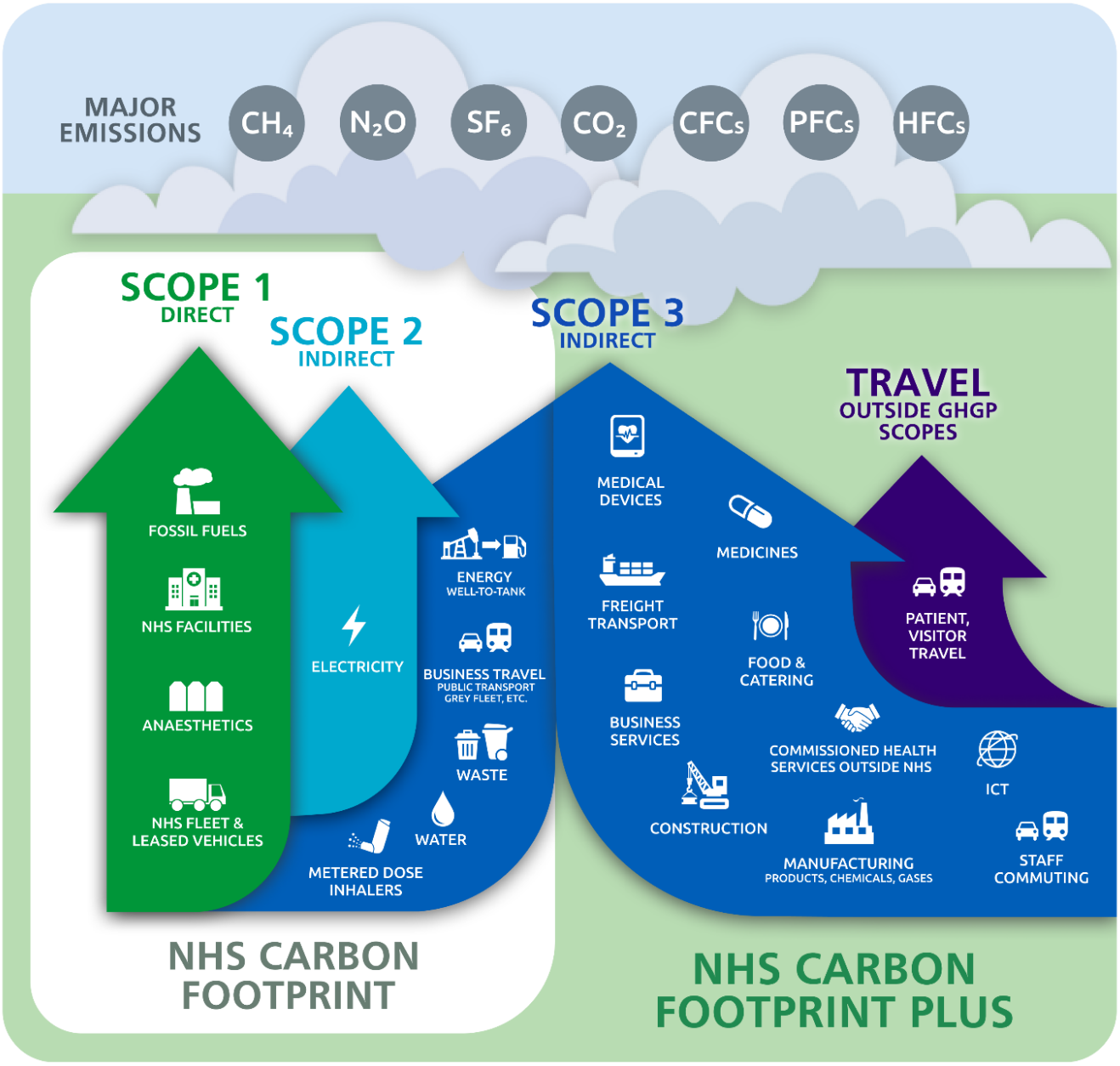
These targets do not, however, cover the full scope of emissions from the NHS. The Greenhouse Gas Protocol (GHGP)[25] scopes cover a wider set emissions, and support international comparison and transparency:

- **GHGP scope 1:** Direct emissions from owned or directly controlled sources, on site
- **GHGP scope 2:** Indirect emissions from the generation of purchased energy, mostly electricity
- **GHGP scope 3:** All other indirect emissions that occur in producing and transporting goods and services, including the full supply chain.

However, there are still some emissions that fall outside these scopes. As agreed with the NHS Net Zero Expert Panel, the NHS will also work towards net zero for a **NHS Carbon Footprint Plus** that includes all three of the scopes above, as well as the emissions from patient and visitor travel to and from NHS services and medicines used within the home (see **Figure 1**).

An independent review by the Lancet Countdown has confirmed that the methods used to calculate the NHS Carbon Footprint and NHS Carbon Footprint Plus remain the most comprehensive, and sophisticated of any health system to-date.

Figure 1: GHGP scopes in the context of the NHS



Considerable progress has been made in reducing the NHS Carbon Footprint. While only an approximation, the estimated 62% reduction in emissions significantly exceeds the 37% requirement for 2020 outlined in the Climate Change Act (see **Table 1**). The wider scope of the NHS Carbon Footprint Plus has also delivered a meaningful improvement on the 1990 baseline, with an estimated reduction of 26% by 2020.

Table 1: NHS emissions from 1990 to 2020

Carbon footprint scope	1990	2010	2015	2019	2020 (est)
Climate Change Act – carbon budget target		25%	31%		37%
NHS Carbon Footprint ($MtCO_2e$)	16.2	8.7	7.4	6.1	6.1
NHS Carbon Footprint as a % reduction on 1990		46%	54%	62%	62%
NHS Carbon Footprint Plus ($MtCO_2e$)	33.8	28.1	27.3	25.0	24.9
NHS Carbon Footprint Plus as a % reduction on 1990		17%	19%	26%	26%

Despite this progress, there is still a significant challenge ahead. To close the gap to net zero the NHS will need to remove 6.1 $MtCO_2e$ from the NHS Carbon Footprint and 24.9 $MtCO_2e$ from the NHS Carbon Footprint Plus, roughly equivalent to the emissions profile of Croatia.

Every area of the NHS will need to act if net zero is to be achieved. However, looking at the wider scope of the NHS Carbon Footprint Plus, **Figure 2** shows that the greatest areas of opportunity – or challenge – for change are in the supply chain, estates and facilities, pharmaceuticals and medical devices, and travel. Similarly, **Figure 3** draws the emissions from medicines and food and catering out, and shows that while the greatest gains can be made in hospitals, change will be needed across every setting of care.

Figure 2: Sources of carbon emissions by proportion of NHS Carbon Footprint Plus

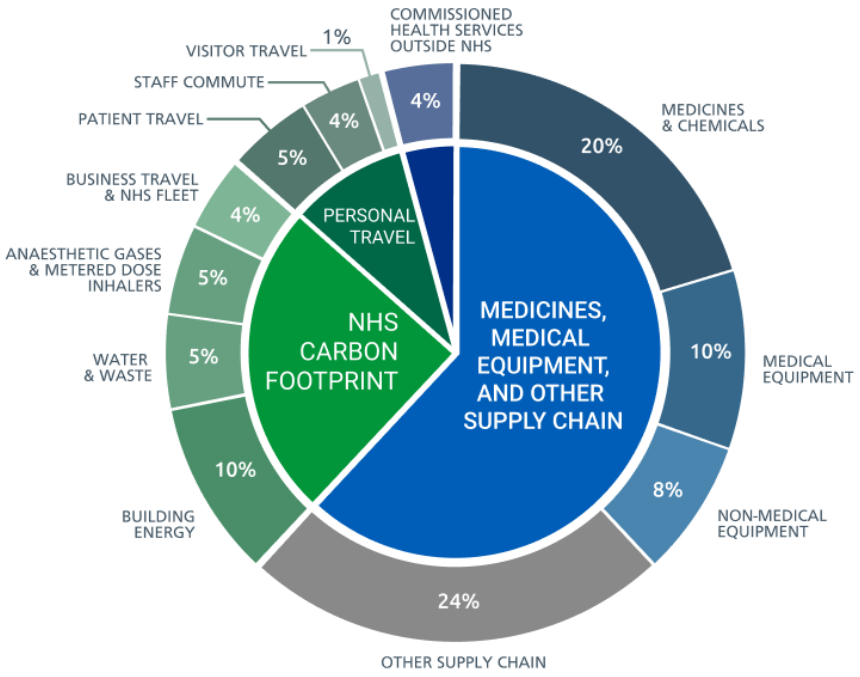
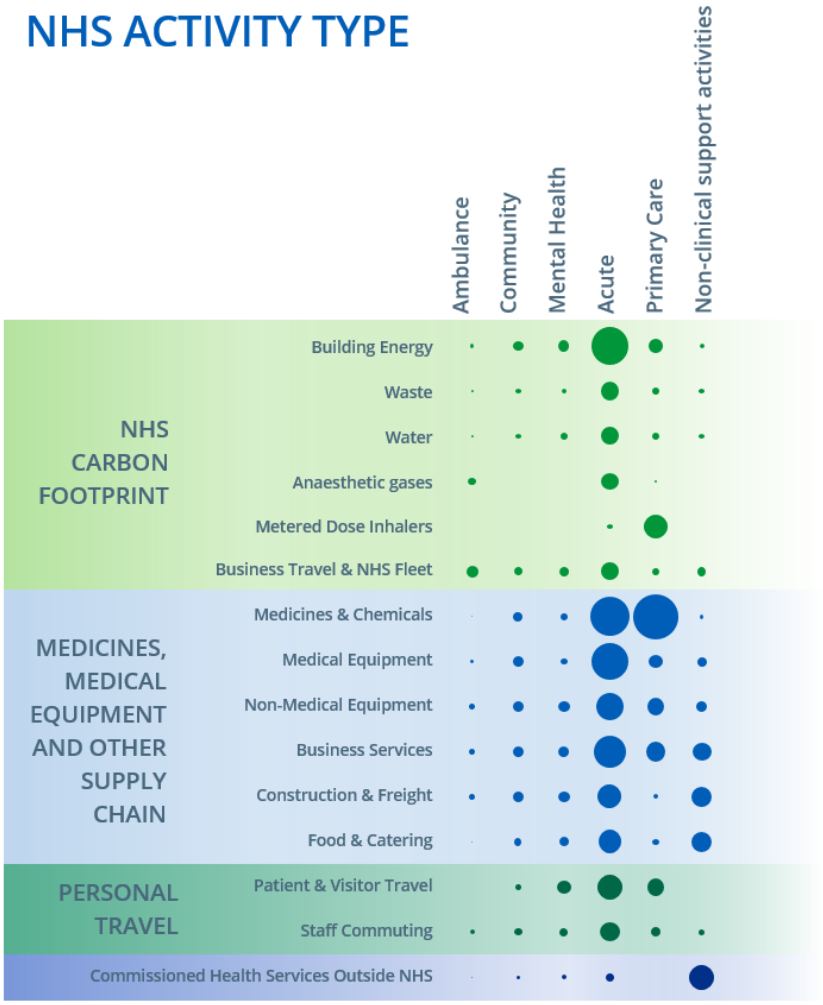


Figure 3: Sources of carbon emissions by activity type and setting of care



2.2. A pathway to net zero carbon emissions

Identifying a trajectory to net zero emissions for a complex, highly specialised system as large as the NHS is particularly challenging. The NHS Net Zero Expert Panel agreed that the targets set should be as ambitious as possible, while remaining realistic; and supported by immediate action and a commitment to continuous monitoring, evaluation and innovation.

Two net zero targets for the NHS have emerged from this process:

- by 2040 for the NHS Carbon Footprint, with an ambition for an 80% reduction (compared with a 1990 baseline) by 2028 to 2032 (**Figure 4**)
- by 2045 for the NHS Carbon Footprint Plus, with an ambition for an 80% reduction (compared with a 1990 baseline) by 2036 to 2039 (**Figure 5**).

These trajectories have been developed based on analysis of current and planned activities for the NHS, and by drawing on national and international best practice that can be scaled across the NHS in England. They also included assumptions about future innovations and the pace at which government, other sectors and the international community will drive change.

Our intention for these targets is to construct the most ambitious, credible declaration to reach net zero of any national healthcare system in the world. However, they can only be delivered if they are supported by collective action from all NHS staff and collaborative partnerships within and beyond the NHS, as well as appropriate investment.

Any analysis that looks forward 30 years will be subject to uncertainty. The pace of change is likely to increase over time and predicting future shifts and innovations that will help accelerate this ambition is particularly challenging. This uncertainty is, in part, reflected in the date ranges above, which will be refined through updated analysis every five years.

Delivering these trajectories will require action across every part of the NHS. However, the main areas of action for the NHS and its partners can be categorised into:

- direct interventions within estates and facilities, travel and transport, supply chain and medicines

- enabling actions, including sustainable models of care, workforce, networks and leadership, and funding and finance mechanisms.

National and international government action to decarbonise electricity, transport and supply chains will also contribute to the ambitions of the NHS and is included in the analysis, but not covered in this report.

While it is difficult to quantify the benefits that a net zero NHS alone can deliver in terms of lives saved, our current analysis makes clear that reaching our national commitments under the Paris Climate Change Agreement[2] and achieving a net zero UK economy would result in significant health benefits. Indeed, by the year 2040, this trajectory would see an estimated: 5,770 lives saved per year from reductions in air pollution; 38,400 lives saved per year from increased levels of physical activity. A peer review of this analysis is currently underway.

Figure 4: Pathway to net zero for the NHS Carbon Footprint Scope

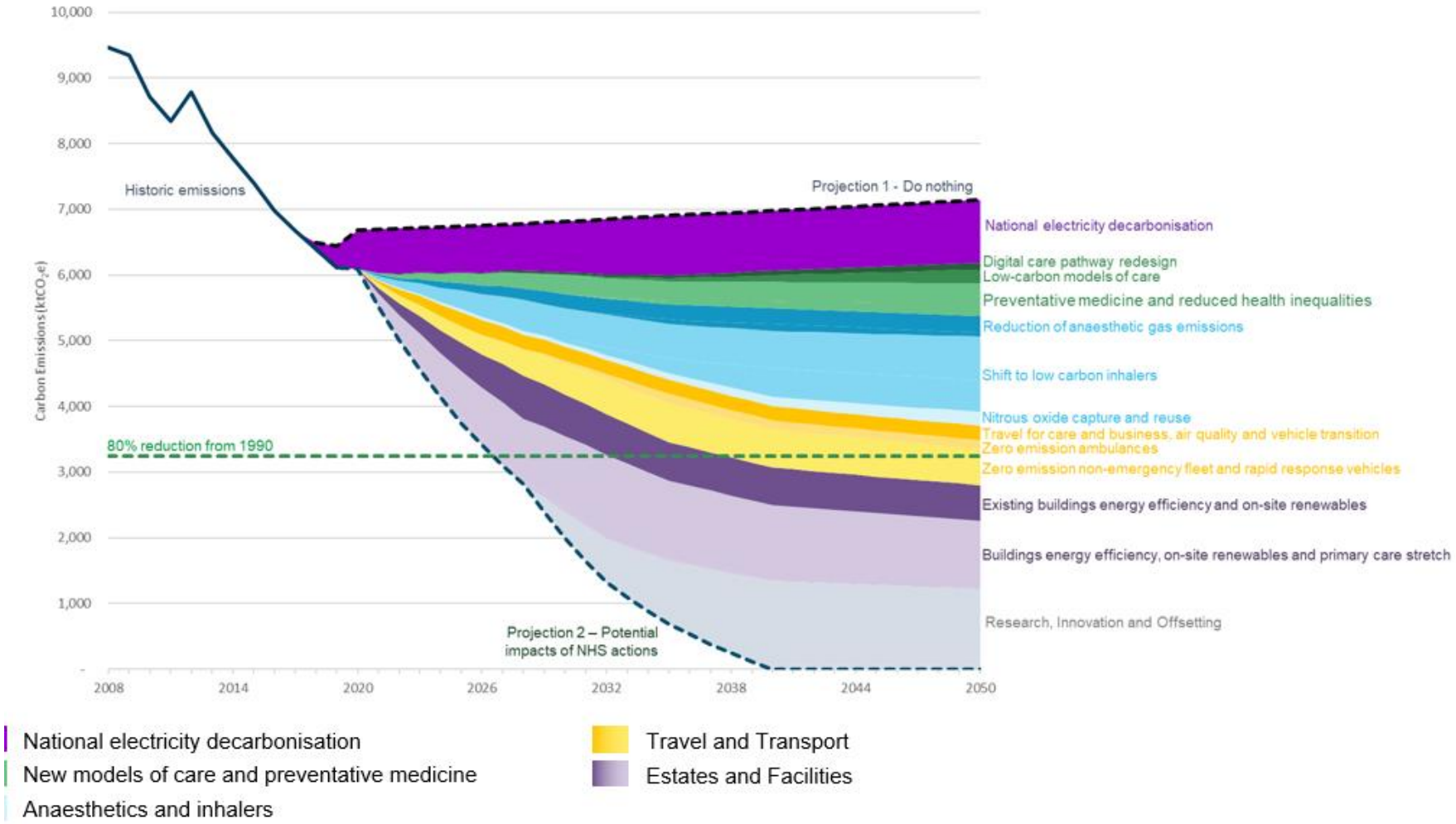
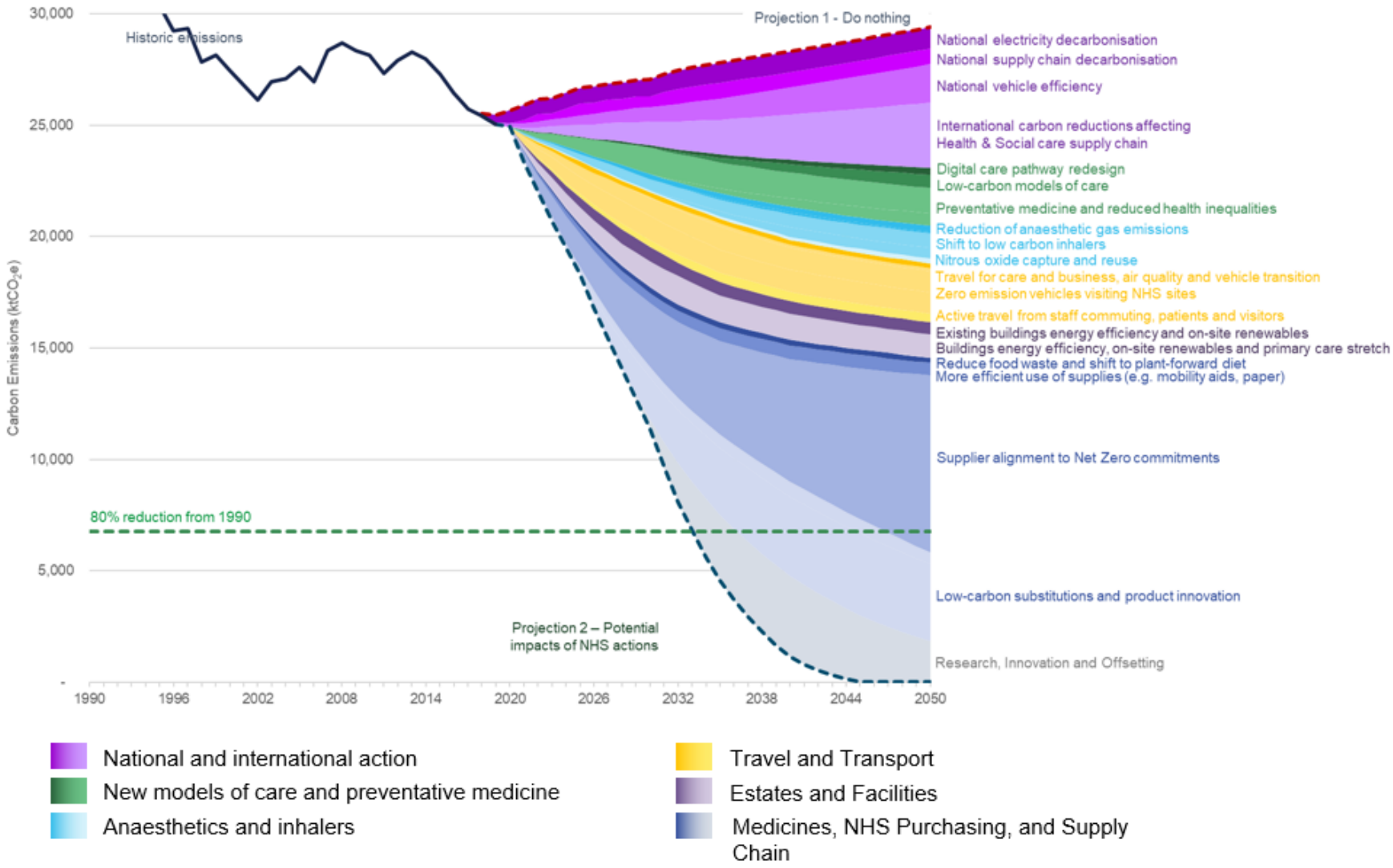


Figure 5: Pathway to net zero for the NHS Carbon Footprint Plus Scope



Box 3: Equality and health inequalities

Delivering a net zero NHS has the potential to secure significant benefits across the population, and particularly for vulnerable and marginalised populations, addressing existing health inequalities. These benefits will only be fully realised through public participation, involvement and engagement with those communities as this work goes forward, having regard to the need to reduce health inequalities and taking into account the public sector equality duty.

As a key priority, the NHS will work to reduce air pollution and improve local environments, thereby supporting the development of local economies in geographical areas of deprivation. Air pollution disproportionately affects people in these areas, many of whom are already at risk of poorer health outcomes. Examples of the links between climate change, sustainable development and health inequalities are seen across the country. For example:

- Access to green spaces has positive mental and physical health impacts, and these beneficial effects are greatest for those from socioeconomically disadvantaged groups. However, these groups also have the least access to green spaces.[26]
- Black, Asian and minority ethnic groups are disproportionately affected by high pollution levels,[27] and children[28] or women[29] exposed to air pollution experience elevated risk of developing health conditions.
- As climate change worsens the demand for energy will increase. This may increase the price of household fuel, which is likely to make it harder for poorer families to maintain good health, particularly in poorly insulated homes.[30]

As part of the development of this report, an equality and health inequalities assessment (EHIA) has been produced, drawing on EHIAs from each of the core analytical workstreams. The EHIA will be further developed based on feedback from further engagement with diverse audiences, and be required as a part of the implementation of future local initiatives.

3. Direct interventions to decarbonise the NHS

The NHS has over a decade of experience in sustainable healthcare, with recent commitments set out in the NHS Long Term Plan,[12], the 2020 NHS Operational Planning and Contracting Guidance[31] and the Standard Contract.[32] There is more work to do, and a range of opportunities to tackle climate change while delivering high quality care and improving public health.

This section sets out the immediate actions the NHS will take to reduce emissions and actions that could be delivered with additional investment and support. For each section, a waterfall chart is provided to give a high level overview of where emissions reductions can be achieved. Where practicable, all savings are expressed in kilotonnes of carbon dioxide equivalent ($ktCO_2e$).

3.1. Estate and facilities

The NHS estate and its supporting facilities services – including primary care, trust estates and private finance initiatives – comprises 15% of the total carbon emissions profile. **Figures 6 and 7** highlight the opportunities for emissions reductions in the secondary and primary care estates respectively, with significant opportunities seen in energy use in buildings, waste and water, and new sources of heating and power generation.

3.1.1. Reducing emissions from hospital estates and facilities

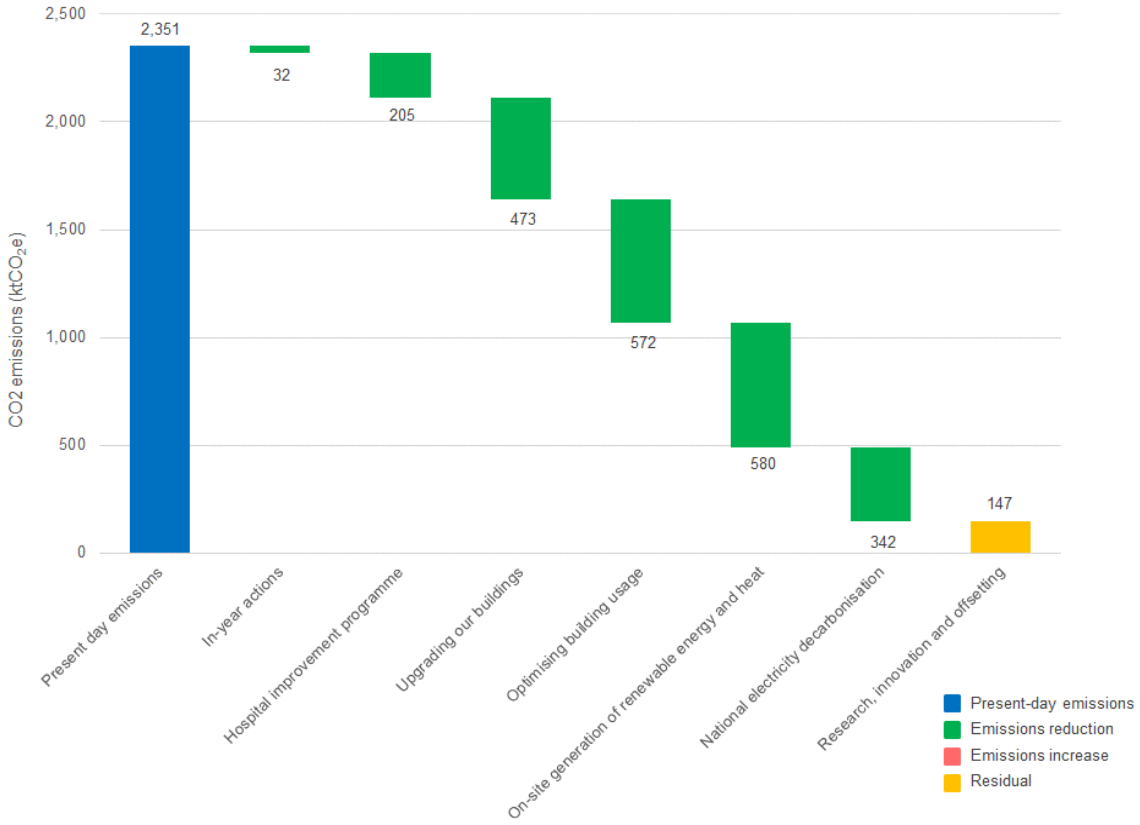
Delivering a net zero health service will require work to ensure new hospitals and buildings are net zero compatible, as well as improvements to the existing estate.

To support this, a new Net Zero Carbon Hospital Standard will be available from spring 2021, and applied across the 40 new hospitals to be built as part of the government's Health Infrastructure Plan.[15,31,32] This will involve both the use of innovative, low-carbon materials, as well as new design that allows for flexibility and shifts in how care will be delivered in the future.

While these new hospitals will need to meet the Net Zero Carbon Hospital Standard, they form less than a fifth of the secondary care estate and so significant interventions will also be required in the retained estate.

A summary of the range of interventions considered is presented in **Figure 6**.

Figure 6: Interventions to reduce emissions in the secondary care estate



Engineering solutions to **upgrade our buildings** represents a total of 473 $ktCO_2e$ in potential emissions savings. Here, the £50 million NHS Energy Efficiency Fund (NEEF) will upgrade lighting across the NHS estate, acting as a pilot for future work and saving £14.3 million and 34 $ktCO_2e$ per year. Delivering 100% LED lighting could be achieved with an additional non-recurrent investment of £492 million, which would be paid back over a 3.7 year period, providing an estimated net saving of over £3.0 billion during the next three decades. A wide range of interventions focused on air conditioning and cooling, building fabric, space heating, ventilation and hot water could all be rolled out throughout the secondary care estate over the next 5 to 10 years, saving some £250 million per year (once all interventions are implemented by 2034). Crucially, a significant portion of the investment required to

deliver this will overlap with that for work underway as part of the regular maintenance and upkeep of the estate.

A range of socio-technical interventions will also be required to **optimise the way the NHS uses its buildings**. Intelligent, real-time energy monitoring and control, including the use of artificial intelligence, would contribute up to 2.3% of the total required reduction in carbon emissions, with an upfront investment of £259 million paid back within two years, and a net annual saving of £120 million once all interventions are implemented by 2034.

Finally, better use of roofs and adjacent ground space will support a shift to **on-site renewable energy and heat generation** across the estate, bringing a potential saving of 580 ktCO_2e per year. Royal Manchester Children's Hospital has invested in an on-site renewable energy project and saved £80,000 in lifetime energy costs and 380 tonnes of carbon, and increased the resilience of its power supply. Installation of photovoltaics across the entire NHS estate would reduce the NHS Carbon Footprint by 1.6%. However, investment costs for this are high – £1.9 billion paid back over 15 years, with a net saving of £1.2 billion – and would need to be considered for early implementation to maximise benefits. In the first instance, the NHS will remove all coal and oil heating systems from its sites as soon as possible, with complete phase-out over the coming years. Finally, the NHS will purchase 100% renewable energy from April 2021. While we are aware this creates no additionality (and hence have not been built any reductions for this shift in purchasing into the existing modelling), it does demonstrate the system's commitment to net zero.

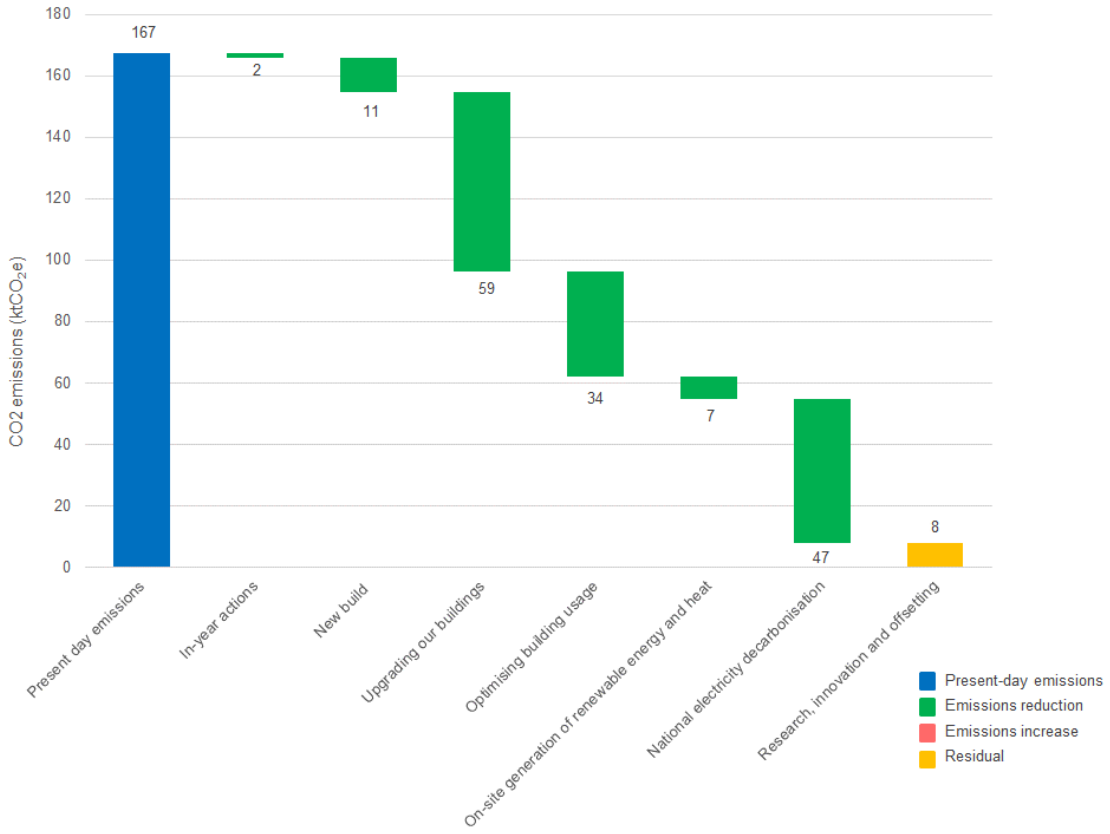
To help organisations understand what action they need to take, a net zero carbon capital planning tool for NHS trusts is being tested with 15 organisations, with the final version to be published later this year, alongside new clinical waste and energy management strategies.

3.1.2. Reducing emissions from the primary care estate

There are approximately 7,000 GP practices in England, spread over some 9,000 buildings. Total emissions for the primary care estate last year were 167 ktCO2e.

A summary of the range of interventions considered is presented in **Figure 7**.

Figure 7: Interventions to reduce emissions in the primary care estate



Additional resource will be required to support older primary care buildings across England to become more energy efficient: engineering interventions such as improved building insulation, lighting and heating could save 59 $ktCO_2e$ annually; improvements to building instrumentation and energy management could save 34$ktCO_2e$ annually; while the installation of photovoltaics and heat pumps could save 7$ktCO_2e$ annually. Although further work is required here, one important resource is the Green Impact for Health toolkit, produced by the Royal College of General Practitioners and the educational charity SOS-UK. It was used by 754 GP practices in 2019/20, and provides accessible and comprehensive guidance on available emissions reductions interventions.

Box 4: COVID-19 and estates and facilities

The NHS' response to COVID-19 led to an increase in some types of activity and hospital capacity including in intensive care units and through the construction of the Nightingale hospitals across the country. Conversely, the number of virtual outpatient consultations has increased substantially over the last six months.

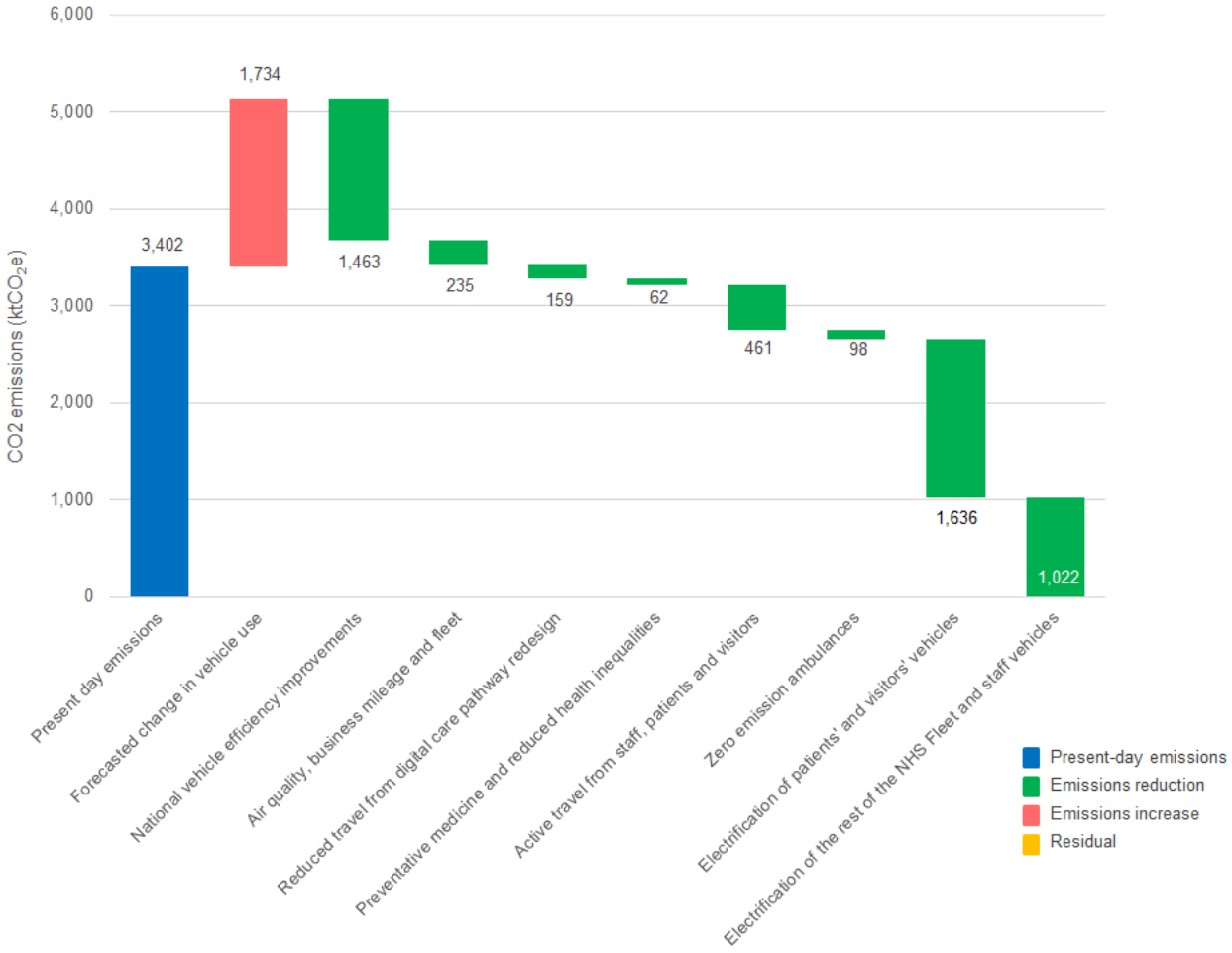
Other changes to practice will have an impact on emissions from NHS facilitates. As noted below (see **Box 6**), enhanced hygiene measures have increased use of single-use PPE to protect staff and patients while maintaining service delivery. This in turn will have generated more waste and increased use of in-house sterilisation and laundry services. Data is not yet available to quantify the net impact of these effects, and further work is needed to understand the overall impact these and other changes have had on emissions from the NHS estate and its facilities.

3.2. Travel and transport

Approximately 3.5% (9.5 billion miles) of all road travel in England relates to patients, visitors, staff and suppliers to the NHS, contributing around 14% of the system's total emissions.[14] This includes approximately 4% for business travel and fleet transport, 5% for patient travel, 4% for staff commutes and 1% for visitor travel.

A summary of the broad range of interventions considered is presented in **Figure 8**, from transitioning the fleet to zero-emission vehicles, to reducing unnecessary journeys and enabling healthier, active forms of travel such as cycling and walking. Forecasted increases in vehicle use are, in part, offset by rapidly evolving vehicle efficiency standards.

Figure 8: Interventions to reduce transport and travel emissions



3.2.1. Electrification of the NHS transport fleet

To deliver high quality care, the NHS makes use of a large and varied fleet of vehicles. This analysis accounts for all vehicles used for NHS duties that are directly owned and leased by the NHS and its staff, with emissions totalling approximately 1,000 $ktCO_2e$ per year. The analysis extends to vehicles from commissioned services, where our influence is less direct and less complete than for our own fleet.

To support this agenda, the NHS will:

- Ensure all vehicles purchased or leased are low and ultra-low emission (ULEV), in line with the existing NHS operating planning and contracting guidance deliverable for 2020/21.

- Meet the NHS Long Term Plan commitment for 90% of the NHS fleet to use low, ultra-low and zero-emission vehicles by 2028, and go beyond this with the entire owned fleet of the NHS eventually reaching net zero emissions.
- Undertake green fleet reviews[31] to identify immediate areas of action at the individual trust level.
- Incentivise staff to use electric vehicles, with increased access to these.
- Develop and test the world's first hydrogen–electric hybrid double-crewed ambulance through the London Ambulance Service as part of project ZERRO (Zero Emission Rapid Response Operations Ambulance), funded by Innovate UK. If approved this would have an important impact on NHS travel emissions, with the seven-year turnover in fleet, recommended by the Carter Review,[33] enabling adoption of this new vehicle within seven years.

The transition to low-emission vehicles will be supported by the UK government pledges to ban the sale of new petrol, diesel and hybrid vehicles from 2040 (and potentially earlier, pending consultation). Ambulances pose a particular challenge and require targeted interventions. However, for the rest of the fleet, rapidly exploring options for a complete transition to zero-emission vehicles by 2032 will be a key focus in engagement over the coming months.

Effective take up of zero-emission vehicles will require a comprehensive electric charging infrastructure across the NHS. This must happen in parallel with the adoption of electric vehicles, in partnership with the NHS estate and wider rollout in the community. More work is required to understand whether electricity capacity needs upgrading to meet new demand. However, there are examples of good practice across the system already. Northumbria Healthcare NHS Foundation Trust has been investing in electric vehicle charging since 2012. Seventy-nine chargers have been installed across nine sites, including 12 fast chargers and two rapid chargers, for essential vehicles.

3.2.2. Cycling, walking and shifting modes of transport

Shifting away from cars and towards cycling, walking and public transport decreases air pollution, improves physical activity and increases access to care for patients. This represents potential savings of some 461 $ktCO_2e$ per year.

To enable this, all NHS trusts will be required to have a green travel plan as part of their annual planning and reporting. This should include targeted interventions that

encourage staff and patients to reduce vehicle use. This might include promoting active travel (walking and cycling), the provision of electric bikes supported by digital platforms (apps), changes in infrastructure (eg improved cycle paths, storage and shower facilities) and policies (eg car parking priority for those car-pooling). Such plans are already implemented across several trusts, with Manchester University NHS Foundation Trust's sustainable travel plan providing personal travel advice for staff and updated travel information, over 200 additional cycle parking spaces, two cycle hubs for staff (including storage, lockers and showers) and a bicycle users group. It has subsidised travel and discount schemes, ensured two public bus route stops on the main sites and a shuttle service between sites and car clubs.

In line with the NHS People Plan, green travel plans should also set out how staff can be offered flexibility in their working patterns and supported to choose sustainable methods of transport for their commute.

Finally, emissions can be reduced through dedicated programmes to tackle air pollution, and prevent unnecessary journeys through improved preventative medicine and enhanced digital care. These interventions, with potential transport emission savings of 456 $ktCO_2e$ per year, are covered in the sections below.

Box 5: COVID-19 and travel

National measures introduced to reduce the transmission of COVID-19 have meant more people are staying at home, working from home and wherever possible accessing services online. While some of these national measures have changed, social distancing remains in place, meaning that workplaces may have lower occupancy and public transport is set up to carry fewer passengers. In the NHS, early estimates suggest that moving outpatient appointments online could have avoided 58,000,000 miles over three months.

A number of more sustainable travel options have also been made available such as Transport for London (TfL) providing free 24-hour access to Santander cycles for NHS workers in London; Uber offering NHS staff in London free use of their Jump electric bikes; BP Chargemaster (EV charging supplier) providing support to electric taxis transporting NHS workers during

the pandemic, allowing them to charge staff reduced fares; and MG Motor supplying up to 100 electric vehicles to the NHS.

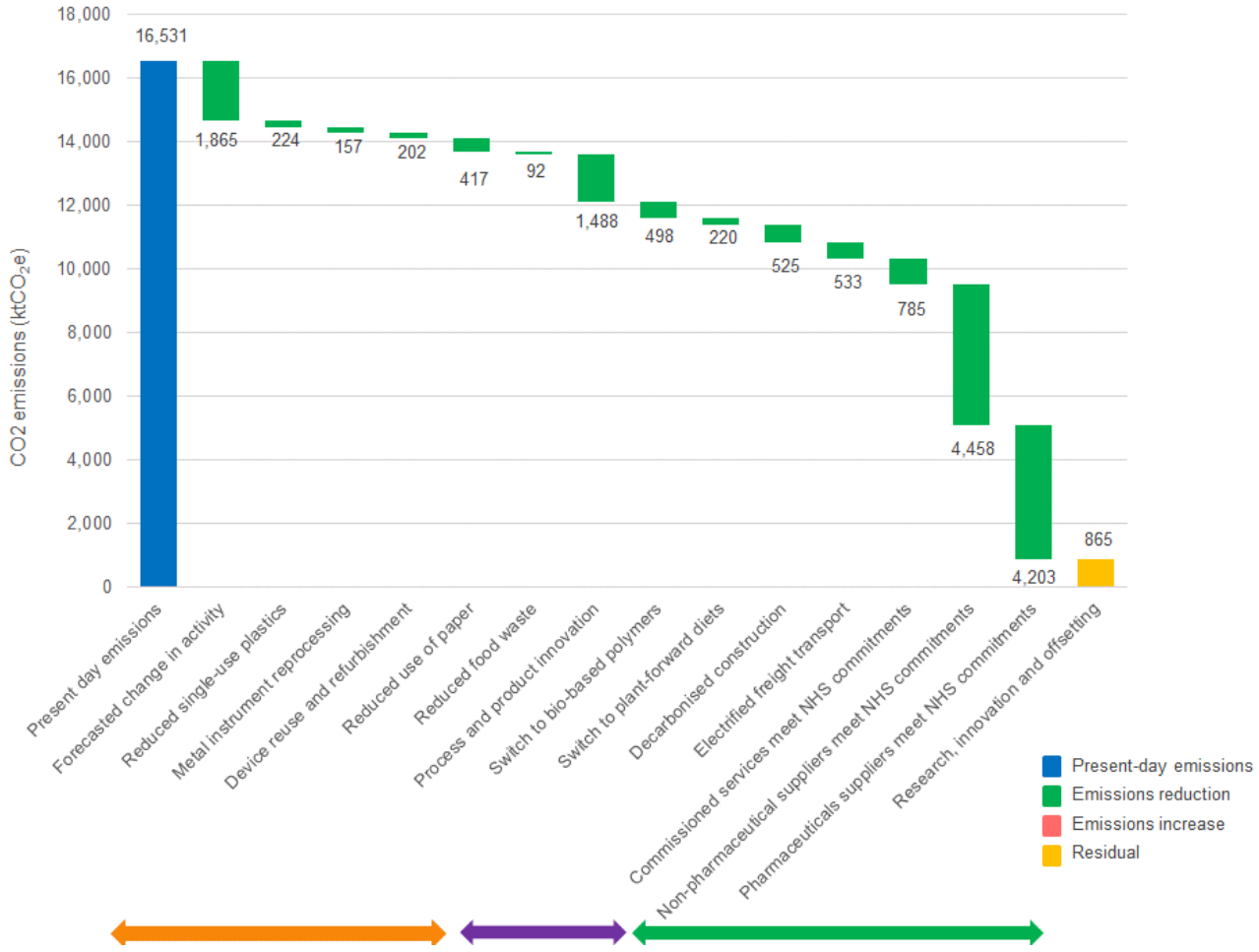
Restrictions on travel are likely to have had a significant, but as yet unquantified, effect on reducing elements of current air pollution levels in the UK. However, whether these effects are retained in the long term will depend on a variety of factors.

3.3. Supply chain

The NHS Carbon Footprint Plus considers an expanded scope of emissions, covering the products procured from its 80,000 suppliers. While the NHS does not control these emissions directly, it can use its considerable purchasing power to influence change.

A summary of the broad range of interventions considered is presented in **Figure 9**, eg for reductions of emissions from medical and non-medical equipment (18%), food and catering (6%), other procurement (18%), commissioned healthcare services outside the NHS (4%) and medicines and pharmaceuticals (20%).

Figure 9: Interventions to reduce supply chain emissions



3.3.1. Decarbonising the supply chain

The NHS can reduce emission from its supply chain in three ways: more efficient use of supplies; low-carbon substitutions and product innovation; and by ensuring our suppliers are decarbonising their own processes. Ultimately though, delivering a net zero health service commits to having a net zero supply chain.

Good progress has already been made in **using resources more efficiently**. Over 1.4% of supply chain emissions are due to single-use devices, some of which could be refurbished and reused, saving the NHS both carbon and money. Action to reduce reliance on disposable products includes:

- Continued commitment to the NHS Plastics Reduction Pledge. To date over 145 trusts have signed up, with one trust, Yorkshire Ambulance Service

NHS Trust, removing 200,000 single-use plastic items from its waste stream in 2019/20; saving four tonnes of waste per year and over £12,000 a year in packaging, delivery and disposal costs.

- A 10% reduction in clinical single-use plastics in the short term, eventually saving a total of 224 $ktCO_2e$.
- Expanding existing walking aid refurbishment schemes, with 40% of all walking aids refurbished in the next five years.
- Reducing reliance on office paper by 50% across secondary care through increased digitisation, with a switch to 100% recycled content paper for all office-based functions.

The NHS will also work to **substitute for low-carbon alternatives** where they are available. New technologies and innovations are developing at an incredibly fast pace. Our role is to identify and encourage innovative approaches that will deliver improved patient outcomes with a reduced impact on the climate. For example, we anticipate that bio-based polymers will produce significant savings of 498 $ktCO_2e$ in the future. In response to COVID-19, the NHS has demonstrated an ability to respond to novel challenges at pace and scale, with the examples in **Box 6** describing the procurement of PPE and other single-use products, and how sustainability will be built into its work going forward.

Finally, the NHS will work to **ensure that suppliers are decarbonising their own processes** and provide clear and long-term signals about the direction of travel. This process has started through the NHS supplier engagement programme aimed at driving significant reductions in carbon emissions through carbon transparency reporting. An early pilot has seen 27 suppliers voluntarily share their plans on carbon reduction. In 2021, engagement will be expanded to 500 significant NHS suppliers. A compact with suppliers of clinical consumables and medical devices focused on reducing the emissions from product packaging will be developed. This process will recognise and support the needs of small and medium sized enterprises and the role the NHS has as an anchor institution in England.

Further work over the next 12 months is required to determine the precise dates, timelines and mechanisms to deliver these initiatives. However, the long-term target is clear: before the end of the decade, the NHS will no longer purchase from suppliers that do not meet or exceed our commitment to net zero. This will be an essential component of any net zero strategy, delivering reductions of 9,446 $ktCO_2e$ per year when fully realised.

Box 6: COVID-19 and personal protective equipment

During the first COVID-19 peak, demand for PPE globally rose to unprecedented levels, putting a strain on global supply chains. The NHS has rightly used exceptionally large volumes of PPE to maintain service delivery and sustain high quality care. However, there are growing concerns about the environmental impact this has had, and may continue to have, due to increases in production and disposal of single-use items, which are predominately made from plastics. The full impact of this on the NHS' emissions is not yet fully known.

Work is already underway seeking to reduce the NHS' PPE environmental impact, and understand how sustainability can be built into plans. As part of the UK Make initiative, we are increasingly looking to domestic PPE manufacturing, to develop a resilient, strategic supply chain, with high quality, innovative products for end users.

Working with our partners to encourage a greater focus towards sustainably sourced and innovative PPE, the NHS will over time focus on PPE that meets the criteria for an improved sustainability profile. Examples of this are the procuring of made-for-reuse PPE items, including masks and gowns.

3.3.2. Food, catering and nutrition

It is estimated that food and catering services in the NHS produces 1,543 $ktCO_2e$ each year, equating to approximately 6% of total emissions. Healthier, locally sourced food can improve wellbeing while cutting emissions related to agriculture, transport, storage and waste across the supply chain and on NHS estate.

The Hospital Food Review, announced by the government in August 2019, is expected to consider sustainability and the impact of the whole supply chain, including sustainable procurement and waste. Alongside this review, new national standards for healthcare food for patients, staff and visitors will be developed by NHS England and NHS Improvement later this year. These standards will signal a more systematic approach to procuring and producing sustainable and healthy food for patients, visitors and staff. This may include, for instance, ensuring suppliers have sustainable production and transportation practices, sourcing local supplies of

food, the use of seasonal produce, increased use of sustainably sourced fish and efforts to limit food waste.

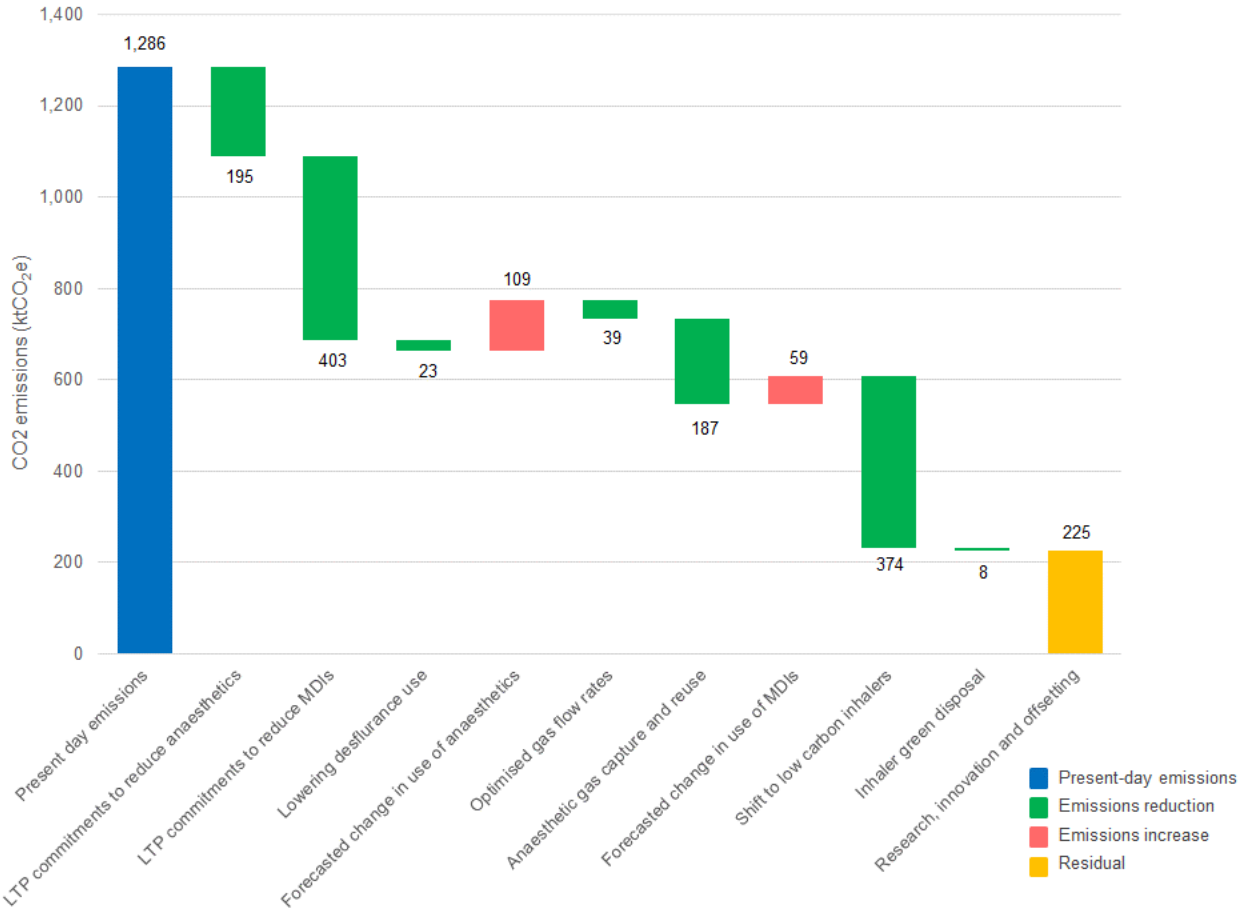
The government's EatWell plate[34] recommends a diet with reduced processed foods high in sugar, salt and fats as part of a healthy balance. Analysis makes clear that this diet is also a low-carbon diet, with seasonally and locally sourced fruits and vegetables greatly decreasing emissions, as well as one for which rates of colorectal cancer and heart disease are lower compared to average diets across the country.

3.4. Medicines

Medicines account for 25% of emissions within the NHS. A small number of medicines account for a large portion of the emissions, and there is already a significant focus on two such groups – anaesthetic gases (2% of emissions) and inhalers (3% of emissions) – where emissions occur at the 'point of use'. The remaining 20% of emissions are primarily found in the manufacturing and freight inherent in the supply chain.

Interventions to reduce the 20% of emissions found in the supply chain have been described in Section 3.3. **Figure 10** focuses on the scope of emissions reductions available from anaesthetic gases and inhalers, including commitments made in the NHS Long Term Plan that are already underway. Here, interventions considered include optimising prescribing, substituting high carbon products for low-carbon alternatives, and improvements in production and waste processes.

Figure 10: Reducing emissions from inhalers and anaesthetic gases



The NHS is working with patients, clinicians and industry to reduce emissions, and will continue to work with pharmaceutical companies to encourage carbon transparency reporting. Further work will include the active consideration of compulsory reporting from suppliers, and the inclusion of carbon accounting in the metric by which suppliers are assessed during procurement exercises.

3.4.1. Low carbon inhalers

Inhalers are used in a variety of respiratory conditions, ranging from asthma to chronic obstructive pulmonary disease. The majority of the emissions come from the propellant in metered-dose inhalers (MDIs) used to deliver the medicine, rather than the medicine itself. The NHS Long Term Plan set targets to deliver significant and accelerated reductions in the total emissions from the NHS by moving to lower carbon inhalers, such as dry powder inhalers (DPIs). Achieving the required reduction in emissions from inhalers will only be possible by:

- significantly increasing the use of DPIs, which may be clinically equivalent for many patients, and come with significantly lower carbon emissions
- increasing the frequency of the greener disposal of used inhalers
- supporting the innovation in and use of lower carbon propellants and alternatives.

The first of these will require shared decision-making between patients and clinicians: a 30% uptake would result in a reduction of 374 $ktCO_2e$ per year. Resources are available for specialists, prescribers and patients to support decision-making, including National Institute for Health and Care Excellence's (NICE's) Asthma Patient Decision Aid to support shared decision-making and a shift to low carbon inhalers.[35] Examples from healthcare systems across the world demonstrate that such a transition is possible while maintaining high standards of care. By learning from these initiatives, and those across the country, NHS England and NHS Improvement will continue to develop resources which aid patients in opting for low impact medicines where clinically appropriate.

Options to support and incentivise the uptake of low carbon inhalers were developed for 2020/21, with potential emissions reductions of 403 $ktCO_2e$ per year in the first instance, growing beyond this as ambition increases. While these are on hold due to COVID-19, further steps will be taken, including through an enhanced focus in the GP contract Investment and Impact Fund. Any measures going forward will need to support patients and ensure they are informed and empowered through the resources above, with inclusive and accessible messaging.

Beyond this, the International Pharmaceutical Aerosol Consortium (IPAC) is co-ordinating a consortium of large pharmaceutical companies to develop a programme encouraging patients to return inhaler devices to pharmacies for green disposal.

Looking to the longer term, two major pharmaceutical suppliers have committed to action on reducing the carbon impact of their MDIs and, from 2025, reformulating their inhalers so they can be used with low carbon propellants.

3.4.2. Anaesthetic gases

The NHS Long Term Plan committed to lowering the 2% of the NHS' carbon footprint from anaesthetic gases by 40%, by transforming anaesthetic practice. This requires efforts to shift from desflurane to lower carbon alternatives such as

sevoflurane; effective capture, destruction or reuse of these gases; and reduction in the atmospheric release from leftover nitrous gas canisters.

Anaesthetic gases used in surgery, such as desflurane, have a particularly high carbon footprint, with the emissions from one bottle equivalent to those from burning 440 kg of coal. However, low carbon alternatives exist, and are clinically appropriate in a wide variety of settings. Engagement with anaesthetists has seen a significant cut in some anaesthetic gas use since 2018, with monthly volumes of some volatiles falling by nearly 50%, saving 17 $ktCO_2e$ per year. With further clinical engagement, it could be feasible to reduce the use of desflurane to as little as 5% by volume, saving a further 23 $ktCO_2e$ per year.

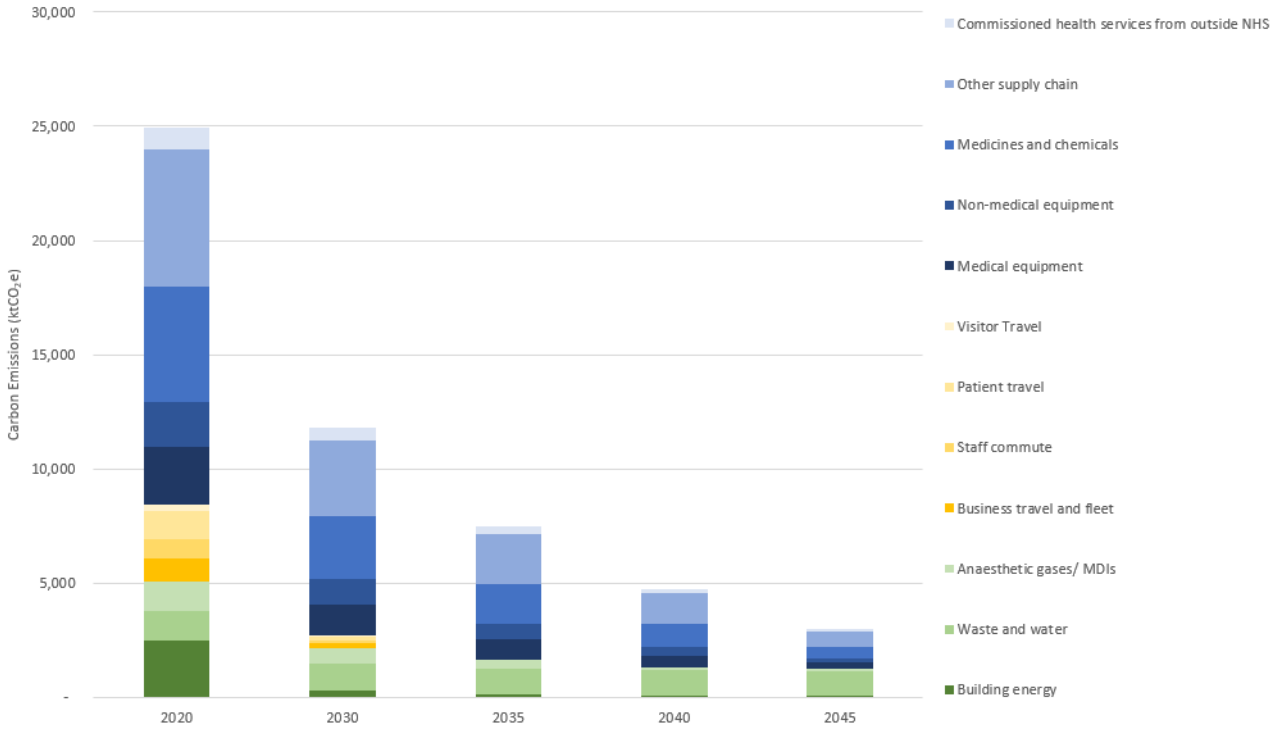
The capture and destruction of nitrous oxide could cut over one-third of NHS anaesthetic emissions. This technology has been readily deployed in Sweden for some 16 years and could save an estimated 90 $ktCO_2e$ emissions if implemented across 132 high impact trusts in the NHS. Scaled across the entire health service, this could deliver up to a 75% reduction in nitrous emissions. Similar technologies for anaesthetic gases went to market in 2020, following successful trials in UK hospitals, with funding from Innovate UK.

Finally, significant carbon savings are available by decreasing nitrous oxide wastage, with the College of Paramedics estimating that 30% of nitrous oxide is left in canisters after use. Recycling or reusing this is technically difficult, with new methods required to address the residual nitrous oxide.

3.5. Research, innovation and offsetting

The four sections above describe the suite of interventions available to reduce carbon emissions and deliver against the NHS' net zero ambition. These go as far as possible, with **Figure 11** describing the sources of the residual emissions.

Figure 11: Further work required from research, innovation and offsetting to reduce the residual



At every point, the NHS will look to reduce this residual through research and innovation. Net zero will be included in the NHS' research strategy, and will inform engagement with industry, research centres of excellence and other key partners. This will clarify areas of unmet need, signal areas in need of innovative solutions and help inform the Accelerated Access Collaborative (AAC).[36] Innovations could include switching from disposable to reusable equipment and use of technologies to avoid plastics in medicine supply, through to low-tech solutions such as the 11 $ktCO_2e$ saved from the reorganising of nephrology services as demonstrated by the Centre for Sustainable Healthcare.[37]

To support the future development and adoption of new technologies and innovations, the NHS will:

- require all applicants to national innovation support programmes to consider and articulate the environmental impact of the products and services for which they are seeking support
- embed sustainability in assessment criteria and decision-making processes for all innovation programmes by the end of 2020

- work with the Academic Health Science Networks (AHSNs) to embed net zero into the AHSNs' business as usual processes, working with them to develop a network-wide ambition and identify specific ways of working to promote the drive to reach net zero
- Use the AAC Horizon Scanning Function to identify the future pipeline of innovations which can support efforts to transition to net zero.

NHS England and NHS Improvement will also consider the feasibility of launching a dedicated sustainability challenge to support the development of technologies and innovations specifically designed to support our ambition of reaching net zero.

Having further reduced emissions as far as possible, the NHS will need to consider offsetting and mechanisms to secure negative emissions. Strategies to address this include direct energy generation from photovoltaics installation (some of which are outlined in Section 3.1), biosequestration and technology-based carbon capture and storage. While the carbon benefit is small, increasing green space and trees on NHS sites also provides opportunity for improving air quality, supporting mental health and social prescribing. Since 2009, the NHS Forest has planted over 65,000 trees across 180 NHS sites, increasing green space, improving air quality and mental health, and capturing carbon.

These mechanisms will need to link in with the government's existing plans in this domain. Technology-based carbon capture methods are in development in the UK, and the NHS will work with the Department of Business, Energy and Industrial Strategy (BEIS), academic institutions, and research and innovation partners nationally to understand what additional options may be available for the NHS to address the residual carbon footprint.

4. Delivering a net zero NHS

Having identified the interventions available to reduce carbon emissions, and the associated targets and trajectories, this section discusses how the NHS will deliver a net zero health service, covering: new models of care and alignment with the NHS Long Term Plan; workforce and leadership; and funding and financial mechanisms.

4.1. Sustainable models of care

The NHS Long Term Plan set out a commitment to deliver a new service model for the 21st century. If the NHS is to reach net zero emissions, that new service model must include a focus on sustainability and reduced emissions, with the section below describing the synergies here.

4.1.1. A new service model for the 21st century

As part of the new service model for the 21st century, multiple commitments are in progress, including boosting 'out-of-hospital' care; empowering people to have more control over their health; digitally enabling primary and outpatient care; and increasing the focus on population health. Optimising the location of care ensures that patients interact with the service in the most efficient place, which may be closer to, or even in, their home. Not only does this improve patient experience and often offer greater access to care, but it also reduces emissions by helping to avoid unnecessary hospital visits and admissions. The urgent and emergency care programme is working in partnership with the primary care and community care teams on this approach, with NHS 111 First helping to rapidly triage and connect patients to the most relevant, and often community-based, health professional. It is estimated that accelerating this approach will directly improve patient treatment, avoiding approximately 8.5 million km of unnecessary travel per year, to and from hospitals, with a carbon saving of 1.7 $ktCO_2e$ per year in the first instance. Similarly, estimates suggest that up to 3 million people who visit A&E each year could have their needs addressed elsewhere, and perhaps by 24-hour urgent treatment centres.[38]

4.1.2. Further progress on care quality and outcomes

Health professionals have long worked to embed best clinical practice and there has been a commitment to further progress on care quality and outcomes. The Getting it Right First Time (GIRFT) approach exemplifies this. Its orthopaedics programme aims to identify and scale best clinical practice, resulting in significant efficiency savings and improvements for patient care.[39] Across the country, this has helped to avoid 49,026 less appropriate procedures, 385,493 bed days from reduced length of stay and 4,967 emergency readmissions, equating to an annual carbon reduction of approximately 26.5 $ktCO_2e$ from 2014/15 to 2018/19. GIRFT covers the full suite of surgical specialties – from cardiothoracic and vascular to urology and general surgery – and has been responsible for a combined reduction of 918,117 bed days, 91,538 admissions and 60.0 $ktCO_2e$ saved per year.

There is also a commitment to set out clear priorities for the diseases which contribute the most to ill health. Earlier and quicker testing, detection and intervention is a key target for the national cancer programme. Rapid diagnostic centres (RDCs) aim to improve outcomes for patients by delivering faster diagnosis and treatment, while also significantly increasing efficiency, and reducing carbon emissions.[40] Our analysis suggests that these RDCs could help avoid GP consultations and visits to the emergency department, by getting patients to the right place for treatment more quickly.

4.1.3. More NHS action on prevention and health inequalities

Preventing ill health not only benefits patients, but also increases efficiency and reduces emissions. The Alcohol Care Team in Nottingham University Hospitals NHS Trust provide one-such example. There, the team achieved a two-thirds reduction in hospital admissions due to detoxification and alcohol-related cirrhosis, saving 36 bed days per month.[41] Over a year, this would lead to estimated carbon savings of 0.27 $ktCO_2e$.

To support the embedding of sustainability and this net zero trajectory into the delivery of the NHS' national programmes, a net zero framework will be developed to help consider and evaluate carbon reductions associated with new models of care. This is currently being tested with NHS@Home and community diagnostic hubs and will soon be expanded to other parts of the system. Options to further incentivise emissions reductions will be considered through appropriate contractual

levers, eg the GP contract Investment and Impact Fund, as well as through partners such as NICE and the Care Quality Commission.

4.1.4. A digital, low-carbon transformation

The NHS Long Term Plan set a number of critical priorities to support digital transformation, seeking to mainstream digitally-enabled care across all areas of the NHS. **Box 7** describes the way these plans were rapidly accelerated in 2020 in response to COVID-19.

Going forward, changes will require significant infrastructure, and an associated increase in carbon emissions, with the supply chain currently estimated to emit 456 $ktCO_2e$ from information and communications technology (ICT). While energy efficiency is improving all the time, a rapid growth in data demand and digital equipment has the potential to add to these emissions unless we specify lower carbon digital products and services.

The NHS will ensure that a trajectory compatible with a net zero health service is embedded in the digital transformation agenda, and work to continuously drive down residual emissions from digital services via a number of actions which include:

- digitally enabled care models and channels for citizens that will significantly reduce travel and journeys to physical healthcare locations, with care closer to home being delivered through remote consultations and monitoring
- developing a blueprint for 'What Good Looks Like' for low carbon digital care, across the system
- building net zero into the digital maturity framework
- issuing policy advice to ensure NHS data centres and companies providing these services minimise their environmental impact and support the drive to reach net zero
- utilising levers, including local spend controls for technology, to incentivise a shift to net zero
- supporting front-line digitisation of clinical records, clinical and operational workflow and communications, aided by digital messaging and electronic health and care record systems.

Future opportunities for net zero identified as part of digital transformation include: digitising the estate and smart hospitals; ensuring large-scale migration of trust data centres into the hyper-scale cloud; and reducing the need for the storage of large volumes of data.

Box 7: COVID-19 and digital care

The response to COVID-19 rapidly accelerated the digitisation of outpatient and primary care appointments, with implementation of a five-year delivery plan being reduced to weeks. While still in the early stages of implementation, preliminary data suggests that during the initial seven weeks of the COVID-19 response in April and May 2020, there were 1.9 million remote outpatient appointments, representing 46% of the total.

Rapid procurement in primary care has enabled the implementation of digital first programmes in GP practices. This, as a part of the COVID-19 response, led to high levels of video consultation capabilities being put in place in GP practices by April 2020.

Adult mental health services have seen 95% of Improving Access to Psychological Therapies (IAPT) appointments being conducted remotely following a rapid movement away from face-to-face appointments. However, there is the expectation that some of these will return to face to face.

These examples indicate that much progress has been made to move care into a virtual setting, but data from a wider range of services and over a longer time horizon is required to more completely assess the full health, health equity and sustainability implications of these shifts, as well as how any beneficial changes can be maintained as part of the phased COVID-19 recovery.

4.2. Workforce, networks and system leadership

The staff who work in the NHS support further action on climate change, with a recent survey demonstrating that 98% of all staff believe the health and care system should be acting more sustainably.[42] This support is further demonstrated in the professional bodies across the country, with the UK Health Alliance on Climate

Change bringing together 21 of the country's major health organisations (including the Royal Medical and Nursing Colleges, the British Medical Association and two leading medical journals) to advocate for a stronger health response to climate change.

4.2.1. Building capability in all staff

An upskilled workforce will be needed to drive and implement the interventions outlined in this report. They will need to be supported to learn, innovate and embed sustainable development into everyday actions in the health service.

So that everyone understands that they have a role, a tailored induction module will be prepared for all NHS England and NHS Improvement staff to support staff understanding of the links between health and climate change, and interventions they can take to reduce emissions. This will draw on insights from the NHS England and NHS Improvement Behavioural Science Unit, setting out the most influential and impactful behaviours, including those in the 2020/21 NHS People Plan.[43] A dedicated net zero training package for staff working in estates and facilities will also be developed.

Meeting the growing demand for skills will require partnerships, which need to be further supported by the introduction of sustainable healthcare into the curricula for all health professionals. This is already being done by the General Medical Council outcomes for medicine graduates,[44] the Nursing and Midwifery Council Standards of Proficiency for Midwives[45] and the World Federation of Occupational Therapy Minimum Standards for the Education of Occupational Therapists.[46] Teaching on climate change, health and sustainable healthcare is also being introduced to a range of medicine and allied courses in the UK – including medicine at the University of Bristol and nursing and dietetics courses at Plymouth University. The Centre for Sustainable Healthcare has also developed a bespoke 'sustainable specialties' programme. Finally, the NHS Confederation is developing training to educate and upskill non-executive directors on the opportunities for sustainable healthcare in their trusts.

4.2.2. Spreading and scaling what works across our regions

Excellent local initiatives with tangible carbon reductions can be found across the system, with many able to be scaled to the national level. Operation TLC (Turning off equipment; Switching off lights; and Closing doors) at Barts Health NHS Trust

improved patient experience, while saving carbon and £500,000 from reduced energy consumption. Expanding this model across the NHS could save up to £45 million and 200 $ktCO_2e$ per year.

Regional networks will be central here, and the sustainability and health networks will help maintain the focus on the net zero ambition and facilitate local learning and sharing of best practice. At a system level, Dame Jackie Daniel, Chief Executive of The Newcastle upon Tyne Hospitals NHS Foundation Trust and member of the Net Zero Expert Panel, is co-ordinating a group of NHS leaders to explore the enablers of accelerated collective action. A complementary group for primary care will be established to support further action.

4.2.3. Embedding sustainability across the NHS

To reflect the NHS' commitment to a net zero health service, we propose that the NHS Constitution is updated to include our net zero ambitions and sustainable development, making it clear that this is a key responsibility of all staff. All NHS organisations – including every region and integrated care system – will also be required to have a board-level lead, responsible for leading on net zero and the broader greener NHS agenda.

National and local levers and incentives will be used to support the delivery of the commitments set out in this report. These will build on the 2020/2021 Standard Contract requirement for providers to produce a green plan, approved by their governing body, along with an annual summary of progress towards net zero.

4.3. Funding and financial mechanisms

Investing in a net zero NHS aligns with investment in the long-term sustainability of the health service and with the health of the people in England. The net zero ambitions outlined in this report go further than the commitments set out in the NHS Long Term Plan. The actions identified will need to be appropriately resourced with the right capital investment and investment in skills and capacity in the right parts of the system to lead these actions. Delivery of this plan will therefore require ongoing, targeted investment and an aligned financial policy and decision-making process.

These net zero ambitions will be aligned with existing commitments as far as possible; for example, to ensure that the design of new hospitals and major refurbishments, including the government's 40 new hospitals, take into account the

need to reduce emissions, and that wherever possible maintenance or the replacement of equipment is done in a way that improves energy efficiency and reduces emissions. We will work to ensure that these factors are taken into account in investment decisions.

We will look to develop tools so that decisions across the NHS are informed by an understanding of environmental impacts, as well as financial ones. We will explore existing policy and decision-making processes to align with the ambition to get to net zero, including through procurement, business cases and reimbursement. As part of this we will review best practice from other sectors, including options such as introducing an internal carbon fee to incentivise consideration of carbon impacts of financial transactions between NHS organisations.

We also need to review how financial mechanisms influence and change behaviour. The role of incentive schemes and removal of disincentives in driving change is well understood. We will undertake a review of contractual mechanisms and levers to understand the opportunities to drive environmental change. We will look to explore opportunities created through the development of integrated care systems for more efficient joint working and to explore how best to enable systems to focus investment in a way that reduces emissions.

We will actively work with government to access funds directed towards the UK-wide ambition for net zero, and with trusts to explore alternative ways to fund this investment. The investment needed for a net zero health service clearly extends beyond its buildings alone. This also requires investment in our people, ensuring they understand what they can do to respond to climate change, and have the expertise needed to implement new ways of working and to embed behaviour changes.

4.4. Data and monitoring

Evidence-based targets and data underpin the analysis and commitments laid out in this report. However, more work is needed to improve the monitoring and data collection capacity of the system.

Sustainability indicators are already reported nationally through a range of systems, such as the Greener NHS Dashboard. This includes key indicators on anaesthetics, inhalers and building energy use, and process indicators to support action to deliver

on current commitments. Annual sustainability reporting is now mandated for clinical commissioning groups (CCGs) and trusts by the NHS Standard Contract (Service Condition 18). The optional Sustainability Reporting Portal tool supports providers and CCGs in demonstrating and reporting on progress in a consistent way as part of their annual report. These indicators will be reviewed in light of the new net zero commitments and used to monitor and understand the scale of the challenge and progress across the NHS. Trusts will be required to include these indicators in their annual report, which will be used to inform a regular update of the NHS emissions profile. This will be supported by efforts to mainstream sustainability into the common data pipeline for the system, and by making a wide range of tools available online to allow NHS organisations to measure their own progress.

5. Next steps – an iterative and adaptive process

The NHS' approach to achieving net zero emissions will be iterative and adaptive and aim to continuously improve with an increasing level of ambition. Its work will inherently be unfinished, and continually subject to change as technology evolves, the regulatory environment changes, resources materialise and more data becomes available.

The long-term targets and direction of travel are set. However, continual review will be required to ensure the system is on track, with regular planning and review. To this end, an expert panel will be re-convened periodically to provide expert input into a process of monitoring, review and planning for the coming years. In this way, the NHS will constantly aim to have certainty on targets and delivery plans in the near-term, while ensuring it is on track to meet its long-term commitments.

To support internal co-ordination, the NHS England and NHS Improvement Sustainability Board will be refreshed to ensure senior coverage across the system, and will report to the NHS Board. Outside the NHS, the national cross-system group will also be revitalised to help co-ordinate action from the full range of organisations involved in delivering against the net zero agenda. A new International Advisory Committee will be formed to support the delivery of the NHS Carbon Footprint Plus scope, in recognition that achieving net zero emissions will require partnerships with health professionals across the world. Finally, the new Greener NHS national programme will build on the work of the former Sustainable Development Unit, with an expanded, outward-facing remit, enhanced capacity, and a focus on net zero healthcare and the broader sustainability agenda.

Box 8: A resilient, net zero health service

A net zero NHS is an essential component of the response to climate change. However, the NHS must also adapt to the impacts of climate change that are already occurring today, and those that cannot be avoided. Heatwaves, storms and floods are already affecting the way that care is delivered across

community, primary and secondary care settings, and the evidence suggests that these events will only become more frequent over the next 30 years.

Mitigation and adaptation priorities are often mutually strengthening. However, without careful planning, they may undermine one another, making both objectives less achievable. The NHS will build resilience and adaptation into the heart of the net zero agenda, and will use the third Health and Social Care Sector Climate Change Adaptation report (due for publication in the coming months) to highlight this approach.

5.1. The next 12 months – an ongoing engagement process

The direction, scale and pace of change outlined in this report have been informed by the near 600 submissions to the call for evidence, national and international technical expertise, and the guidance of the NHS Net Zero Expert Panel. Ongoing engagement is required from a broad range of stakeholders within and beyond the NHS to provide further detail and advance this work. Over the coming months, this will include:

- continuing to finalise and then publish the analysis underpinning the dates presented here
- working with government and the full range of NHS organisations to explore the resources available to deliver a net zero health service
- publishing the third Health and Social Care Sector Climate Change Adaptation Report (**Box 8**)
- restarting the national campaign For a greener NHS to engage with our staff and patients, and to ensure that the health service's commitments on climate change and net zero are clear to the world.

Importantly, the publication of this report, and the commitments and discussion within it, will be used as a basis of an engagement process over the next six months. Engaging with key stakeholders and across government, this will be used to provide further clarity on what is possible, always with the aim of increasing ambition over time. Importantly, it will ask several targeted questions about the

medium-term direction of this work, and explore mechanisms further to support staff and the wider system to deliver against the NHS' net zero ambitions. For example, while the rapidly evolving technology and infrastructure needed to reduce road transport emissions presents an opportunity, there is a need to further understand the mechanisms available to deliver on this. The results of this process will be used to inform further commitments and will be published throughout 2021.

The evidence-based targets laid out in this report provide ambitious and credible targets for net zero emissions. With the UK government hosting the UN Climate Change negotiations (COP26) in Glasgow in 2021, the NHS is well-placed not only to meet, but to exceed its commitments under the Climate Change Act, and to become the world's first net zero national health service.

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7. Glossary

AAC	Accelerated Access Collaborative
AHSN	Academic Health Science Network
CFCs	chlorofluorocarbon gases
CO_2e	carbon dioxide equivalents
Defra	Department for Environment, Food and Rural Affairs
DPI	dry powder inhaler
GDP	gross domestic product
GHGP	Greenhouse Gas Protocol
GIRFT	Getting It Right First Time
GWP	Global Warming Potential
HEE	Health Education England
HES	Hospital Episode Statistics
HFCs	hydrofluorocarbons
ICT	information and communication technology
IPAC	International Pharmaceutical Aerosol Consortium
IPCC	Intergovernmental Panel on Climate Change
LED	light-emitting diode
MDI	metered-dose inhaler
NEEF	NHS Energy Efficiency Fund
NICE	National Institute for Health and Care Excellence
PPE	personal protective equipment
WHO	World Health Organization

Annex 1: The NHS Net Zero Expert Panel

Member	Affiliation
Dr Nick Watts (Chair)	Executive Director, The Lancet Countdown on Health and Climate Change
Preeya Bailie	Director of Procurement Transformation & Commercial Delivery, NHS England and NHS Improvement
Kay Boycott	Chief Executive, Asthma UK and British Lung Foundation Partnership
Dr Isobel Braithwaite	Public Health Registrar and Academic Clinical Fellow, University College London
Professor Paul Cosford	Emeritus Medical Director, Public Health England
Dame Jackie Daniel	Chief Executive, The Newcastle upon Tyne Hospitals NHS Foundation Trust
Professor Mike Davies	Professor of Buildings Physics and the Environment, Bartlett School of Environment, Energy & Resources, University College London
Ian Dodge	National Director, Primary Care, Community Services and Strategy, NHS England and NHS Improvement
Professor Piers Forster	Professor of Climate Physics, University of Leeds
Dr Fiona Godlee	Editor in Chief, *British Medical Journal*
Sara Gorton	Head of Health, UNISON
Professor Hilary Graham	Professor of Health Sciences at the University of York
Prerana Issar	Chief People Officer, NHS England and NHS Improvement
Richard Murray	CEO, The King's Fund
Professor Donal O'Donoghue	Registrar, Royal College of Physicians
Sonia Roschnik	International Climate Policy Director, Health Care Without Harm
Professor Harry Rutter	Professor of Global Public Health, University of Bath

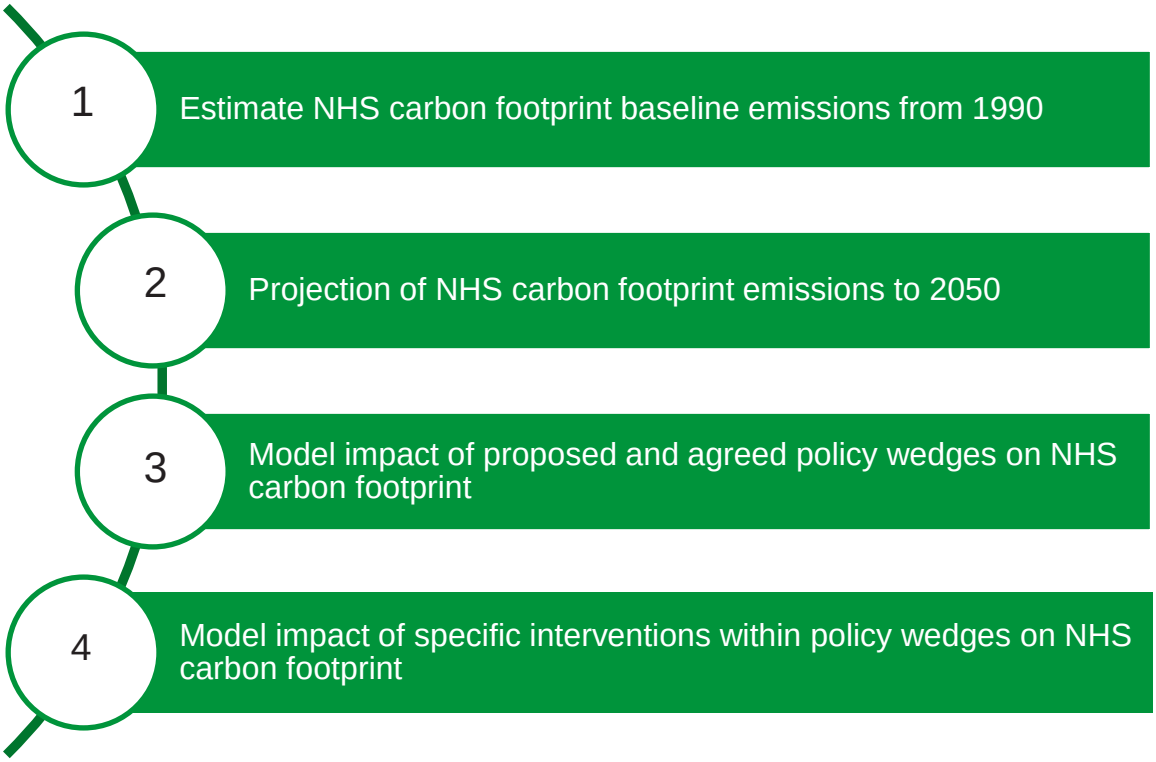
Professor Emily Shuckburgh	Director of Cambridge Zero, University of Cambridge
Dr Richard Smith	Chair, UK Health Alliance on Climate Change
Professor Helen Stokes-Lampard	Chair, Academy of Royal Medical Colleges
Dr Madeleine Thomson	Interim Head, Our Planet, Our Health, the Wellcome Trust
Dr Matthew Tulley	Director of Built Environment, Imperial College Healthcare NHS Trust

Annex 2: The analytical approach to net zero

The net zero modelling and analytics approach provides the basis for setting out the pathway to net zero for the NHS. It combines the following: outputs of estimates of the NHS carbon footprint emissions from 1990 to date; a forecast of emissions to 2050; a model of the impact of the combined actions from agreed policy wedges that deliver expected emission savings and individual analysis; and modelling of specific interventions or set of interventions to demonstrate the scale of change required to reach net zero for the NHS.

The four main elements of the modelling and analytics approach that underpin the recommendations in this report are detailed below.

Figure 12: The four main elements of the modelling and analytics approach



Estimating NHS carbon footprint emissions from 1990

The NHS carbon footprint model quantifies emissions within scopes 1, 2, and 3 of the Greenhouse Gas Protocol, as well as 'out of scope' patient and visitor travel emissions, from 1990 to 2019. This allows for benchmarking with the Climate Change Act. The estimates blend:

- Location-generic (top-down) results for categories that can only be measured in economic terms, or that are too complex to model physically. Financial information is combined with environmentally extended input output (EEIO) carbon intensities per unit spend ($kgCO_2e/£$) for 105 economic sectors.[47] The 2020 carbon footprint update uses the 2016 EEIO model.
- Product and location-specific (bottom-up) results for categories that can be measured and described physically. Organisational data collections of activity (units of energy, waste, travel miles, etc) are combined with carbon factors from BEIS.[48]

Environmental and economic datasets are collated internationally so the base dataset is four years older than the bottom-up information.

Location generic (top-down) modelling

NHS supply chain and commissioned health services emissions are calculated using the location generic (top-down) modelling approach. This relies on economic models of the interconnections between different sectors, and their associated satellite accounts on emissions or resource use data. Estimates of the emissions or resource use associated with expenditures on goods or services are made by calculating the share of economy-wide emissions due to those expenditures.

The analysis uses the UK Multi Region Input Output (MRIO) model developed by researchers at University of Leeds for Defra to estimate the impact that UK consumption has on CO_2 emissions. The worldwide production of goods consumed in the UK is considered, as well as goods produced in the UK and emissions directly generated by UK households. This version is adapted for use for the NHS.[47]

The MRIO model links the flows of goods and services described in monetary terms with the emissions generated in the process of production. Forecasting uses a static model of an economy, represented in economic input–output tables using

linear fixed assumptions on technology mixes and prices. This limits the capacity of the forecast to capture the effects of new technologies, price shifts or changes to the structure of economies. The model combines UK national input–output tables, taking advantage of their high sectoral resolution, and complements them with EXIOBASE's MRIO model (an MRIO table produced by a prominent consortium of EU research institutes), more accurately representing economic structures and emissions intensities of other countries and world regions.

The model uses UK government spend data on health from HM Treasury Public Expenditure Supply and Use (Final Demand) tables and from Statistical Analysis (Public Expenditure Statistical Analysis) apportioned to England based on population. Broadly, the process is as detailed in **Figure 13**.

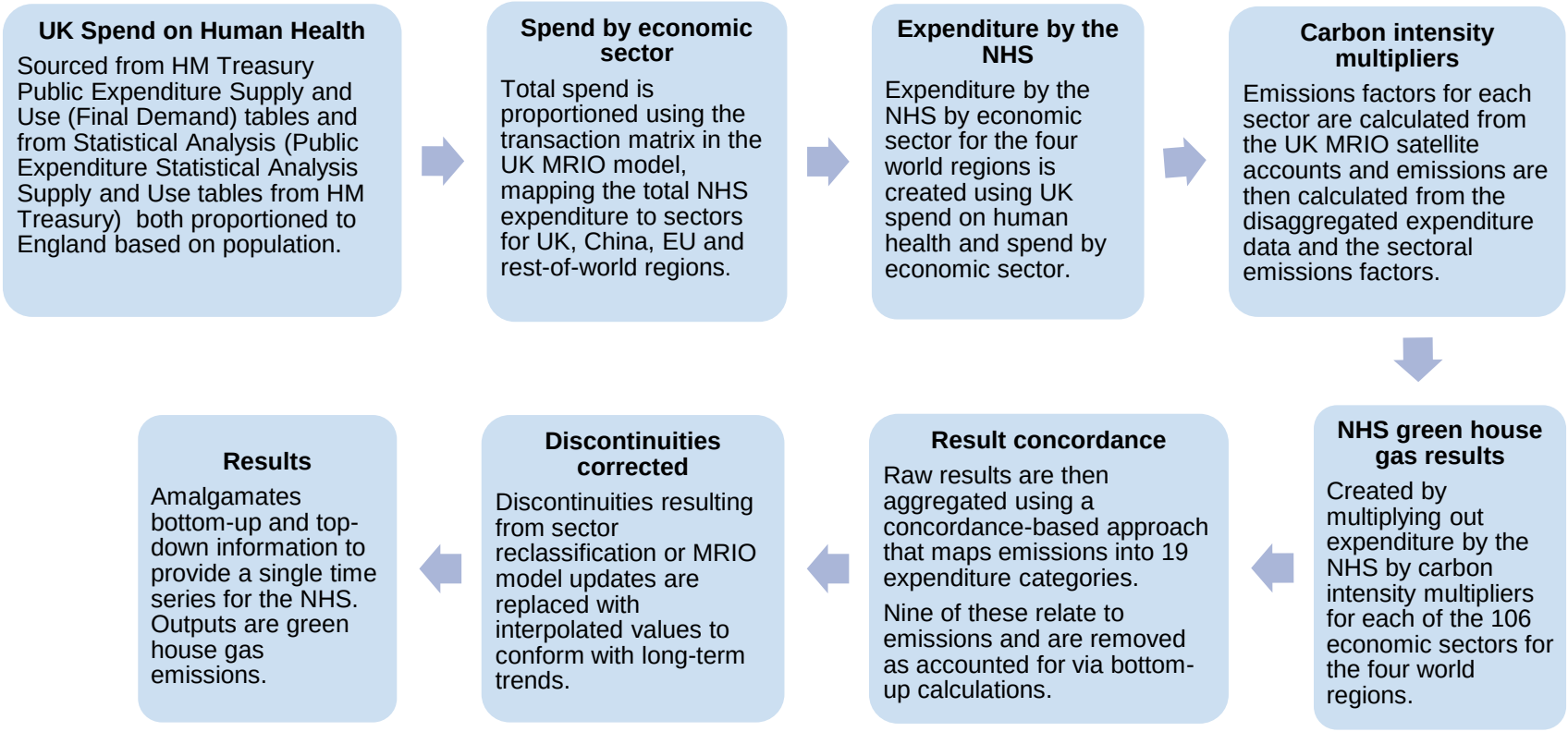
Product and location-specific (bottom-up) modelling

Staff, visitor and patient travel

Business travel and freight and business-related transport are calculated using the top-down approach. National Travel Survey (NTS) results have been used to estimate the patient travel to and from NHS sites including primary care, such as pharmacy and GP practices, and patient transport services not paid for by the NHS.[49] This is also used to estimate visitor travel accompanying patients, visiting patients in hospital, escort and staff commute to and from NHS sites. No consistent surveys were available for travel to and from NHS sites, so this national dataset provides the only source information.

Carbon intensity factors from BEIS have been mapped to each mode of travel to calculate emissions[48] and a continuing trends model has been used to calculate the carbon intensities of travel in the future. This assumption will need re-visiting with scenarios for moving to electric vehicles and regulation already in place which reduces the carbon emissions from cars.

Figure 13: Process to develop UK MRIO model



Building energy use and electricity intensity

Data from the Estates Return Information Collection (ERIC) system is used to estimate emissions from NHS buildings in NHS trusts and ambulance trusts within England.[50] The data includes the consumption of energy, water and limited other goods for all buildings and NHS-leased sites, covering 24 million m^2 of hospitals and other clinical facilities across the country. It does not include other healthcare buildings such as those for primary care, sites below 150 m^2 with fewer than 10 inpatient beds or office buildings of non-clinical organisations. ERIC reporting requirements and NHS structures have changed over time and an annual adjustment is included to account for this. Annual emissions factors for fuels and electricity, are taken from the UK Government Energy (BEIS) and Environment (Defra) ministry publications for 2002 to 2019, and from company reporting guidance for older calculations.[48] Future electricity factors are published in the HM Treasury Green Book supplementary guidance for the valuation of energy use and greenhouse gas emissions for appraisal.[51] These are modelled based on predicted grid mix of energy generation.

Anaesthetic gases (volatiles and N_2O)

Anaesthetic gases analysis uses four different categories of data sources for estimation purposes:

1. supplier data from distribution or manufacturing companies; voluntary health facility reporting
2. hospital data obtained at the facility, trust, or ambulance trust level
3. NHS pharmacy hospital-level electronic data (volatiles only)
4. dental clinic N_2O data from work commissioned by Public Health England.[52]

UK data is scaled to England by population, and all bottom-up data is extrapolated to England by occupied bed-days. The model assumes there are four activity drivers for the use of N_2O. These are in surgery as a carrier gas for volatiles, gas and air in maternity, ambulance and emergency room. Volatiles are assumed only to be used by anaesthetists during surgery. Surgical activity is modelled on bed days for surgical specialties using hospital admitted patient care activity from the Hospital Episode Statistics (HES). Maternity activity is based on the number of maternities. A&E activity is recorded by the number of A&E attendances.

Ambulance activity is used in terms of calls to the ambulance service that receive a face-to-face response from the ambulance service.

Global warming potential factors (GWP100) for the volatiles are taken from Sulbaek Anderson (2011) and for N_2O from the IPCC AR5.[51,53]

Metered dose inhalers

Metered dose inhalers analysis uses the internationally reported national atmospheric emission intensity (NAEI) data (including private prescriptions) for 2006 onward, and back dates to 1990 using population and assuming no change in inhaler use per capita prior to 2006.[54] For the years between 2006 and 2017, this data is scaled down from the UK to England, by proportion of population.

Projection of NHS carbon footprint emissions to 2050

The projections of NHS carbon emissions build on the carbon footprint baseline using assumptions to develop a conditional forecasting model to 2050. The outputs of this model are then used to set out a pathway to net zero for the NHS. This includes the short-term forecasts to extend from available time series data to present day (2020) and longer-term projections to 2050.

- For categories that can be measured and described physically (bottom-up), historical trends and known interventions have been used to create independent assumptions for each category of emissions. Both activity (changes in energy use, travel, spend, etc) and carbon intensities are combined to produce a forecast of emissions for each year to 2050.
- For categories that can only be measured in economic terms, expenditure has been modelled in line with Office for National Statistics (ONS) and Office for Budget Responsibility (OBR) published projections of health expenditure and the NHS proportion of this in England has been calculated using known expenditure figures.[55,56] Nominal gross domestic product (GDP) for 2018 and Consumer Price Index assumptions are taken from the OBR Economic Outlook supplementary (2019). These are combined with the GDP deflator index from the HM Treasury Green Book supplementary (2019) and growth forecasts from the OBR Fiscal Sustainability Report (FSR) (2018) to produce projections of future NHS spend.[57,58]

Where forecasts for carbon intensity or spend have been published, by BEIS or other government departments, this information was used, however many categories do not have this information available. Forecasts therefore use one of three options: continuing trend, continuing growth or known trajectory.

Table 2: Details of data used and projections modelled

Category	Bottom-up or top-down?	Source	Backcast years	Actual data	Projection years	Projection basis
Building energy use – hospitals	Bottom-up	ERIC	None	1990–2018	2019–2050	Gas, oil, coal – continuing trends Electricity – expenditure adjusted for inflation
Building energy use – other sites (GP, offices)	Estimate	Sample data source	1990–2013	2014–2015	2016–2050	Backcast based on hospital energy use Forecast based on expenditure adjusted for inflation
Electricity factors	Bottom-up	BEIS HMT Green Book	1990–2002	2002–2017 2018–2050		All BEIS factors have been used for grid composition year and HMT Green Book modelled factors have been used for subsequent years. For 2018 an average of 2019 BEIS (2017 grid composition) and 2020 Green Book factor has been used
Waste and water	Top-down	EEIO	1990–1996	1997–2016	2017–2050	Comparison with bottom-up data shows a large variance so top-down totals are being used
Travel – staff, visitor and patient	Top-down	NTS	1990–2001	2002–2018	2019–2050	Continuing trends model

Category	Bottom-up or top-down?	Source	Backcast years	Actual data	Projection years	Projection basis
Supply chain	Top-down	EEIO	1990–1996	1997–2016	2017–2050	Forecast based on OBR FSR 2018 growth projections
Anaesthetics – volatiles	Bottom-up	Supplier information	1990–2015	2016–2018	2019–2050	
Anaesthetics – nitrous oxide	Bottom-up	Supplier information	1990–2010	2011	2012–2050	
Meter dose inhalers hydrofluorocarbons (HFCs)	Bottom-up	NAEI	1990–2005	2006–2017	2018–2050	Backcast uses linear increase between introduction of HFC inhalers in 1997 to first recorded emissions data in 2006
Meter dose inhalers chlorofluorocarbon gases (CFCs)	Bottom up	NAEI		1990	1991–2050	Linear reduction 1990 to 2006

Model impact of proposed and agreed policy wedges on NHS carbon footprint

The wedges model combines the estimate of the NHS carbon footprint emissions from 1990 to the present day with projection of emissions to 2050 and the modelling of the impact of specific interventions to deliver carbon savings. Areas where policy action are needed to tackle the carbon emissions in the NHS carbon footprint have been identified as a ‘wedge’ and broken down into smaller ‘sub-wedges’. Potential carbon savings are estimated to create a wedge trajectory and contribution towards the delivery of net zero. This is based on evidence, bottom-up analysis, modelling and data where available. The savings are applied to the NHS carbon footprint forecast from 2020 to 2050 to provide projections of emissions post policy actions and the potential path to achieve net zero under the different scopes.

The wedges assume an ‘order’ such that the carbon reduction is applied sequentially (that is, each reduction is being applied to the remaining footprint only). The order of the wedges is set so that national and international actions are applied

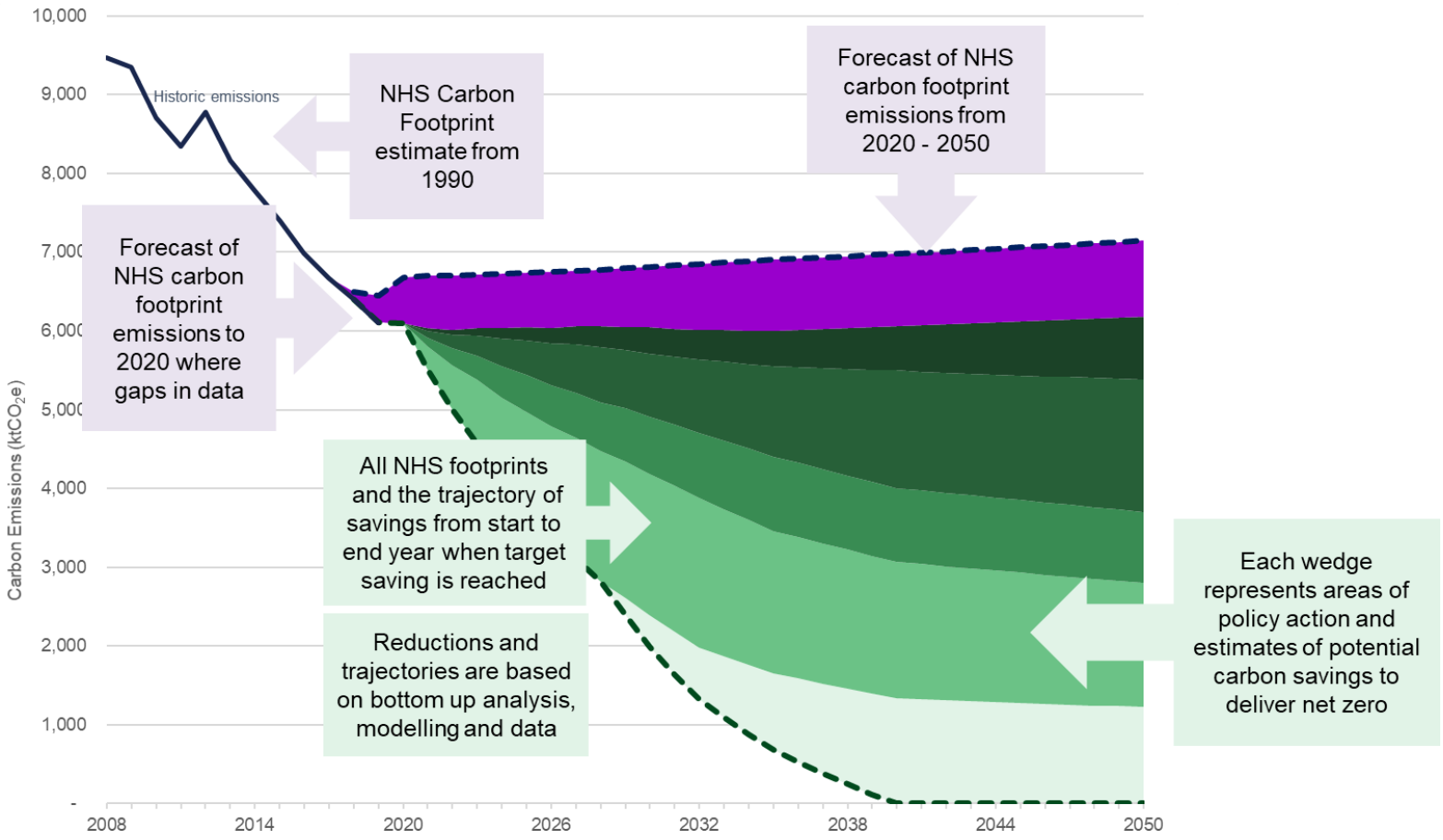
first, followed by any existing commitments (eg NHS Long Term Plan actions), followed by wedges with cross-sector impacts (eg new models of care), and any remaining emission would be addressed by the sector-specific wedges. This approach ensures that any duplication of emissions reductions is removed. However, the emissions reductions derived using this ordering process may slightly differ from the reductions identified in the bottom-up analysis.

Model impact of specific interventions within policy wedges on NHS carbon footprint

Each of the policy areas modelled by the wedges has conducted bottom-up modelling or analysis to understand the key interventions required to deliver net zero. This analysis sets the basis for the target carbon reduction (as a percentage of the footprint). The trajectory of savings used in the wedges model estimates the delivery savings each year from the start of implementation to the year when the target saving is reached.

Some of the wedges may have more impact than one carbon sector. For example, new models of care interventions (such as earlier intervention, rapid discharge, etc) aim to reduce the numbers of treatments and/or the carbon intensity of the treatment required. These interventions therefore can deliver savings across the NHS' footprint. The bottom-up analysis is not able to fully consider consequences of these cross-sector impacts; this is accounted for in the wedges model.

Figure 14: Detail of the carbon reduction wedges



Annex 3: Summary of the net zero call for evidence

The NHS net zero programme opened a call for evidence on 25 January 2020, inviting ideas on how the NHS could continue to reduce its carbon emissions and become greener.

The call for evidence formally closed on 22 March 2020, although to take account of the NHS response to COVID-19 we accepted a number of late submissions via e-mail. A total of 568 submissions were received and we are grateful to everyone who took the time to submit their ideas and evidence.

There was a diverse range of information from a broad range of contributors:

- **57% of submissions were provided by NHS staff**, with the remaining **43% coming from other sources** including industry, academia, the third sector and members of the public.
- Around **50% of the submissions represented ideas and expert opinions** and **30% included case studies or research**. The remainder comprised other resources, including links to sustainability blogs, outputs from projects, dissertations and innovative local policies.
- More than **40% of submissions contained a package of multiple ideas and resources**, applicable to a range of areas which we identified as discrete but interconnected workstreams. The remainder focused on specific individual ideas or innovations.

The main themes and ideas arising from our review of evidence is set out by workstream below.

Table 3: Percentage of submissions by area

Workstream	Percentage of submissions
Estates and facilities	21.4%
Travel and transport	12.7%
Supply chain	8.2%
Food, catering and nutrition	7.7%
Medicines	6.7%
Research, innovation and offsetting	4.6%
Sustainable models of care	11.8%
Workforce, networks and system leadership	9.9%
Funding and financial mechanisms	4.2%
Adaptation	1.8%
Strategic ambition	6.2%
Communications and engagement	4.8%

Estates and facilities

The submissions highlighted a range of tangible and visible ideas that can be implemented by both staff and patients; many of which are already being actioned across the estate.

- This includes a range of measures under energy generation and use, for instance: purchasing renewable energy, LED lighting, efficient infrastructure, and retrofit and installation of solar panels.
- Many suggestions noted the need for improved waste and recycling facilities at their local site, such as reduced use, improved waste management, sorting, reusing and recycling, with some suggestions relating to surgical theatres and food. The theme of the NHS going

paperless also emerged, with suggestions around a digital-first approach and stopping paper letters.

Submissions included a range of ideas that are not currently being implemented. These require further investigation to fully understand their impact:

- For energy generation, suggestions included the installation of fuel cells, biomass boilers and combined heat and power engines that run on hydrogen, developing heat networks and exploring heat generation. A suggestion to invest in batteries designed for storing photovoltaic power has been investigated further.

Under waste, ideas included switching to multi-use equipment where possible, such as reusable sharps bins, and reusing equipment that has been loaned to individuals (eg crutches, wheelchairs or supporting frames). Applying circular economy principles to waste management was also proposed, by fixing, rather than replacing, broken equipment (non-clinical) such as chairs, flooring and office equipment.

Travel and transport

Submissions related to avoiding travel and reducing the emissions from vehicles where travel is still required.

Some suggestions highlighted ideas that are already underway, including NHS employer initiatives to support sustainable travel for staff, patients and visitors such as:

- organisational or personal travel plans
- changes to business travel and expenses polices
- encouraging active travel (eg walking, cycling)
- car-pooling where appropriate.

Greening the NHS fleet, particularly ambulances, by transitioning to low, ultra-low and zero-emission vehicles was highlighted, along with the associated need for electric vehicle charging.

Some submissions related to action that has already been accelerated during the COVID-19 response. For example, avoiding staff travel by using video conferencing

and increased working from home reduced patient travel through digital GP and outpatient appointments or care provided at the patient's home.

Supply chain

Many submissions relating to supply chain highlighted projects already underway to increase the sustainable procurement of goods and services through, for example:

- embedding sustainability and carbon in decision-making
- setting whole-system and local-level targets for carbon reduction targets
- conducting life cycle assessments and evaluations of high volume products, most notably single-use products
- pooling NHS purchasing power to enable sustainable procurement of goods and services.

The wastefulness of paper usage and plastics was a frequently raised concern from respondents both within and outside the NHS. There was a particular focus on plastics, which fall into two broad groups:

- non-clinical plastics: catering plastics and excessive supply chain packaging, with proposals to switch from single-use to reusables (eg cups, plates, water bottles and food packaging)
- clinical plastics: proposals from staff to re-evaluate alternative options for many single-use items, disposable or expired equipment and unused pharmaceuticals, as well as calls for the NHS to consider reusable or refurbishable alternatives.

Food, catering and nutrition

The most frequently submitted proposal focused on increasing plant-based food and drink options available to patients, staff and visitors, notably for inpatient meals. Evidence submitted highlighted both the environmental and health benefits of an increased consumption of plants and a reduction in consumption of highly processed foods. Benefits include significant reductions in carbon emissions, water consumption, land-use needed for food production and a reduced risk of cardiovascular disease, stroke and obesity.

Other submissions included:

- offering healthier or more sustainable choices for concessions food
- carbon labelling of food to empower consumers to understand the environmental impact of products to make informed choices
- switching to local food suppliers to reduce food miles and utilise seasonal produce
- reducing food waste and reducing single-use plastics in canteens and food packaging.

Medicines

Most of the submissions related to one of four categories:

1. metered dose inhalers (MDIs)
2. anaesthetic gases
3. pharmaceuticals
4. logistics and storage of medicines.

Of the four categories, the majority of submissions related to inhalers and anaesthetics.

Several submissions related to work already underway, such as switching from meter dose inhalers to dry powder inhalers, reducing volatile anaesthetic gas use and more recycling. Others were new ideas, including: individually tailored medicine packaging, disposal of chemotherapy waste and looking at comparisons with veterinary anaesthesia.

Another significant category of responses related to the impact of single-use compared to reusable items, broadly split into plastics and metal items.

Research, innovation and offsetting

Research and innovation were reflected as important enablers to reduce NHS carbon emissions through finding new approaches to delivering healthcare, alongside the potential contribution of offsetting. Submissions in relation to research and innovation fell into two categories:

Innovations in or research into the delivery of a specific service or treatment, an aspect of its delivery or an aspect of its sustainability

In this category, there were significant overlaps with several other workstreams, including digital care, medicines and estate and facilities, since the innovation or research would relate to an operational aspect of healthcare. For example, ideas included switching from disposable to reusable equipment, application of technology to support care pathways, and research into improving the energy efficiency of buildings.

Strategy and policy interventions to support the spread and uptake of research and innovation, encouraging more sustainable healthcare

This included through:

- greater consideration of sustainability principles in decision-making across all areas of healthcare
- alternative procurement mechanisms to stimulate innovation in sustainable healthcare
- greater support to spread innovation and learning for innovators and policy-makers.

Offsetting

Tree-planting and greening of the NHS estate made up the overwhelming majority of submissions addressing how to offset residual carbon emissions. These ideas were mainly suggested for their health benefits, including impacts on staff and patient wellbeing, aiding recovery and social prescribing, rather than carbon capture.

Sustainable models of care

Generally, submissions regarding sustainable models of care related to three areas: principles underpinning models of care, prevention and health inequalities, and the role of digital in supporting low carbon transformation.

Principles

Submissions to the call for evidence highlighted four broad principles or approaches to reduce carbon emissions:

- optimising the location of care, eg care closer to home and in the community
- earlier and faster diagnosis, to allow for earlier and less intensive treatment
- reduced unnecessary treatments and interventions
- ensuring that all activity in the system represents best clinical practice.

The majority of these submissions supported an increase in use of digital technology to provide appointments and services virtually where possible. Several specifically suggested rolling out virtual appointments across primary and secondary care, replacing or supplementing face-to-face appointments. A few submissions also suggested streamlining the way that different forms of care are provided. For example, combining several treatments or diagnostic services in a single patient visit to save time and reduce the number of visits.

Prevention and health inequalities

The NHS Long Term Plan outlines specific activity to encourage prevention of ill health and to address health inequalities. This includes specific action primarily in secondary prevention, such as supporting changes in behaviours or lifestyle factors that are needed to improve a person's healthy life expectancy. Several submissions took a broader view of how the system could reduce carbon emissions, of which the majority focused on the need to tackle wider determinants of health (such as levels of education, income and types of employment) and health inequalities, to prevent people from becoming ill in the first place. This would require working across government, national and local public sector bodies and local authorities.

Many of the examples submitted included principles that align with personalised care approaches. There was a strong focus on patients taking responsibility for their own health, supported by continuity of carer, improved shared decision-making skills between clinicians and patients, and a move to reduce overdiagnosis.

A digital, low-carbon transformation

Many of the submissions related to ideas that are already in train under the NHS Long Term Plan ambitions. These included:

- Telehealth and web-based communication platform usage. Babylon was cited as a comprehensive and mature example of this type of activity already underway, which has subsequently been scaled up significantly due to COVID-19.
- Internet of Things and app-based health sensing and ill health prevention tools which represent a carbon reduction opportunity, building on examples underway. For example, smart inhalers, as cited in the NHS Long Term Plan, and arrhythmia devices.
- Moving away from paper, which is in line with the Digital First agenda.

Submissions also highlighted a range of new ideas and proposals, including:

- Smart hospitals which would link smart buildings to patient flow and experience.
- Data storage, resolution and retention, where submissions emphasised many opportunities such as reducing video or medical scan resolution to lower energy requirements to store and process data.
- Creating low impact ICT systems, including through a focus on circular economy (utilising re-manufactured kit and leasing over ownership). This would need to consider a wide dashboard of environmental and social sustainability factors, including consumption of energy, carbon, material, critical raw materials (rare earth metals) and consideration of ethical and social factors as well as modern slavery legislation.

The Fourth Industrial Revolution emerged as an important theme, which includes a focus on big data, artificial intelligence and machine learning. All these have high potential in terms of diagnostic tools and system efficiencies. This is an area which would need more investigation as there are concerns about what the energy sustainability impact will be. For example, machine learning is a hugely energy intensive process.

Workforce, networks and system leadership

The majority of submissions focused on how the workforce can be supported to operationalise and spread the greener NHS programme. Submissions fell into five broad themes:

Training and guidance

Suggestions made in the call for evidence ranged from national, mandated training for all NHS staff, to role-specific training as part of inductions, to including sustainable development in the curriculum. This would mean that all staff understand the challenges faced due to climate change, and how they can make a difference. It was noted that many trusts already undertake their own training programmes but may vary in the focus of the training. It was suggested that introducing a single narrative, aligned with the national greener NHS approach, would be beneficial.

Behaviour change

Many submissions highlighted the importance of knowing what can be changed to make the biggest difference. This included actions that anyone can take, clinical practice changes and specific changes based on topics (eg waste, travel).

Supporting staff resilience

Another theme emerging from submissions was that of resilience. This includes both managing the eco-anxiety that is being increasingly experienced as we understand the challenges posed by climate change, and ensuring that our workforce and health systems are able to manage those challenges in the future.

Influencing and enabling

Submissions highlighted the crucial role of commitment to the sustainability agenda from system and organisational leadership to enable staff to make changes. This would allow capacity and skills to be built in the right places in the workforce (eg sustainability managers, accountable board members) and would empower enthusiastic staff to have a more influential role. Additionally, submissions suggested that incentivising sustainable behaviours through policies and salary sacrifice schemes would demonstrate a level of commitment and leadership.

Wider system changes

It was noted that for any influential changes to be spread and shared across the system, early engagement with our workforce is essential. This includes engagement over changes to how care is delivered (eg increased use of digital and tech, social prescribing), changes to support services (eg digital-first approach to communication) and facilities management (eg recycling, use of green space).

Funding and financial mechanisms

A number of submissions explored the role of finance in delivering net zero. Some of these expressed support for ideas already underway, such as:

- specific funds or loans, including interest-free loans focused on energy efficiency.
- incentives like salary sacrifice schemes for sustainable travel
- improving information and data, including common measures of carbon to enable fair decision-making.

Others suggested new ideas or approaches, and broadly fell into three categories:

- targeted funding to support the move to more sustainable practices, such a specific greener NHS fund or a sustainable prevention fund to develop and implement green prevention strategies
- policy changes to deliver our net zero commitments, including calls for organisational divestment from fossil fuels, developing ringfenced funding to target sustainability and redesigning payment mechanisms to better incentivise more sustainable care models.
- changes to decision-making processes, including using a sustainability impact assessment for any new investments or financial decisions, adopting practices which consider sustainability in policy and practice from other parts of the public sector and industry (eg Wellbeing of Future Generations Act,[59] Accounting for Sustainability[60]).

Adaptation

Submissions relating to adaptation largely overlapped with at least one other workstream, mostly notably estates and facilities, in particular with a focus on

interventions for cooling and heating buildings. In this sense, and because adaptation interventions rarely have a direct carbon saving, and indeed can increase carbon emissions, proposed interventions have been reviewed and included as a cross-cutting theme within relevant workstreams.

Communications and engagement

Most submissions within this workstream focused on the enabling role of communications and engagement to support positive environmental actions. Campaigns, sharing resources, and use of digital tools and virtual events were recurring suggestions to support greater understanding of climate change and encourage positive activity.

There was a clear overlap here with themes arising under the workforce workstream, including the importance of engaging with staff and the need to increase carbon literacy.

A small number of submissions also provided ideas for the delivery mechanisms of a greener NHS, to make sure that the right decisions and activities happen at the right levels of the system. This will be relevant to planning delivery through local, regional and national teams.

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This publication can be made available in a number of other formats on request.

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University Hospitals Dorset
NHS Foundation Trust

INTERIM BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 27 January 2021

Agenda item: 10.2

Subject:	Board of Directors Governance Cycle

Prepared by:	Carrie Stone, Company Secretary
Presented by:	Carrie Stone, Company Secretary

Purpose of paper:	To present the draft Governance Cycle for the Board of Directors.
Background:	In line with good governance, a governance cycle for the Board of Directors has been produced to outline the work of the Board for the year. The initial draft was reviewed by the Chairman and Chief Executive and clarification received from the Chief Medical Officer and Chief Nursing Officer.
Key points for Board members:	The governance cycle is presented in draft form and will be reviewed on an annual basis. It sets out the frequency of reporting and the leads for all reports. It will be reviewed on an annual basis, or earlier if the Board's Scheme of Delegation is amended.
Options and decisions required:	To agree the governance cycle or highlight any further changes if necessary.
Recommendations:	To approve the governance cycle for the Board of Directors
Next steps:	The governance cycle will continue to be reviewed formally on an annual basis or as required.

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

Committees/Meetings at which the paper has been submitted:	**Date**
Not applicable	

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

BOARD OF DIRECTORS

GOVERNANCE CYCLE 2020 (November 2020)

REGULAR REPORTS	**Lead**	**Part 1/2**
CEO Report (Receive)	CEO	Part 1
Risk Register Report: new red risks (Nov; Jan; March; May; July; Sept)	DoN	Part 2
Integrated Performance Report	Lead COO Support CNO/CMO/CPO	Part 1
Financial Performance Report	CFO	Part 1
Benefits Realisation Update	CSO	Part 1
Serious Incident Report (Including Initial Notification of Potentially Serious Incidents) (Nov; Jan; March; May; July; Sept)	CMO/CNO	Part 2
Patient Story	CNO	Part 1

QUARTERLY REPORTS	**Lead**	**Part 1/2**
Mortality Report (Q4 – May; Q1 – September; Q2 – November; Q3 – March)	CMO	Part 1
Quality Impact Assessment Overview Report (January; March; July; September)	CMO/CNO	Part 2

½ YEARLY & ANNUAL REPORTS	**Lead**	**½ Year**	**Annual**	**Part 1/2**
Board Assurance Framework • Close/sign off previous year's framework.	CNO	---	May	Part 1
Board Assurance Framework • Annual Framework (Approve)	CNO	---	May	Part 1
Board Assurance Framework • ½ Year Review (Scrutinise) (Subject to Audit Committee scrutiny of process - Nov)	CNO	Nov	---	Part 1
Risk Register Report	CNO	November	May (AR)	Part 2
Annual Infection Prevention and Control Report – Board Assurance Statement	CNO	-----	July	Part 1
Nursing Establishment Review (summary)	CNO	March	September	Part 1
Freedom to Speak Up Guardian Report	CPO	January	May	Part 1
Guardian of Safe Hours Report	CMO		July	Part 1
Annual Complaints Report	CNO	---	July	Part 1
Annual Safeguarding Report and Statement of Commitment	CNO	----	September	Part 1

½ YEARLY & ANNUAL REPORTS	Lead	½ Year	Annual	Part 1/2
National Inpatient and Outpatient Surveys Results	CNO	---	When published	Part 1
Quality Improvement Programme	CSO		March	Part 1
Annual CQC Report	CNO	----	July	Part 1
Quality Assurance for Responsible Officers and Revalidation	CMO	----	July	Part 1
7 Day Services Board Assurance Framework	CMO	May	November	Part 1
Annual Health and Safety Report	CNO		July	Part 1
Annual Staff Survey Report and Action Plan	CPO	-----	When published	Part 1
Workforce Race Equality Standards Action Plan	CPO	----	September	Part 1
Local Clinical Excellence Awards	CPO	September to approve	November (part 1)	Part 2 Part 1
Annual SIRO Report	CIO	---	May	Part 1
Annual Estates Report	CSO		September	Part 1
Annual Winter Plan	COO		November	Part 1
EPRR Assurance	COO		September	Part 1
Annual Security Report	COO	---	May	Part 1

CORPORATE GOVERNANCE REPORTS	Lead	Annual Reports	Part 1/2
Code of Conduct (5 yearly)	CoSec/ Chairman	October 2025	Part 1
Constitution (3 yearly) (Note CoG Approval)	CoSec/ Chairman	October 2023	Part 1
Scheme of Reservation & Delegation (Approve 3 yearly)	CoSec/ CEO	March 2023	Part 1
Standing Financial Instructions	CFO	October 2021	Part 1
Approve Register of Compliance with Licence Conditions	CEO/CoSec	March	Part 1
Approve Register of Compliance with Code of Governance	CEO/CoSec	March	Part 1
Annual review of the effectiveness of third party processes and relationships (Code of Governance: Comply or Explain)	CEO/HoC	January	Part 1
Audit Committee Terms of Reference	Chair (AC)/CoSec	September 2021	Part 1
Finance & Performance Committee Terms of Reference	Chair F&P/CoSec	September 2021	Part 1
Quality Committee Terms of Reference	Chair QC/CoSec	September 2021	Part 1
Workforce Strategy Committee Terms of Reference	Chair WSC/CoSec	September 2021	Part 1

CORPORATE GOVERNANCE REPORTS	Lead	Annual Reports	Part 1/2
Workforce Strategy Committee Annual Report	CoSec	July 2021	Part 1
Quality Committee Annual Report	CoSec	July 2021	Part1
Finance and Performance Committee Annual Report	CoSec	July 2021	Part 1
Audit Committee Annual Report	CoSec	May 2021	Part 1
Seal of Documents Register	CoSec	May 2021	Part 1
Gifts & Hospitality Register	CoSec	May 2021	Part 1
Register of Interests	CoSec	May 2021	Part 1
Board Reporting Governance Cycle (Approve)	Co Sec	March 2021	Part 1
Annual Board Effectiveness Report	CoSec	September	Part 1
Independence of Non-Executive Directors (Annual Report requirement)	CoSec	March 2021	Part 1
Board Meeting Schedule	CoSec	May 2021	Part 1

ANNUAL BUSINESS PLANNING/REPORTING	Lead	Annual	Part 1/2
Strategic Plan (Approve)	CSO	(5 Year)	Part 2
Supporting Functional Strategies & Policy Intent (Approve)	Chief Officers	(5 Year)	Part 2
Annual Operational Plan & Certification			
Receive Draft (BoD Pt 2)	CSO/CFO	January	Part 2
Approve Final (BoD Pt 2)	CSO/CFO	March	Part 2
Final Annual Operational Plan (BoD Pt 1) To receive	CSO/CFO	May	Part 1
Commissioner Contract(s) (Approve) - Preliminary scrutiny by Finance & Performance Committee	CFO	March	Part 2
Annual Report and Accounts (for approval):			
Annual Governance Statement	CEO/CNO	May	Part 2
Annual Report - all	CFO	May	Part 2
Annual Report – Financial Statements	CFO	May	Part 2
Annual Going Concern Statement	CFO	March	Part 2
Annual Report – Quality Report	CNO	May	Part 2
Audit Letter to Auditor (Agree)	CFO	May	Part 2
Annual Membership Report	Chairman	May	Part 2
Other Annual Certificates:			
Availability of Resources	CFO	May	Part 1
Systems for Finance Compliance (condition G6)	CFO	May	Part 1
Certification of Governance and AHSCs – The Corporate Governance Statement	CEO	May	Part 1
Training of Governors (S151 Act)	Chairman	May	Part 1

EXCEPTION REPORTS (e.g.)	Lead	Part 1/2
Charitable Funds – Expenditure Over £250k	CFO	Part 1
Working Capital Utilisation Report (Receive)	CFO	Part 2
Commissioner Contract Variations (Approve)	CFO	Part 2
Cash Investments (Approve)	CFO	Part 2
Amendments to Directors' Interests (Receive)	CoSec	Part 1
Board Governance Cycle (Approve)	CoSec	Part 1
Exception Reports from the Chairs of the Board Committees	Chairman	Part 1
Regulatory Exception Reports e.g. HSE Reports (Health and Safety Executive), Care Quality Commission (CQC) Reports.	CNO	Part 1
Guardian of Safe Hours Report (Q4 – May; Q1 – July; Q2 – November; Q3 – March)	CMO	Part 1

CS – Company Secretary

November 2020

University Hospitals Dorset
NHS Foundation Trust

INTERIM BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 27 January 2021

Agenda item: 10.3

Subject:	Chairman v Chief Executive Responsibilities Statement

Prepared by:	Carrie Stone, Company Secretary
Presented by:	Carrie Stone, Company Secretary

Purpose of paper:	To present the responsibilities statement
Background:	In Monitor's Code of Governance for NHS Foundation Trusts, one of their main principles (A.2 Division of Responsibilities) is that there should be a clear division of responsibilities at the head of the NHS Foundation Trust between the Chairing of the Board of Directors and the Council of Governors and the Executive responsibility for the running of the NHS Foundation Trust business. No one individual should have unfettered powers of decision.
Key points for Board members:	One of the specific code provisions is that the division of responsibility between the Chairman and Chief Executive should be clearly established, set out in writing and agreed by the Board.
Options and decisions required:	To agree the statement or highlight any further changes if necessary.
Recommendations:	To approve the Statement
Next steps:	If approved, the statement will be placed on the Trust's website.

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

Committees/Meetings at which the paper has been submitted:	**Date**
Not applicable	

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

DIVISION OF RESPONSIBILITIES BETWEEN THE CHAIRMAN AND CHIEF EXECUTIVE

1. In Monitor's Code of Governance for NHS Foundation Trusts, one of their main principles (A.2 Division of Responsibilities) is that there should be a clear division of responsibilities at the head of the NHS Foundation Trust between the Chairing of the Board of Directors and the Council of Governors and the Executive responsibility for the running of the NHS Foundation Trust business. No one individual should have unfettered powers of decision. One of the specific code provisions is that the division of responsibility between the Chairman and Chief Executive should be clearly established, set out in writing and agreed by the Board.

2. Both the Chief Executive and the Chairman have job descriptions which describe their responsibilities and evidence the fact that the Chairman and Chief Executive's role are distinctly different. Whilst the Chairman is accountable for giving leadership to the Board of Directors ensuring that the Trust meets its legal obligations, the Chief Executive is accountable for the effective management and delivery of the organisation's services and as the Accountable Officer, ensures that the Trust meets its statutory responsibility and has appropriate systems of control in place.

3. The Board is asked to agree the Chairman and Chief Executive's responsibilities.

Carrie Stone
Company Secretary
January 2021

Agreed: Board of Directors September 2007
Updated: January 2009 to reflect title changes

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University Hospitals Dorset
NHS Foundation Trust

INTERIM BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 27 January 2021

Agenda item: 10.4

Subject:	Statement on the Composition of the Non-Executive Directors

Prepared by:	Carrie Stone, Company Secretary
Presented by:	Carrie Stone, Company Secretary

Purpose of paper:	To receive the non-executive director composition statement prior to submission to the Council of Governors for approval
Background:	It is a requirement of Monitor's Code of Governance that the Trust should regularly review the structure, size and composition of the board of directors and make recommendations for changes where appropriate through the nomination committee(s). In particular, the Governors' "nominations" committee should review the balance of skills, knowledge, composition and experience on the board of directors and make a recommendation to the Council of Governors, in the light of this evaluation and prepare a description of the role and capabilities required for appointment of both executive and non-executive directors, including the chairman.
Key points for Board members:	The statement is drawn up by the Board of Directors and provides guidance on the background and abilities required by Trust Non-Executive Directors. This statement is one of the documents of the Foundation Trust that is available for inspection by members of the public, free of charge, at all reasonable times and shall be available on the Trust's website. The statement includes: • Background; • Experience required; • Attributes; • Remuneration principles; • Terms of office; • Appraisal; • Review, and; • References. The statement has been reviewed by the Chairman and Chief Executive.

Options and decisions required:	To agree the Statement or highlight any further changes if necessary.
Recommendations:	To agree the Statement and recommend approval to the Council of Governors.
Next steps:	The Statement will be added to the Trust's website. Work is underway to consider the principles of succession planning for the Board of Directors.

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

Committees/Meetings at which the paper has been submitted:	**Date**
Not applicable	

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

STATEMENT ON THE COMPOSITION OF NON-EXECUTIVE DIRECTORS

1. INTRODUCTION

1.1 The Board of Directors (The Board) consists of both Executive and Non-Executive Directors. The Non-Executive Directors are the public's representatives on the Board and share responsibility for the success of the organisation and the duties of the Board. The Trust's Constitution requires the Board to be constituted so that the number of Non-Executive Directors exceeds the number of Executive Directors, the Chairman being a Non-Executive Director.

1.2 The Trust's Chairman and Non-Executive Directors are appointed by the Council of Governors in accordance with paragraph 24 of the Trust's Constitution. Annex 5 of the Constitution Standing Orders for the practice and procedures of the Council of Governors: paragraph 19.9.3 states that the Nominations, Remuneration and Evaluation Committee shall review the structure, size and composition of the Board of Directors from time to time and make a recommendation to the Council of Governors.

1.3 This statement, which is drawn up by the Board of Directors, provides guidance on the background and abilities required by the Trust's Non-Executive Directors.

1.4 This statement is one of the documents of the Foundation Trust that is to be available for inspection by members of the public free of charge at all reasonable times and shall be available on the Foundation Trust's website.

2. BACKGROUND

2.1 Non-Executive Directors should bring a variety of backgrounds and experience to the Board. Whilst it is important that this is diverse, it should remain relevant to the Trust's role as a provider of healthcare in a competitive market and to the Board's role as a corporate decision-making body. The role of the Non-Executive Directors, as members of the Board, will be to consider the key strategic and leadership issues facing the Trust in carrying out its statutory and other functions.

2.2 Ideally, a Non-Executive Director should have held a board position in the past and will usually have enjoyed a long and successful career in one or more areas of industry, commerce, a profession or public life (see below). However, it is important not to be prescriptive about preferred background as each individual will bring particular abilities to the Board. The Council of Governors should consider what "added value" would be brought to the Board by the specific expertise of each individual.

3. EXPERIENCE REQUIRED

3.1 The Board will refer to the skills identified in Appendix A in developing the person specification for the Non-Executive Directors, including the Chairman (taking into consideration the views of the Council of Governors).

4. ATTRIBUTES

It is important to take account of the Code of Conduct for NHS Boards and the Code of Accountability for NHS Boards for selection to public appointments which emphasises the need for applicants to uphold standards in public life and display:

Selflessness, integrity, objectivity, accountability, openness, honesty and leadership (the Nolan Principles).

4.2 NHS Improvement identifies a number of competencies required for this type of senior board role. These include: commitment to patient needs and commitment to devote the necessary time; common sense; courage to ask questions that no one else has asked or query why a certain approach is being recommended; forward planning capability; ability to challenge constructively; influencing and persuasion skills; communication skills; team working approach; self-motivation; clear and creative thinking.

4.3 The Monitor Code of Governance describes the need for Non-Executive Directors to be independent in character and judgement. Non-Executive Directors must also meet the "fit and proper" person test as required by each Trust's provider licence and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

5. REMUNERATION

5.1 The level of remuneration for the Chairman and Non-Executive Directors will be recommended by the Nominations, Remuneration and Evaluation Committee and approved by the Council of Governors.

6. TERM OF OFFICE

6.1 Initial terms of office will be for up to three years, with the opportunity for re-appointment at intervals of three years. Any term longer than six years (ie. two three-year terms) will be subject to particularly vigorous review. Non-Executive Directors may serve longer than six years (ie. two three-year terms), subject to annual re-appointment, and rigorous determination of the Non-Executive's continued independence.

7. APPRAISAL

7.1 The Chairman will conduct annual appraisals of each Non-Executive Director, and will advise the Nominations, Remuneration and Evaluation Committee of the suitability of a Non-Executive Director of re-appointment as required.

8. STATEMENT REVIEW

8.1 This statement will be reviewed at intervals not exceeding three years by the Board of Directors and subsequently approved by the Council of Governors. Specifically, it will be reviewed before each Non-Executive Director recruitment campaign. Suggested amendments are to be discussed in the first instance with the Chairman and Chief Executive Officer.

9 REFERENCES

9.1 Monitor – Code of Governance (July 2014): Section B: effectiveness/B1 the composition of the Board;

9.2 Nolan Principles on Conduct in Public Life

9.3 UHDFT Constitution.

October 2020

Appendix A

Non-Executive Director Skill Matrix Key areas of performance

Non-Exec	Finance – Operational/ Corporate Restructuring	Legal/ Regulation/ Governance & Risk	Strategic Business Planning	Commercial Operational Management	Human Resources/ Organisational Development	Clinical	Healthcare/Public sector Experience	University	Marketing & Communications
Skills, experience, attributes specific to key areas	Financial Director experience gained in a large and complex organisation, handling large business portfolios	A detailed understanding of corporate governance frameworks and regulatory environments	Experience of leading strategy formulation, strategic planning & process implementation in a comparable organisation	Experience of working in a senior operational role, encompassing an entrepreneurial flair in a complex organisation	Extensive previous experience of operating at a senior HR/OD executive level in complex or diverse organisations	Senior experience of strategic healthcare and clinical issues	Experience of working in a healthcare management role or other public sector leadership role	Experience in relevant field at University	Experience of working at senior level in a marketing and/or communications role
	Proven track record in managing major financial transactions and experience of large scale mergers/ transactions	Experience of corporate restructuring, due diligence and associated processes	Experience of critically reviewing existing processes & successfully delivering new processes	Experience of delivering an organisation through large scale & complex change, transformation, merger or acquisition	A record of success in communicating and engaging with a wide range of staff	Experience of working in a senior clinical management role in a relevant environment	A track record of holding senior management positions in the wider public sector	Ability to provide meaningful link with University	Ability to understand and articulate the application of marketing concepts to the NHS
	Qualified accountant	Ability to analyse corporate risks & development	Ability to keep abreast & apply new strategic approaches & thinking	Experience of critically appraising business options and a	Strong organisational development skills and experience	Knowledge of the primary/secondary/tertiary mental health	Previous experience at Board level and other forms of governance eg	Previous experience at Board level	Experience of managing communications within a complex organisation

		of appropriate risk assurance processes		track record in managing the implementation of new business opportunities		or community mental health environment	Trustee of a large charity		
	Experience of evaluating, appraising and approving complex and large scale financial proposals	Knowledge, understanding and experience of corporate law	Experience of creating the strategic context for transformation, operational change &/or mergers in a complex organisation	Experience of delivering cultural alignment within an organisation going through change	Previous employee engagement experience and an ability to translate to the NHS environment	Credibility in a senior clinical role	Knowledge and understanding of the commissioning and provider functions, structures and governance	Operated at a senior level in University with significant responsibilities	Experience of developing marketing programmes in the commercial sector
	Proven track record of applying entrepreneurial vision to the financial management of the Trust	Experience of a customer service environment that can be applied to the continual development of the patient experience/governance framework	Ability to make links between various strategic problems (eg finance, IT, capital and the market)	Knowledge and understanding of the tension between delivering quality & profitability	Collaborative partnership working across stakeholders and building relationships and productive partnerships		A track record of success in a complementary healthcare role	Able to use experience in the healthcare FT environment	Understanding how to exploit new digital capabilities (e.g. social media, automation, telemedicine, genomics, assistive technology, Internet of Things, Apps etc) for citizen engagement, patient safety and operational efficiency
	Experiencing of chairing committees (highly desirable would be Finance	Knowledge and understanding of the NHS Provider Licence for Foundation	Experience of creating & delivering performance management processes & systems	Experience of delivering performance management systems & processes in large complex	Experience of managing during major organisational change		Knowledge and understanding of the wider health and care system	Experience of critically appraising business options	Able to transpose commercial marketing principles to NHS environment

	Committees)	**Trusts**		**organisations**					
	Understanding and experience of audit and compliance	**Experience of evaluating complex proposals in terms of risk, governance and compliance**	**Brings commercial experience from outside the NHS for business development**	**Ability to understand & consider commercial operating best practice in the context of the NHS**			**Understanding of the National policy context for Health and care**	**Experience of working at a senior level in a large organisation**	
	Track record in managing performance in a contractual environment	**A qualified lawyer in practice, or a lecturer or professor of law in an academic department, preferably with experience of corporate law; or significant commercial experience/contract law.**	**Experience of critically appraising business options and managing the implementation of new business opportunities**	**Experience of critically appraising and managing operational performance against quality and financial indicators**					
	Ability to transfer commercial principles to NHS environment	**Understanding of the structure of and inter-relationship between public sector organisations**		**Experience of managing the implementation of new business opportunities**					
				Understanding of the key change drivers & how they impact on the organisation					

				Experience of partnership/partnering in a commercial or industrial sector during a period of significant organisational change, transformation or through merger processes					

Skills and qualities across all roles	**Ensuring people are held to account for performance and driving improvement**
	Patient and customer focused
	Commitment to NHS principles and Trust sustainability
	Effective influencing and communication
	Team working
	Astute, able to grasp relevant issues and understand relationships between interested parties
	Intellectual flexibility
	Analytical thinker
	Non-Exec Director board level experience
	Knowledge and appreciation of the healthcare system and the context of working in an NHS Foundation Trust
	Understanding of structure of & inter-relationship between public sector organisations
	Keeping up to date and abreast of policy changes, legislation and practice affecting the healthcare system
	Managing relationships with significant stakeholders and collaborative partnership working

	Able to interpret financial information
	Display the principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership (Nolan principles)
	Independent – high ethical standards; independent judgement; ability and willingness to probe; exercising influence; acting in the best interests of the Trust; having no relationships or circumstances that create a conflict of interest and affect judgement.

C Stone, Company Secretary

University Hospitals Dorset
NHS Foundation Trust

INTERIM BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 27 January 2021

Agenda item: 10.5

Subject:	Policy for Engagement with the Council of Governors

Prepared by:	Carrie Stone, Company Secretary
Presented by:	Carrie Stone, Company Secretary

Purpose of paper:	To seek approval of the Policy for Engagement with the Council of Governors
Background:	This Engagement Policy has been developed in recognition of the recommendations in the NHS Foundation Trust Code of Governance to address engagement between the Board of Directors and the Council of Governors.
Key points for Board members:	The key points are: • The paper fulfils the requirement of Monitor's Code of Governance (provision A.5.6); • Reflects Annex 6, Section 6: Governors and Directors: Communication and Conflict of the Trust's Constitution, previously approved; • It emphasises the importance of informal and formal communication and confirms the formal arrangements for communication within the Trust; • Informal and frequent communication between Governors and the Directors is an essential feature of a positive and constructive relationship designed to benefit the Trust and the services it provides; • Some aspects of formal communication are defined by the constitutional roles and responsibilities of the Council of Governors and the Board of Directors respectively; • Paragraph 6.1 gives discretion to the Chairman to manage questions from the governors in the light of other Board business; • Responses to questions put by individual governors to the Board will be reported in a subsequent edition of the Governors' weekly newsletter; • The chairmen of the Committees of the Board to attend Governor briefings to discuss the work of their respective Committees to assist Governors in their duty to hold the Non-Executive Directors individually and collectively to account for the performance of the Board. • Section 8 describes the process for raising concerns/dispute resolution procedure, as per the Constitution.

Options and decisions required:	For approval or to make further amendment
Recommendations:	To approve the attached paper.
Next steps:	To submit the paper to the Council of Governors at their Council meeting on 28 January 2021.

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

Committees/Meetings at which the paper has been submitted:	**Date**
Not applicable	

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

ENGAGEMENT POLICY:

THE COUNCIL OF GOVERNORS AND THE BOARD OF DIRECTORS

1. INTRODUCTION

1.1 This Engagement Policy has been developed in recognition of the recommendations in the NHS Foundation Trust Code of Governance (A.5.6) to address engagement between the Board of Directors and the Council of Governors. The principles in this policy may be applied to engagement between the Council of Governors and committees of the Board of Directors.

1.2 The engagement between the Council of Governors and the Board of Directors is enshrined within the Constitution Annex 6, Section 6: Governors and Directors: Communication and Conflict. This describes the processes intended to ensure a successful and constructive relationship between the Council of Governors and the Board of Directors. It emphasises the importance of informal and formal communication, and confirms the formal arrangements for communication within the Trust. It suggests an approach to informal and formal communications between the Council of Governors and the Board of Directors.

2 Purpose

2.1 This Engagement Policy outlines the mechanisms by which the Council of Governors and Board of Directors will interact and communicate with each other to support ongoing interaction and engagement, ensure compliance with the Regulatory Framework and specifically provide for those circumstances where the Council of Governors has concerns about:

2.1.1 the performance of the Board of Directors;
2.1.2 compliance with the Trust's Provider Licence; or
2.1.3 other matters related to the overall wellbeing of the Trust.

3 Definitions

3.1 In this Policy the following definitions shall apply:

Board of Directors	means the Board of Directors as constituted in accordance with the Constitution
Chairman	means the chairman of the Trust appointed in accordance with the Constitution
Chief Executive	means the Chief Executive (and Accounting Officer) of the Trust appointed in accordance with the Constitution
Company Secretary	means the Company Secretary of the Trust or any other person appointed to perform the duties of the secretary of the Trust
Constitution	means the Constitution of the Trust
Council of Governors	means the Council of Governors of the Trust as constituted in accordance with the Constitution
Director	means a director on the Board of Directors

Governor	means a member of the Council of Governors, being either an elected or an appointed Governor
Independent Regulator	he independent regulator of foundation trusts known as Monitor, as provided by Section 61 of the 2012 Act
Lead Governor	means one Governor appointed by the Council of Governors to communicate directly with Monitor in certain circumstances
Provider Licence	means the Trust's provider licence granted by the Independent Regulator under section 87 of the NHS Act 2006
Senior Independent Director	means the Non-Executive Director appointed by the Board of Directors
Trust	means the University Hospitals Dorset NHS Foundation Trust

4 Informal Communications

4.1 Informal and frequent communication between the Governors and the Directors is an essential feature of a positive and constructive relationship designed to benefit the Trust and the services it provides.

4.2 The Chairman shall use reasonable endeavours to encourage effective informal methods of communication including:

i) participation of the Board of Directors in the induction, orientation and training of Governors;

ii) development of special interest relationships between Non-Executive Directors and Governors;

iii) discussions between Governors and the Chairman and/or the Chief Executive and/or Directors through the office of the Chief Executive or a nominated officer;

iv) involvement in membership recruitment and briefings at public events organised by the Trust.

5 Formal Communications

5.1 Some aspects of formal communication are defined by the constitutional roles and responsibilities of the Council of Governors and the Board of Directors respectively.

5.2 Formal communications initiated by the Council of Governors and intended for the Board of Directors will be conducted as follows:

i) specific requests by the Council of Governors will be made through the Chairman to the Board of Directors;

ii) any Governor has the right to raise specific issues to be put to the Board of Directors at a duly constituted meeting of the Council of Governors through the Chairman but if the Chairman declines to raise any such issue the said Governor may nonetheless still raise it provided two thirds of the Governors present approve his request to do so. The Chairman shall then raise the matter with the Board of Directors and provide the response to the Council of Governors;

iii) joint meetings will take place between the Council of Governors and the Board of Directors as and when appropriate as determined by the Chairman (in his capacity as the Chairman of both the Board of Directors and the Council of Governors.

5.3 The Board of Directors may request the Chairman to seek the views of the Council of Governors on such matters as the Board of Directors may from time to time determine.

5.4 Communications between the Council of Governors and the Board of Directors may occur with regard to, but shall not be limited to:

i) the Board of Directors' proposals for the strategic direction of the Trust and the annual business plan;

ii) the Board of Directors' proposals for developments;

iii) Trust performance;

iv) involvement in service reviews and evaluation relating to the Trust's services; and

v) proposed changes, plans and developments for the Trust not covered by paragraph 5.4 above.

5.5 Some or all of the Board of Directors shall also present to the Council of Governors the Annual Accounts, the Annual Report including the Quality Account and any report of the Auditors in accordance with the terms of the Constitution and of the 2006 Act.

5.6 The following formal methods of communication may also be used as appropriate with the consent of both the Council of Governors and the Board of Directors:

i) attendance by the Directors at a meeting of the Council of Governors;

ii) provision of formal reports or presentations by Executive Directors to a meeting of the Council of Governors;

iii) inclusion of appropriate minutes for information on the agenda of a meeting of the Council of Governors;

iv) reporting the views of the Council of Governors to the Board of Directors though the Chairman, the Vice Chairman or the Senior Independent Director.

6 Other Communication

6.1 The Governors are welcomed to Part 1 meetings of the Board of Directors. There is an item on each Part 1 agenda "Questions from the Governors". These are requested by the Chairman, enabling individual governors to put questions to the Board. Verbal responses will be supplied as far as reasonable at the time of the meeting and reported in a subsequent edition of the Governors' newsletter. The Chairman has discretion to manage this item in the light of other Board business. It is also a matter for Governors as to whether the question is for a formal Board meeting or can be raised through the informal route. Board time is set aside for informal discussion between individual Governors and Board Members prior to commencement of the Part 1 meetings. Shortly following a Board of Directors meeting a briefing meeting takes place with the Chairman and Governors with the

purpose of informing the Governors as far as reasonable about the discussions conducted under the private session of the Board of Directors meetings. Approved Part 2 minutes of the Board of Directors are made available to Governors on a confidential basis. Where able, Executive and Non-executive Directors may attend these briefings to support the Chairman and impart further information if required. The Chairmen of the committees of the Board of Directors are also to attend meetings or briefings annually to discuss the work of the committees to assist the Council of Governors in their duty to hold the Non-Executive Directors individually and collectively to account for the performance of the Board.

6.2 A weekly newsletter from the Chairman, Chief Executive and Company Secretary will also be sent to Governors containing relevant information and updates.

7 Senior Independent Director

7.1 The Senior Independent Director (SID) can act as an alternative source of advice to Governors from the Chairman.

7.2 The SID shall be available to Governors if they have concerns that contact through normal channels has failed to resolve any issues which have been raised or for which such contact is inappropriate.

8 Raising Concerns/ Dispute Resolution Procedure

8.1 The Council of Governors adopts a policy to proactively engage with the Board of Directors in those circumstances where they have concerns. The Council of Governors is encouraged to ensure its interaction and relationship with the Board of Directors is appropriate and effective. Governors can raise concerns with the Company Secretary who may in the first instance be able to resolve the matter informally.

8.2 Where the Company Secretary has been unable to resolve the matter, the Lead Governor shall be the first point of contact when Governors wish to seek advice and/or raise issues and who acts as the Council of Governors lead representative to the Chairman on Governor matters.

8.3 In the event of a dispute arising between the Council of Governors and the Board of Directors, the Chairman (or Vice-Chairman if the dispute involves the Chairman) will endeavour to resolve the dispute informally, through discussions within the Council of Governors.

8.4 Within twenty-eight days of the Council of Governors of the Board of Directors resolving that a dispute exists with the other, the Company Secretary shall call a joint meeting to be held as soon as reasonably practicable within three months of the resolution. The joint meeting shall be held under the Trust's Board of Directors' Standing Orders, but the provisions of the Standing Orders of the Council of Governors in relation to interests shall apply to Governors attending the joint meeting as they apply to a Council of Governors meeting.

8.5 The joint meeting shall be chaired by the Chairman and the agenda shall be agreed with the Chief Executive. The joint meeting shall either recommend to each of the constituents the formula for resolving the dispute which each shall receive and consider formally as soon as practicable, or, if possible, shall agree the relevant issues and the possible way forwards.

8.6 If either constituent resolves to refer the issue to mediation, the Lead Governor and a second nominated Governor on behalf of the Council of Governors and the Chief Executive and the Vice-Chairman of the Board of Directors shall meet within twenty-eight days of such resolution to agree a mediator. In default of agreement, either constituent may resolve to refer the dispute for resolution by Monitor.

8.7 On the satisfactory completion of this disputes process the Board of Directors and the Council of Governors, as appropriate, shall implement any agreed actions.

8.8 The existence of the dispute shall not prejudice the duty of the Board of Directors in the exercise of the Trust's powers on its behalf.

8.9 Nothing in this procedure shall prevent the Council of Governors, if it so desires, from informing Monitor that, in the Council of Governors' opinion, the Board of Directors has not responded constructively to concerns of the Council of Governors and that the Trust is not meeting the conditions of its provider licence. The Lead Governor will act as the conduit between the Council of Governors and Monitor.

9. Supporting Documents or Relevant References

9.1 Monitor – The NHS Foundation Trust Code of Governance (July 2014);
Monitor – Your Statutory Duties: A Reference Guide for NHS Foundation Trust Governors (August 2013);
UDHFT Code of Conduct for Board of Directors;
UDHFT Code of Conduct for the Council of Governors.

10. Conclusion

10.1 This policy will be made available to the Board of Directors and the Council of Governors.

CARRIE STONE
Company Secretary
October 2020

DAVID MOSS
Chairman
October 2020

The procedure for any such mediation shall be as follows:

1.3.1 A neutral person, being an *accredited mediator, (the "**Mediator**") shall be chosen by agreement between the two parties. Alternatively, either party may within seven days from the date of the proposal to appoint a mediator, or within seven days of notice to any party that the chosen mediator is unable and unwilling to act, apply to the Centre for Dispute Resolution ("**CEDR**") to appoint a Mediator.

1.3.2 The parties shall within seven days of the appointment of the Mediator agree a timetable for the exchange of all relevant and necessary information and the procedure to be adopted for the mediation. If appropriate, the parties may at any stage seek from CEDR guidance on a suitable procedure.

1.3.3 All negotiations and proceedings in the mediation connected with the dispute shall be conducted in strict confidence and shall be without prejudice to the rights of the parties in any future proceedings.

1.3.4 All information (whether oral or in the form of documents, tapes, computer disks etc) produced for, during, or as a result of, the mediation will be without prejudice, privileged and not admissible as evidence or discoverable in any litigation or arbitration relating to the dispute. This does not apply to any information which would in any event have been admissible or discoverable in any such litigation or arbitration.

1.3.5 The Mediator's reasonable fees and other expenses of the mediation will be borne by the Foundation Trust. The Foundation Trust will bear the reasonable costs and expenses of the participation in the mediation.

1.3.6 If the parties reach agreement on the resolution of the dispute that agreement shall be reduced to writing and shall be binding upon the relevant parties.

1.3.7 For a period of ninety days from the date of the appointment of the Mediator, or such other period as the parties may agree, neither party may commence any proceedings in relation to the matters referred to the Mediator.

1.3.8 If the parties are unable to reach a settlement at the mediation and only if both parties so request and the Mediator agrees, the Mediator will produce for the parties a non-binding recommendation on terms of settlement. This will not attempt to anticipate what a court might order but will set out what the Mediator suggests are appropriate settlement terms in all of the circumstances. Such opinion shall be provided on a without prejudice basis.

1.3.9 Subject to Conditions 1.3.6 and 1.3.7, should either party decide to pursue the dispute in a court, the Foundation Trust shall not be liable for any of the costs or expenses in relation to such proceedings.

University Hospitals Dorset
NHS Foundation Trust

INTERIM BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 27 January 2021

Agenda item: 10.6

Subject:	Declaration of Interests and Fit and Proper Persons Compliance of the Board of Directors

Prepared by:	Carrie Stone, Company Secretary
Presented by:	Carrie Stone, Company Secretary

Purpose of paper:	To provide the Board with the most recent register of interests and confirmation of compliance with the Fit and Proper person requirements.
Background:	A register of interests of the Board of Directors is a requirement of the Trust's license agreement and is completed annually and updated should a Director's interests change. The Care Quality Commission's (CQC) registration requirements include the need for Trusts to be able to demonstrate that all Board members are of good character and meet the CQC's fit and proper persons regulation.
Key points for Board members:	• The Directors of University Hospitals Dorset completed and signed individual declarations of interest following merger; • Following establishment of UHD, Directors were asked to sign individual declarations to confirm that they have read and understood the Fit and Proper Person Regulations and that they meet the required standards, and all have done so; • Checks against the Insolvency Register and the Disqualified Directors list have been conducted; • No concerns about Directors' fitness or ability to carry out their duties or information about a Director not being of good character have been identified or brought to the attention of the Chairman; • The Chairman therefore provides the Board with assurance that all Directors continue to meet the Fit and Proper Person requirements.
Options and decisions required:	For assurance
Recommendations:	To note the register of interests and accept the assurance that all Board members meet the Fit and Proper Persons requirements.

Next steps:	The Register of Interests will be published on the Trust's website.

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

Committees/Meetings at which the paper has been submitted:	**Date**
Not applicable	

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

REGISTER OF BOARD OF DIRECTORS' INTERESTS

The following interests were declared by the Directors of University Hospitals Dorset NHS Foundation Trust:

NAME AND TITLE	INTEREST REGISTER
Ms Karen Allman Chief People Officer	• None
Mr Pankaj Dave Non-Executive Director	•
Mrs Debbie Fleming Chief Executive	• Director of The Bournemouth Private Clinic Limited • Director and Trustee of The Bournemouth Healthcare Trust • Chair of the Dorset Cancer Partnership • Member of Wimborne Academy Trust
Mr Peter Gill Chief Informatics Officer	• None
Mr Philip Green Non-Executive Director Vice Chairman	• Leeds University Business School International Research Advisory Board
Prof Christine Hallett Non-Executive Director	• None
Mr John Lelliott Non-Executive Director	• Non-Executive Director – Environment Agency • Non-Executive Director – Covent Garden Market Authority • Non-Executive Director – The Capitals Coalition • Daughter – Pharmacist • Son-in-law - Pharmacist
Mr David Moss Chairman	• Vice-President – Hospital Services Cricket Club
Mr Stephen Mount Non-Executive Director	• Non-Executive Director: Gama Aviation PLC
Mr Mark Mould Chief Operating Officer	• Director of Concept Works Ltd (property rental/refurbishment company) 50% share. • Trustee – Poole Africa Link • Wife owns Iskincare Ltd (Aesthetic Company) • Step daughter Bank Worker – adhoc shifts
Dr Alyson O'Donnell Chief Medical Officer	• None
Mr Pete Papworth Chief Finance Officer	• Director The Bournemouth Healthcare Trust • Director the Bournemouth Private Clinic Limited • Trustee The Bournemouth Healthcare Trust • Wife – HR Business Partner at Dorset Healthcare University NHS Foundation Trust

NAME AND TITLE	INTEREST REGISTER
Mr Richard Renaut Chief Strategy and Transformation Officer	• None
Prof Clifford Shearman Non-Executive Director	• Independent Non-Executive Director Spire Health Care • Company Secretary Wessex Medical Reporting Limited • Vice-President Royal College of Surgeons of England
Prof Paula Shobbrook Chief Nursing Officer	• Visiting Professor at Bournemouth University
Mrs Caroline Tapster Non-Executive Director	• Sister-in-law employed by the Trust. • Nephew employed by the Trust

In compliance with paragraph C.1.13 of the Monitor/ NHS Improvement Code of Governance for NHS Foundation Trusts, no executive director holds more than one non-executive directorship of an NHS Foundation Trust or another organisation of comparable size and complexity.

Carrie Stone
Company Secretary
1 January 2021

GLOSSARY OF ABBREVIATIONS

A

A&E	*Accident and Emergency*
A&G	*Audit and Governance Committee*
ACT	*Alcohol Care Team*
ADHD	*Attention deficit hyperactivity disorder*
AF	*Atrial fibrillation*
AfC	*Agenda for Change*
AHPs	*Allied Health Professionals*
AHSN	*Academic Health Science Network*
AI	*Artificial intelligence*
AIRS	*Adverse Incident Reporting System*
ALB	*Arm's Length Body*
AMM	*Annual Members' Meeting*
API	*Application programming interface*
AQP	*Any Qualified Provider*
ASI	*Appointment Slot Issues*

B

BAF	*Board Assurance Framework*
BAME	*Black, Asian and Minority Ethnic*
BCF	*Better Care Fund*
BMA	*British Medical Association*
BMI	*Body mass index*
BoD	*Board of Directors*

C

CAS	*Clinical Assessment Service*
CAU	*Clinical Assessment Unit*
C.Diff	*Clostridium difficile*
CCG	*Clinical Commissioning Group*
CCIO	*Chief Clinical Information Officer*
CCU	*Coronary Care Unit*
CE	*Chief Executive*
CEA	*Clinical Excellence Awards*
CEPOD	*Confidential Enquiry into Perioperative Death*
CETR	*Care, Education and Treatment Review*
CGG	*Clinical Governance Group*
CHKS	*A national independent provider of comparative performance and healthcare data*
CI	*Confidence interval*
CIO	*Chief Information Officer*
CIP	*Cost Improvement Plan*
CMA	*Competition and Markets Authority*
CNST	*Clinical Negligence Scheme for Trusts*
COAST	*Children's Observations and Severity Tool*
CoG	*Council of Governors*
COO	*Chief Operating Officer*
COPD	*Chronic obstructive pulmonary disease*
CoSRR	*Continuity of Service Risk Rating*
CP	*Chief Pharmacist*
CPD	*Continuing professional development*

CPR	*Cardiopulmonary resuscitation*
CQC	*Care Quality Commission*
CQUIN	*Commissioning for Quality and Innovation*
CRES	*Cost Releasing Efficiency Saving*
CRN	*Clinical Research Network*
CRT	*Clinical Record Tracking*
CSR	*Clinical Services Review*
CSTR	*Community Service Treatment Requirement*
CT	*Computerised Tomography*
CTR	*Care and Treatment Review*
CVD	*Cardiovascular disease*

D

Datix	*National Software Programme for Risk Management*
DBS	*Disclosure and Barring Service*
DHSC	*Department of Health and Social Care*
DNA	*Did not attend*
DoF	*Director of Finance*
DoH	*Department of Health*
DoN	*Director of Nursing*
DDoN	*Deputy Director of Nursing*
DoW&OD	*Director of Workforce and Organisational Development*
DoS	*Director of Strategy*
Dr Foster	*Provides health information and NHS performance data to the public*
DToC	*Delayed Transfer of Care*

E

EBITDA	*Earnings Before Interest, Taxation, Depreciation and Amortisation*
EBME	*Electrical, Biomedical Equipment*
ECDS	*Emergency Care Data Set*
EEA	*European Economic Area*
EHCH	*Enhanced Health in Care Homes*
eNEWS	*National Early Warning Score*
ENT	*Ear, Nose and Throat*
EPR	*Electronic patient record*
EPRR	*Emergency Planning Resilience & Reponse*
EPS	*Electronic Prescription Service*
ERCP	*Endoscopic Retrograde Cholangiopancreatography*
ESBL	*Extended Spectrum Beta Lactamase (producer) Klebsiella*
ESCAPE-pain	*Enabling Self-management and Coping with Arthritic Pain through Exercise*
ESR	*Electronic Staff Record*
EWTD	*European Working Time Directive*

F

FCE	*Finished Consultant Episode*
FCP	*First Contact Practitioner*
FFCE	*First Finished Consultant Episode*
FFT	*Friends and Family Test*
FH	*Familial Hypercholesterolemia*
FIC	*Finance and Investment Committee*
FOI	*Freedom of Information*
FRP	*Financial Recovery Fund*

FT	*NHS Foundation Trusts*
FTE	*Full-time equivalent*
FPPRG	*Future Plans and Priorities Reference Group.*
FRP	*Financial Recovery Plan.*

G

GBD	*Global Burden of Disease*
GDE	*Global Digital Exemplar*
GDP	*Gross domestic product*
GIRFT	*Getting It Right First Time*
GMC	*General Medical Council*
GP	*General practitioner*
GTDRG	*Governor Training & Development Reference Group*
GVA	*Gross Value Added*

H

H@N	*Hospital at Night*
HDU	*High Dependency Unit*
HEE	*Health Education England*
HEI	*Higher Education Institution*
HFMA	*Healthcare Financial Management Association*
HFSS	*High in fat, salt and sugar*
HoC	*Head of Communications*
HPV	*Human papilloma virus*
HR	*Human Resources*
HRG	*Healthcare Resource Group*
HSE	*Health & Safety Executive*
HSMR	*Hospital Standardised Mortality Ratios*

I

I&E	*Income and Expenditure*
IAPT	*Improving Access to Psychological Therapies*
ICP	*Integrated Care Provider*
ICS	*Integrated Care System*
ICU or ITU	*Intensive Care Unit or Intensive Therapy Unit*
IG	*Information Governance*
IPG	*Investment Planning Group*
IPR	*Integrated Performance Report*
IPS	*Individual Placement and Support*
ISDN	*Integrated Stroke Delivery Network*
IT or IM&T	*Information Technology or Information Management & Technology*

K

KPI	*Key Performance Indicator*
KSF	*Knowledge & Skills Framework*

L

LCFS	*Local Counter Fraud Specialist*

LeDeR *Learning Disabilities Mortality Review Programme*
LGBT+ *Lesbian, Gay, Bisexual, Transgender*
LHCR *Local Health and Care*
LHRP *Local Health Resilience Partnership*
LiNAC *Linear Accelerator*
LNC *Local Negotiating Committee*
LocSSIPs *Local Safety Standards for Invasive Procedures*
LoC *Letter of Claim*
LoS *Length of Stay*
LTFM *Long Term Financial Model*
LTP *Long Term Plan*

M

MARS *Mutually Agreed Resignation Scheme*
MCP *Multispecialty community provider*
MD *Medical Director*
MDT *Multi-Disciplinary Team*
MERG *Membership Engagement and Recruitment Group*
Mortality rate *The ratio of total deaths to total population in relation to area and time.*
MRI *Magnetic Resonance Imaging*
MRSA *Methicillin Resistant Staphylococcus Aureus*
MSC *Medical Staffing Committee*
MSK *Musculoskeletal*

N

NatSSIPs *National Safety Standards for Invasive Procedures*
NCEPOD *NCEPOD (National Confidential Enquiry into Perioperative Death)*
NED *Non-Executive Director*
NEWS2 *National Early Warning Score 2*
NHS *National Health Service*
NHSI *NHS Improvement - The independent regulator of NHS Foundation Trusts*
NHSIQ *NHS Improvement Quality*
NHSLA *National Health Service Litigation Authority*
NICE *National Institute for Health & Clinical Excellence*
NICU *Neonatal Intensive Care Unit*
NIHR *National Institute for Health Research*
NMC *Nursing and Midwifery Council*
NMG *Nursing and Midwifery Group*
NOF *Neck of Femur*
NPfIT *National Programme for Information Technology*
NPSA *National Patient Safety Agency*
NREC *Nominations, Remuneration & Evaluations Committee*
NRLS *National Reporting and Learning System*
NSF *National Service Framework*
NVQ *National Vocational Qualification*

O

OD *Organisational Development*
OECD *Organisation for Economic Co-operation and Development*
OFRG *Operational Finance Reference Group*
OFT *Office of Fair Trading*
OMF *Oral Maxillo Facial*

P

PA/SPA	*Programmed Activities and Supporting Professional Activities*
PACS	*Picture Archiving and Communications System – the digital storage of x-rays or Primary Acute Care Systems*
PALS	*Patient Advice and Liaison Service*
PBC	*Practice Based Commissioning*
PbR	*Payment by Results*
PEAT	*Patient Environment Action Team*
PET	*Position emission tomography scanning system*
PEWS	*Poole Early Warning System*
PFI	*Private Finance Initiative*
PHB	*Personal health budget*
PHE	*Public Health England*
PHFT	*Poole Hospital NHS Foundation Trust*
PHR	*Personal health record*
PID	*Project Initiation Document*
PLICS	*Patient Level information and costing systems – data collection system*
PMO	*Project Management Office*
PROM	*Patient Recorded Outcomes Measures*
PST	*Patient Safety Thermometer*
PTIP	*Post Transaction Implementation Plan*
PYLL	*Potential Years of Life Lost*

Q

QI	*Quality Improvement*
QIA	*Quality Impact Assessment*
QIPP	*The Quality, Innovation, Productivity and Prevention Programme*
QNI	*Queen's Nursing Institute*
QOF	*Quality and Outcomes Framework*
QPR	*Quarterly Performance Review*
QSPC	*Quality, Safety & Performance Committee*

R

R&D	*Research and development*
RACE	*Rapid Assessment and Consultant Evaluation for older people*
RBH	*Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust*
RCI	*Reference Cost Index*
RDC	*Rapid Diagnostic Centre*
RTT	*Referral to Treatment. The current RTT Target is 18 weeks.*

S

SaaS	*Software as a Service*
SALT	*Speech and Language Therapy*
SAU	*Surgical Assessment Unit*
SBLCB	*Saving Babies Lives Care Bundle*
SCCL	*Supply Chain Coordination Limited*
SDEC	*Same Day Emergency Care*
SHMI	*Summary Hospital Mortality Indicator*
SFIs	*Standing Financial Instructions*

SI	*Serious Incident*
SID	*Senior Independent Director*
SIRO	*Senior Information Risk Owner*
SLA	*Service Level Agreement*
SLM	*Service Line Management*
SLR	*Service Line Report*
SMR	*Standardised Mortality rate – see Mortality Rate*
SPF	*Staff partnership Forum*
SpR	*Specialist Registrar – medical staff grade below consultant*
SSNAP	*Sentinel Stroke National Audit Programme*
STEIS	*Strategic Executive Information System*
STAMP	*Supporting Treatment and Appropriate Medication in Paediatrics*
STOMP	*Stopping over medication of people with a learning disability autism or both*
STP	*Sustainability and Transformation Plan*
SUS	*Secondary Uses Service*

T

TAL	*NHS Direct provides The Appointments Line service as part of Choose & Book*
TIAA	*The trust's internal auditors*
TOR	*Terms of Reference*

U

UCLH	*University College London Hospitals*
UNICEF	*United National International Children's Emergency Fund*
UTC	*Urgent Treatment Centre*

V

VCSE	*Voluntary, Community and Social Enterprise*
VFC	*Virtual Fracture Clinic*
VfM	*Value for Money*
VIP Score	*Visual Infusion Phlebitis of intravenous cannuloe – scoring system*
VSM	*Vey Senior Manager*
VTE	*Venous Throboembolism*

W

WODC	*Workforce and Organisational Development Committee*
WTE	*Whole Time Equivalent*

Y

YTD	*Year to Date*

January 2019