University Hospitals Dorset
NHS Foundation Trust

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

BOARD OF DIRECTORS – PART 1 MEETING

Wednesday 28 July 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

BOARD OF DIRECTORS – PART 1
HELD IN PUBLIC

The next meeting of the University Hospitals Dorset NHS Foundation Trust Board of Directors held in public will commence at 13:15 on Wednesday 28 July 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 on Wednesday 28 July 2021

Time	Item		Method	Purpose	Lead
13:15	**1**	Welcome, Introductions, Apologies & Quorum	**Verbal**		**Chair**
	2	Declarations of Interest	**Verbal**	**Assurance**	**Chair**
	3	Patient Story	**Slides**	**Discussion**	**CNO**
	4	For Accuracy and to Agree: Minutes of the Board of Directors Meeting held on 26 May 2021	**Paper**	**Approval**	**Chair**
	5	Matters Arising - Action List	**Paper**	**Review**	**Chair**
	6	Chief Executive Officer's Report	**Paper**	**Noting**	**CNO**
13:50	**7**	**QUALITY AND PERFORMANCE**			
	7.1	Integrated Quality, Performance, Workforce and Finance Report	**Paper**	**Discussion**	**EDs**
14:20	**8**	**STRATEGY AND TRANSFORMATION**			
	8.1	Annual Operating Plan 2021 - 2022	**Paper**	**Discussion**	**COO**
14:30	**9**	**GOVERNANCE**			
	9.1	CQC Action plan	**Paper**	**Discussion**	**CNO**
	9.2	Quality Strategy 2021/22	**Paper**	**Approval**	**CNO**
	9.3	Information Governance Annual Report	**Paper**	**Discussion**	**CIO**
	9.4	Board and Committee Schedule 2022	**Paper**	**Noting**	**Chair**

	9.5	Board Committees: Annual Reports • Workforce Strategy Committee • Audit • Finance and Performance Committee • Quality Committee • Transformation • Sustainability	**Paper**	**Noting**	**Chair**
15:00	**10**	Questions from the Council of Governors and Public arising from the agenda. Governors and Members of the public are requested to submit questions relating to the agenda by no later than Sunday 25 July 2021 to fiona.ritchie@uhd.nhs.uk		**Receive**	**Chair**
	11	Any Other Business	**Verbal**		**Chair**
	12	**Date and Time of Next Public Board Meeting:** Board of Directors Part 1 Meeting on Wednesday 29 September 2021 at 13:15 via Microsoft Teams 2021 Meeting Dates: 24 November 2021.			
	13	**Resolution Regarding Press, Public and Others:** To agree, as permitted by the National Health Service Act 2006 (as amended), the Trust's Constitution and the Standing Orders of the Board of Directors, that representatives of the press, members of the public and others not invited to attend to the next part of the meeting be excluded due to the confidential nature of the business to be transacted.			
	14	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.			
15:15	**15**	**Close**	**Verbal**		**Chair**

AGENDA – PRIVATE MEETING – PART 2

15:30 on Wednesday 28 July 2021

Time	Item	Method	Purpose	Lead

15:30	**16**	Welcome, Introductions, Apologies & Quorum	**Verbal**		**Chair**
	17	Declarations of Interest	**Verbal**	**Assurance**	**Chair**
	18	For Accuracy and to Agree: Part 2 Minutes of meeting held on 26 May 2021	**Paper**	**Approval**	**Chair**
	19	For Accuracy and to Agree: Part 2 Minutes of meeting held 9 June 2021	**Paper**	**Approval**	**Chair**
	20	For Accuracy and to Agree: Part 2 Minutes of meeting held on 30 June 2021	**Paper**	**Approval**	**Chair**
	21	Matters Arising – Action List	**Paper**	**Review**	**Chair**
15:40	**22**	**QUALITY, PERFORMANCE & RISK**			
	22.1	Risk Register Report: new red risks	**Paper**	**Discussion**	**CNO**
	22.2	Serious Incident Report	**Paper**	**Discussion**	**CMO**
16:00	**23**	**STRATEGY AND TRANSFORMATION**			
	23.1	ICS Update	**Paper**	**Discussion**	**CSTO**
	23.2	Poole Hospital Estates Report	**Paper**	**Assurance**	**CSTO**
	23.3	Draft Innovation Strategy	**Paper**	**Approval**	**CSTO**
	23.4	Naming of the MCEC	**Paper**	**Decision**	**CSTO**
16:25	**24**	**GOVERNANCE**			
	24.1	Out of Committee Approval: The 'Think Big' Proposal	**Paper**	**Noting**	**Co Sec**
	24.2	Endoscopy Consumables	**Paper**	**Approval**	**CFO**
	24.3	Bed Capacity Business Case	**Paper**	**Approval**	**COO**
	24.4	Annual Health & Safety Report	**Paper**	**Discussion**	**CPO**
	24.5	Private Patients Committee Terms of Reference	**Paper**	**Approval**	**Cosec**
	24.6	Board Committees: Exception Reports	**Verbal**	**Noting**	**Non-Exec Chairs**
16:40	**25**	Any Other Business	**Verbal**		**Chair**
	26	Reflections on the Board Meeting:	**Verbal**		**Chair**
	27	**Date and Time of Next Private Board Meeting:** Board of Directors Part 2 Meeting on Wednesday 25 August 2021 at 11:00 via Microsoft Teams.			
16:45	**28**	**Close**	**Verbal**		**Chair**
	29	Patient story	**Video**	**Discussion**	**CNO**
17:15	**30**	**Close**	**Verbal**		**Chair**

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

BOARD OF DIRECTORS – PART 1

Minutes of the meeting of the Board of Directors – Part 1 held on Wednesday 26 May 2021 at 13:15 hours via Microsoft Teams.

Members:	**Name**	**Designation**
	David Moss	Non-Executive Director and Chair
	Pankaj Dave	Non-Executive Director
	Philip Green	Non-Executive Director
	Christine Hallett	Non-Executive Director
	John Lelliott	Non-Executive Director and Chair of the Sustainability Committee
	Caroline Tapster	Non-Executive Director
	Cliff Shearman	Non-Executive Director
	Debbie Fleming	Chief Executive Officer
	Alyson O'Donnell	Chief Medical Officer
	Paula Shobbrook	Chief Nursing Officer and Deputy Chief Executive Officer
	Peter Gill	Chief Informatics and IT Officer
	Pete Papworth	Chief Finance Officer
	Richard Renaut	Chief Strategy and Transformation Officer
	Mark Mould	Chief Operating Officer
In Attendance:	James Donald	Interim Associate Director of Communications
	John Vinney	Associate Non-Executive Director
	Helen Martin	Freedom to Speak up Guardian
	Jenny Williams	Head of Patient Experience
	Hannah Stuart	Clinical Nurse Specialist
	Tracy Gallacher	Lead Cancer Nurse
	Carla Jones	Deputy Director of Workforce and Organisational Development
	Tracy Lyons	Medicines Optimisation Pharmacist
	Annabel Platt	Communications Assistant
	Will Blackman	Matron for Theatres
	Fiona Ritchie	Company Secretary
	Zoe Jones	Corporate Governance Manager
	Jennifer Nabwogi	Interim Assistant Company Secretary (Minutes)

Minute Reference	
BoD 107/21	**Welcome, Introductions, Apologies & Quorum** The Chair welcomed everyone to the meeting. Apologies were received from Non-Executive Director, Stephen Mount and Chief People Officer, Karen Allman who was represented by Carla Jones, Deputy Director of Workforce and Organisational

	Development. The meeting was declared quorate.
BoD 108/21	**Declarations of Interest** No additional declarations of interest were made.
BoD 109/21	**Patient Story: Breast Cancer Experience of a member of staff** The Clinical Nurse Specialist presented a video recording of a Trust patient's story. The patient was also a member of staff. In the video, the patient narrated her journey from the time of discovering a lump in her breast in 2019, through diagnosis and then to treatment. The patient faced initial challenges which included; • A misdiagnosis because she was deemed 'too young to have cancer', • A second misdiagnosis when she sought a second opinion, • Receiving a full report of the cancer diagnosis once a biopsy was done. The results were received online with no prior warning or contact by a clinician. The patient had been distraught by the mode of delivery of her results. • A case of misdiagnosed lymphedema. The patient had symptoms that were misdiagnosed and, for five weeks, was treated for different illnesses. The patient praised the hospital staff for the care and support she received at different stages of her journey. For example: • She was well looked after once a cancer diagnosis was made and she had to undergo surgery, • She received *wonderful* care during her radiotherapy sessions, • She received *excellent* care from the occupational therapy team, • The HR team had put her in touch with a support network which enabled her to get in touch with colleagues who had undergone similar circumstances. • She received *wonderful* support from breast cancer nurses who had a 24 hour support line that enabled her to access support at any time. • The hospital has an in house McMillan Cancer support worker and that too was helpful. The patient narrated her on-going challenges which included: • Trouble with her bones due to radiotherapy, • During treatment, she received injections to her stomach which put her into early menopause. Based on her experience, the patient suggested that the Trust provides training on lymphedema and cellulitis so that patients presenting with similar symptoms to hers would not be misdiagnosed as she was.

	ACTION: To commence providing lymphedema and cellulitis training to staff to help improve diagnosis. **Paula Shobbrook/ Hannah Stuart.** The Board received the patient story, acknowledging that it demonstrated the human aspects and an alignment with Trust values.
BoD 110/21	**For Accuracy and to Agree: Minutes of the Board of Directors Meeting held on 31 March 2021** The minutes of the meeting held on 31 March 2021 were APPROVED as a true and accurate record.
BoD 111/21	**Matters Arising - Action List** The Chair introduced the action list. Items 014/21 and 064/21 were closed. Item 063/21 was closed as the action would be picked up under item 8.2 Mortality Report. The Board NOTED the action list update
BoD 112/21	**Chief Executive Officer's Report** The Chief Executive Officer presented the paper and outlined highlights which include the following: • There were currently no patients in the Trust with Covid -19. This was a big improvement from previous months however, precautions remained in place; • The innovative work underway within clinical teams and new ways to catch up with the back log; • National workforce shortages. This was an on-going priority to ensure that the Trust was fully staffed. • A lot of pressure on beds. The trust was keeping a close eye on bed pressures. • 'Think Big' project. This was the Trust's way of staying on top of the waiting lists, mainly by using space very differently. • Commending the work of culture champions who enabled the Trust to hear the staff voice. • The different staff networks to tackle inequality and improve health and well-being for both patients and staff. • Merger transactions. The Trust was taking stock and looking at the progress made in the first six months of existence. • Estates and transformation programme. A lot of estates work was underway. • The Trust had planned a virtual open day scheduled for 11 September 2021 with a variety of events s so that the public could see what was occurring in the Trust.

	The CEO informed the Board that Dr Alyson O'Donnell, the Trust's Chief Medical Officer, had gained a professorship from Bournemouth University. The Board congratulated Alyson. The Board NOTED the Chief Executive Officer's report.
BoD 113/21	**Board Assurance Framework (BAF) (Oct 2020 – Mar 2021**) The Chief Nursing Officer presented the paper. The governance around the BAF had been reviewed at the Audit Committee meeting in May 2021. There was work underway to review all BAF risks in line with the Trust's risk strategy. The Chair of the Audit Committee confirmed that the BAF for October 2020 – March 2021 had been reviewed at the Audit Committee and the Committee had acknowledged a significant improvement in the way that risk was managed in the Trust. The Board NOTED the 2020 -21 Board Assurance Framework.
BoD 114/21	**Integrated Quality, Performance, Workforce and Finance Report** The Chair introduced the paper and invited different Executive Directors to present headlines of the report. The Chief Operating Officer reported the following; • A reduction in patients waiting over 52 weeks. • The 6 week diagnostic standard had been maintained, with 96% of patients receiving their diagnostics within the standard. • Emergency Department: There had been increased patient numbers in April and May 2021, resulting in an increase in patients waiting. • Cancer: The Trust is measured on the *faster diagnostic standard*. The standard had been maintained. • Recovery activity: For UHD and Dorset as a whole, there had been significant recovery in activity in April and May 2021. The Chief Nursing Officer reported the following; • A reduction in Covid-19 related activity. There was a lot of learning relating to the covid-19 post infection review process and in the way that beds and pathways were managed in the Trust. • Staffing: More staff were returning to the Trust after shielding. The Chief Finance Officer reported the following; • Capital programme: This was very challenging due to restrictions on the ICS capital expenditure limit. • The Trust currently had a good cash balance although the balance was fully committed in the medium term.

	The Deputy Director of Workforce and Organisational Development reported that; • The trend in high staff turnover continued. • Overall staff sickness levels were stabilising. • Covid-19 related absences had significantly reduced although some members of staff were experiencing post covid-19 syndrome. • Appraisal levels and mandatory training remained steady. • The Trust continued to work with the OD-EU network to support EU staff with their settled status applications. • System alignment was progressing well. • Wellbeing thank-you vouchers to qualifying bank staff were due to be distributed to thank them for their work during Covid-19. • The occupation health team and respiratory physiotherapy teams were putting together a rehabilitation programme to support staff affected by post covid-19 syndrome. • Tier 3 consultations: The appointment process was near completion with a target date of 21 June 2021. The Chair acknowledged the contribution made by the HR department during a period of a pandemic and of organisational change. The Chief Operating Officer provided an update on the screening programme which had been suspended during the pandemic. The Board was informed that there was a cohort of around 22,000 patients waiting for breast screening appointments. There was work underway to increase capacity and there was a recovery plan to deliver by February 2022. The Board also learnt that the bowel screening centre was the first in the South West Region to offer every patient an appointment within six weeks. The Board discussed patients waiting over 78 weeks. Although this was a small cohort of patients, the number was increasing. The Board NOTED the integrated quality, performance, and workforce and finance report.
BoD 115/21	**Mortality Report Q4 (Jan – Mar 2021)** The Chief Medical Officer (CMO) presented the paper. Mortality metrics presented a complex picture at national level, with about three quarters of acute Trusts in England showing above average mortality metrics in January and February 2021. The SMR metric which captures Covid-19 related mortality had increased. The bulk of the covid-19 second wave figures were not included in the statistics in the report. The CMO reported currently unexplainable differences between the mortality metrics from the different UHD hospital sites. There was work underway to interrogate the data to find out the reason for the differences. In-depth mortality

	reviews were also being carried out in areas of high risk. The outcomes of the mortality investigation would be presented to the Quality Committee and the Board part 2 in July 2021. The Board NOTED the Q4 (Jan – Mar 2021) mortality report.
BoD 116/21	**Quality Impact Assessment Report** The Chief Nursing Officer affirmed the Trust's robust quality improvement assessment (QIA) process for all cost improvement programmes (CIPs) undertaken in the Trust. Due to the pandemic, CIPs had not been delivered as robustly in 2020/21 as in previous years and there was very little to escalate to the Board. The Board could expect to receive further reports with the resumption of CIP work. The Board NOTED the Quality impact assessment.
BoD 117/21	**Draft Bournemouth University Partnership Strategy** The Chief Strategy and Transformation Officer presented the paper. He outlined some of the key themes of what a relationship between the Trust and the University could deliver. These included; • Strategic alignment; • Stimulus for research and innovation; • Education and training of future workforce; • Meeting future challenges, for example, environmental sustainability; and • Digital improvements. The Associate Non-Executive Director/Vice Chancellor of Bournemouth University emphasised the opportunity present in the bringing together of the University and Trust expertise. The Chair presented a question from the Lead Governor around how the partnership could promote the benefits of working in healthcare. The Associate Non-Executive Director responded that the university carried out a lot of events to communicate the benefits of coming into health careers as well as raising the profile of the work that both the university and hospital do. The Chief Nursing Officer added that the partnership contributed to embedding the Trust's practice and research offering. Consequently, the Trust was bringing new people to the Dorset area, for example, consultants who found the University status a key attraction to working at the hospital. A Non-Executive Director questioned whether there would be specific investment to support the partnership especially regarding research. The Chief Strategy and Transformation Officer responded that there wouldn't be separate funds but the

	partnership would focus on key targeted areas thereby creating joint work, joint bids and opportunities that would generate revenue. The Chair thanked everyone involved in working on the partnership. The Board APPROVED the draft Bournemouth University partnership strategy.
BoD 118/21	**Draft Sustainability Strategy** The Chief Strategy and Transformation Officer presented the paper. The NHS has a target to achieve a zero carbon health service and the strategy presented was the Trust's response to the NHS target. The strategy had previously been discussed in detail by the Board and it was being presented again on this occasion for approval. There were targets and measures in place as well as reporting mechanisms to support the strategy. The Chair of the Sustainability Committee assured the Board that the sustainability Committee would have a role in monitoring the strategy and controlling actions in order to ensure achievement of the sustainability benefits. The Chief Executive Officer reiterated that the Trust had made a decision not to declare a climate emergency and instead focus on delivering the sustainability strategy which, once achieved, would address the climate requirements. The Board APPROVED the draft sustainability strategy.
BoD 119/21	**Draft Quality Improvement strategy** The Chief Strategy and Transformation Officer presented the paper. The strategy aimed at embedding a culture of continuous improvement and learning across the Trust in which everyone was empowered to make changes to improve the quality of clinical and non-clinical services to enable improved patient care. The strategy consisted of three foundations and five strategic aims. Foundations: • Patient involvement • Digital first • Sustainability Strategic aims: • Leadership, governance and culture • Vision and buy in • Improvement skills and infrastructure • Aligning activity • Sustain and spread

	The Board APPROVED the draft quality improvement strategy.
BoD 120/21	**Integrated Care System (ICS) Update** The Chief Executive Officer presented the paper. Past Chief Executive Officer reports had highlighted on-going work to establish the Dorset ICS. The Trust was now part of the ICS. The Trust and partners were working through what this meant given that the ICS was to be set on a formal footing as set out in the white paper published by NHSE/I. The CEO outlined the purpose of a strengthened ICS as; • Improving outcomes in terms of population health and healthcare • Tackling inequalities • Enhancing productivity and value for money • Supporting broader social and economic development in the area. Clinical Commissioning Groups would not exist from April 2022, there would be ICSs instead. Formalising of the ICSs would come with new duties and powers yet to be Defined. There would be regular ICS updates at future Board meetings. The Board NOTED the ICS update.
BoD 121/21	**Care Quality Commission (CQC) Well Led Inspection April 2021** The Chief Nursing Officer provided a verbal update of the CQC Well Led inspection which had taken place on 20 April 2021. The CQC had met with 31 members of staff during their investigation. The Trust had now received the draft inspection report. Among the findings were that; leaders had the skills and abilities to lead, were approachable, there was an open culture and staff were clear about their roles and responsibilities. The key improvements identified in the report were; • The monitoring of patient pathways within the Trust, • Ensuring that governance around information was clear throughout the Trust, • Review of how Never Events were reported to the Board. The Board NOTED the CQC Well Led Inspection update.

BoD 122/21	**Freedom to Speak Up Guardian Annual Report** The Freedom to Speak Up (FTSU) Guardian made the presentation, acknowledging the importance of sharing concerns from staff and the learning arising from it. The Board was informed of the well-established governance of the Trust FTSU function. It was also a well-recognised function both internally and externally and had been shortlisted as a finalist for the HSJ speak-up organisation of the year 2020/21. The Trust's Matron for Theatres presented to the Board examples of lived experiences of staff, described the learning from the experiences and outlined the initiatives put in place as a result. The Board was asked to role model speaking up and to promote the Trust's cultural cornerstone of being open and honest. The Board commended the work of the teams involved in putting in place the learning from speaking up. The Board NOTED the Speak Up Guardian annual report.
BoD 123/21	**Annual Security Report** The Chief Operating officer presented the paper. He drew the Board's attention to the fact that the report was for the period from 1 April 2020 – 31 March 2021 whilst the Trust had only been in existence from October 2020 – March 2021. An assessment based on the self-review tool had been carried out and a work plan was in place to address the findings. The Board was informed that during the period under review, there had been a higher level of challenging behaviour driven by alcohol and neurological conditions. There were various pieces of work underway to address this. The Board NOTED the annual security report.
BoD 124/21	**Charitable Funds Expenditure over £250k** The Chief Finance Officer provided a verbal update. There was no charitable fund expenditure over £250k to report. The Board NOTED the update.
BoD 125/21	**Register of Interests** The Board NOTED the register of interests.

BoD 126/21	**Gifts & Hospitality Register** The Board NOTED the gifts and hospitality register.
BoD 127/21	**Terms of Reference - Transformation Committee** The Board APPROVED the terms of reference for the Transformation Committee.
BoD 128/21	**Terms of Reference - Quality Committee and Finance & Performance Committee** The Chair introduced the paper. The terms had been amended to remove the Chief Executive Officer from the membership of the two Committees but she would be able to attend meetings on an adhoc basis or as when required. The Board APPROVED the amended Quality Committee and Finance and Performance Committee terms of reference.
BoD 129/21	**Questions from the Council of Governors and Public arising from the agenda.** A Governor asked about the support available to the occupational health and respiratory physiotherapy staff who had worked so hard to support others during the pandemic. The Chief Nursing Officer responded that the Trust had invested in additional funding for long term well-being support for staff and there was also a very good in-house psychological support function. In addition, Listening Support sessions were being provided to staff. Another Trust Governor, referring to the Trust's sustainability strategy, commented on the large amount of single use PPE he had noticed on various occasions as a Trust inpatient. The Chief Operating Officer responded that reviewing clinical waste and single use items was on the forward programme. In addition, there was a plan to recruit a full time Waste Officer.
BoD 130/21	**Any Other Business** Deaf awareness week: The Chief Informatics and IT Officer informed the Board of training he had done on death awareness. The training included very good tools and technics on how to offer support. He commended the training to the Board. The Chair informed the Board that Professor Stephen Tee was retiring as Dean of Health and Social Sciences at Bournemouth University and consequently as a Trust Governor. The Board acknowledged the contribution that Professor Tee had made to the Trust.
BoD 131/21	**Key points of communication** The Chair asked that the Associate Director of Communications communicate to staff the strategy and performance key issues from today's meeting.

BoD 132/21	**Date and Time of Next Public Board Meeting:** The next Board of Directors Part 1 Meeting was announced as taking place on Wednesday 28 July 2021 at 13:15 via Microsoft Teams Further Board of Directors Part 1 meetings were; 29 September 2021 and 24 November 2021. The Chair closed the meeting at 15:10

MATTERS ARISING: ACTION TRACKER PART 1 BOARD OF DIRECTORS JULY 2021

Meeting Date	Minute No.	Matter Arising / Action	Trust / Lead	Due Date	Update
26/05/21	BoD 109/21	To commence providing lymphedema and cellulitis training to staff to help improve diagnosis. **Paula Shobbrook/ Hannah Stuart.**	PS	July 2021	Complete Training commenced

Key:	Outstanding	In Progress	Complete	Future Action

Chief Executive Report
July 2021

1. NHS 73rd Birthday

It has been an extremely challenging year for the NHS and the country as a whole, but this month, on Monday 5 July, we were pleased to celebrate the 73rd birthday of the NHS. The Trust took part in in a range of national and local initiatives aimed at celebrating the achievements of the service and the vital role that it plays in our lives. This birthday also allowed us the opportunity to recognise and thank our extraordinary NHS staff for the enormous contribution that they make every day.

It was great to be able to welcome BBC Radio Solent to our RBH site on the birthday itself – their team spoke to staff from across our sites about their work and their experiences, which really helped us to celebrate the day and bring these stories to life.

It was also very moving that on the day itself, it was announced that Her Majesty The Queen had awarded the George Cross to the National Health Services of the UK – this award being the highest civilian gallantry award, equivalent to the Victoria Cross. The award came in recognition of 73 years of dedicated service, including for the courageous efforts of healthcare workers across the country in battling the COVID-19 pandemic. This was an unprecedented honour for all of us in the NHS, and clearly recognises the skill, compassion and fortitude of staff working within UHD, and right across the National Health Service

2. Update on Covid-19

Members will be aware that Step 4 of the Government's Roadmap was enacted on 19 July 2021, resulting in the lifting of the national lockdown restrictions. This clearly signals a change in the national response - away from legal curbs to encouraging people to exercise personal judgement as to how best to protect themselves and others from Covid-19.

However, it is important to note that this does not change the Public Health England Infection, Prevention and Control guidance which remains in place across all healthcare settings. As a consequence, little will be changing on our hospital sites with regards to the way in which we shall be delivering our services. Everyone accessing or visiting healthcare settings must continue to wear a face covering and follow social distancing rules; we shall also be continuing to operate the same policies in terms of remote working and hospital visits. This will allow us to maintain the safest possible environment for our staff and patients, and to minimise nosocomial infections.

At the time of writing, we are expecting further national guidance about the self-isolation requirements for essential frontline staff. It is recognised that with the lifting of lockdown, infection rates are expected to rise - and even though this is not expected to result in a significant increase in hospitalisation rates, it is likely to have an impact on staff absence, as more people are asked to self-isolate.

Unfortunately, cases of Covid-19 have continued to increase across Dorset over the past few weeks. At the time of writing, the case rate for BCP Council is 236.8 (below the England average of 263.9 but above the South West average of 201.8). Dorset Council's rate is 94.2. As restrictions eased following Step 3 of the Government's roadmap, social mixing has increased, thus giving the virus more chances to spread, particularly in indoor settings where it is more likely to be transmitted. There is a higher proportion of case rates in younger age groups compared to older age groups.

Data shows that the Delta variant, which is now the dominant strain of Covid-19 in the UK, is more transmissible than previous variants, meaning it is more likely to be passed on to close contacts. It is for this reason that it is important to maintain our current stance on infection and prevention controls, including social distancing and the use of appropriate PPE in all settings.

At the time of writing, we have 21 positive Covid-19 patients within our Trust, with 3 receiving treatment in critical care.

The Trust continues to be very busy across all its sites. Our emergency departments are operating under considerable pressure, with an increase in the number of patients being brought in by ambulance. At the same time, maintaining the flow of patients throughout our hospitals continues to be very challenging. We have been operating with high levels of occupancy for some time, which puts significant additional pressure on our staff.

As always, we are very grateful to our staff (and volunteers) for their ongoing commitment and hard work – particularly during the recent hot weather.

3. Vaccination Programme

Over 1 million doses of the vaccine have now been given in Dorset, and within UHD, 82.7% of staff have had two doses. Thanks to the vaccine rollout, we are seeing a significant weakening of the link between the increase in the number of Covid-19 cases and the number of people becoming seriously unwell and requiring hospital treatment.

We are now developing our plans to provide boosters to our staff, alongside our annual flu vaccination programme. This will be finalised once the final details have been published by the Joint Committee of Vaccination and Immunisation.

Meanwhile, I am pleased and proud of the fact that UHD continues to be involved in the latest Covid-19 research, with the Dorset Research Hub (based at RBH) taking part in the world-first vaccine booster trial. This research will be pivotal in helping to determine which members of the public will require a booster and which vaccine is most effective. The trial is being funded by the Vaccine Task Force and the National Institute for Health Research, with approximately 2,800 volunteers being recruited by a network of trial sites across the UK.

4. Elective Recovery

Despite the on-going emergency pressures, our teams have continued to focus on reducing waiting times and the number of patients waiting for planned treatment/care, and very good progress has been made to date. Earlier this year, there were 5865 patients waiting more than 52 weeks for treatment; at the end of June, this figure had reduced to 3737. Clearly, there is still much to be done to get back to the swift access times that we have been accustomed to in Dorset, but within UHD, we have made a good start.

As part of our overall recovery plans, the “Think Big” project - which involves the redesign and streamlining of certain outpatient services, and providing these from a specially designed space within a local retail facility - is also progressing well:-

- there has been significant patient engagement, facilitated through Healthwatch and Dorset CCG Patient Engagement Group;

- good progress has been made in developing the clinical operating model plans, with "anchor specialities" agreed and engagement taking place with wider clinical specialities and support services across Dorset for the potential use of the space;

- the IT workstream has been mapping requirements at a service level and testing new ways of working, in anticipation of moving towards paperless processes.

It is anticipated that this new facility will be operational by October 2021.

5. Developing Our Organisation

Earlier this month, we formally announced the structures for our new care groups and operational management team, following another round of appointments to senior clinical and non-clinical management roles. Recruitment to these 'tier 3' posts is a very significant milestone in the life of our new organisation, as it is these leaders who will in future play such an important part in bringing teams together and integrating front-line clinical services.

Work has also continued to further embed the values of our new organisation. All our recruitment and appraisal processes have been redesigned so that these are "values-based", and various groups across the Trust have been thinking about our values in more detail, at a number of different development sessions.

During a recent Joint Leadership Forum, senior leaders and clinicians from across the Trust came together to review our workforce data and some of the feedback from our staff survey, asking themselves *'are we an inclusive organisation?'* This really challenging session was led by one of our surgeons, Mr Mukhtar Ahmad and our Director of Organisation Development, Deb Matthews, who bravely shared their personal stories. We were also joined by Paul Iggulden, Public Health Consultant who provided an overview of the demographics within the Dorset population, and highlighted some of the health inequalities that persist within the local area.

Within University Hospitals Dorset, we recognise that "difference" adds value, as we seek to provide the very best care for our patients. The Trust is committed to promoting equality, diversity and inclusion, and is actively seeking to develop a culture where neither staff nor patients experience discrimination. We want to consistently treat each other in a positive way so that UHD is a great place to work - for all those employed within it - and is able to consistently deliver the very highest standards of patient care.

6. Armed Forces Covenant

Members will be aware that on 6 July 2021, the Chairman and I joined Kevin Moore (Dorset Armed Forces Covenant programme coordinator) in the signing of the Armed Forces Covenant – one that applies to our new organisation. This was a very important occasion marking UHD's commitment to honouring and supporting the Armed Forces community. Signing the covenant enabled us to shine a spotlight on the enormous contribution that is made by reservists and veterans within our organisation, and to honour the dedication of serving personnel who provided so much assistance during the recent pandemic.

We employ a large number of staff within our hospitals who have served in the armed forces, and they play an immensely important role within our organisation. In signing the covenant at this time, UHD affirmed its committed to upholding the principles of the covenant and being an "Armed Forces-friendly organisation" to its staff, patients, suppliers, contractors and the wider public.

7. Meeting with NHS England/NHS Improvement: six-month post-merger review

Last month, we attended a meeting with representatives of the NHS England/NHS Improvement (NHSE&I) Regional Team to take stock of progress with our merger, as part of the formal merger process. Clearly, many of our plans have been disrupted by the Covid-19 pandemic, but we are still extremely proud of the progress that has been made and we were delighted to meet with members of the Regional team. It was good to reflect on the fact that all critical actions had been delivered on/before Day 1, that our planned cultural changes were well underway and that despite the pandemic, we have made real progress in integrating some of our clinical services.

Themed discussions took place regarding quality & safety, workforce & culture, finance & capital, performance & operations, service reconfiguration & transformation, and the development of the Dorset Integrated Care System (ICS). It was encouraging to reflect once again on the significant patient benefits that have been (or will be) delivered as a consequence of our merger. The Covid-19 pandemic has tested all NHS organisations, and it is evident that UHD is stronger and more resilient as a larger organisation, and will be better able to serve local people than either of its predecessors.

8. Capital Programme – Estates & Transformation

Following the Trust's Full Business Case (FBC) submission of the Wave 1 STP scheme in March 2021, the FBC has now passed all fundamental checks, and we shall be presenting the case for approval at the Joint Investment Committee (NHSEI/DHSC) on Friday 30 July 2021. We are anticipating Treasury approval in September 2021, following on from this meeting.

I am pleased to confirm that the work on the new Poole Theatres has been progressing extremely well, with the demolition and groundworks now virtually complete. As such, we are now able to progress with the installation of a tower crane on Longfleet Road, which is due to take place over the weekend of Friday 30 July to Monday 2 August. The size of the crane and complexity associated with placing it safely on the hospital site means that this will be a very significant event. A section of Longfleet Road will be closed for the weekend in order for this work to take place, and this will be managed in conjunction with the local highways department. Our communications team is working with colleagues at BCP Council to ensure that staff, local residents and members of the public are kept properly informed.

Significant changes will also be taking place on the Royal Bournemouth site over the next few months, as the Main Entrance is due to close from the 2 August 2021. The new upgraded West Entrance will become the temporary Main Entrance from that date, with a new retail pharmacy and Orthopaedics outpatients due to open around the same period. An updated site map has been created as part of the information campaign, with details posted on the UHD website and in over 3500 leaflets distributed around the RBH site.

Meanwhile, the naming process for the new (maternity, critical care and emergency care services) building on the Royal Bournemouth site is well underway. Following widespread staff and stakeholder engagement, a clear name has now emerged that is favoured by the majority of people. The proposed name will be considered by the Board later this month and will be announced early in the autumn.

There is also positive progress to report on the development of the Christchurch Hospital site, with the new expanded physiotherapy facilities now close to completion. This development, which has been funded with the support of the hospital's League of Friends, will be a state-of-the-art resource designed to provide much improved rehabilitation facilities for patients and staff alike.

Finally, I am pleased to report that the New Hospital Programme (NHP) Strategic Outline Case (SOC) for Dorset (which incorporates plans for further building work on our hospital sites) was submitted on time and will go to the Joint Investment Committee in August 2021.

From the above, it can be seen that a great deal of work is underway to take forward the Trust's very ambitious transformation programme. Our new Transformation Committee and its associated Groups will continue to oversee this work, ensuring that key risks and decisions are escalated to the Board as required.

9. Development of the Dorset Integrated Care System (ICS)

Work continues with partners across the Dorset system, as we seek to further develop the Dorset ICS, in line with national guidance.

The Dorset ICS is being designed to achieve four fundamental purposes:

- improve population health and healthcare;
- tackle unequal outcomes and access;
- enhance productivity and value for money;
- help the NHS to support broader social and economic development.

Tim Goodson (Chief Officer for the Dorset Clinical Commissioning Group and Senior Responsible Officer for the Dorset ICS) recently attended an informal meeting of our Trust Management Group (TMG) in order to discuss this development and listen to the views of our senior leaders. It is clear that clinicians from across UHD (and indeed, the wider Dorset system) are committed to the development of the ICS, given the very significant benefits associated with the closer integration of services.

The Dorset System Partnership Board (SPB) will be meeting later this month to take stock of progress and consider the latest national guidance. The SPB includes the most senior leaders from all the statutory organisations in Dorset.

10. System Oversight Framework

In another move to further strengthen system working, the NHS System Oversight Framework 2021/22 was published in June 2021. The document describes NHS England & NHS Improvement's approach to the oversight of systems and organisations / collaboratives for 2021/22. The framework introduces a new integrated and system-focussed "Recovery Support Programme" (RSP) that replaces the previously separate quality and finance 'special measures' regimes for provider trusts.

ICSs will agree a memorandum of understanding with regional teams that sets out the delivery and governance (finance and quality) arrangements across the ICS and the role of place-based partnerships and provider collaboratives in delivering the NHS priorities set out in the 2021/22 planning guidance. It will also detail the oversight mechanisms and structures and the local strategic priorities that have been agreed between partners.

Work is now underway amongst partners in Dorset to finalise the memorandum of understanding for 2021/22. Our Business Intelligence and Performance teams are currently reviewing the oversight metrics that will be needed to ensure that appropriate mechanisms are in place in Dorset to monitor collective performance.

11. Provider Collaboration Review Cancer Services in Dorset

In April/May of this year, the Care Quality Commission (CQC) conducted a review of cancer services in Dorset, assessing how partners across the system worked collaboratively together in order to maintain services during the pandemic. In undertaking this work, they engaged with more than 40 stakeholders, including holding conversations with patients and their representatives.

Dorset has long benefitted from a joined-up approach in the planning and provision of cancer services. Initially, this was facilitated by means of the Dorset Cancer Network, but in more recent years, this has been maintained through the Dorset Cancer Partnership, established in 2014. As Chief Executive of University Hospitals Dorset, home to the Dorset Cancer Centre, I chair the Dorset Cancer Partnership and lead as the Senior Responsible Officer for Cancer Services within the Dorset Integrated Care System (ICS).

The results of the CQC review were fed back to partners at an expanded meeting of the Dorset Cancer Partnership Board in early June, and we were all encouraged by the feedback. The final report highlighted that Dorset did well in maintaining services during the pandemic, and that good progress has been made in focusing on health inequalities.

There were 4 key lines of enquiry (KLOE):

- People – Dorset is immensely proud of all the staff in cancer services and beyond, who have worked tirelessly throughout the pandemic to ensure cancer services were maintained, patients were supported and access to services were good
- Shared plan & leadership – Dorset has good partnership working and strong leadership resulting in close collaboration and impressive links with GPs and primary care
- Workforce – there is strong teamwork across Dorset, and the wellbeing & safety of our staff will continue to be a top priority in all parts of the system
- Digital – Dorset has good quality cancer data, good governance around digital systems and has efficiently implemented new ways of working

We were pleased to receive such a positive report but recognise that more needs to be done to further improve access and waiting times following the pandemic. Most importantly, partners are committed to working together (and with colleagues in Hampshire and the Isle of Wight, as part of the wider Wessex Cancer Alliance) to achieve the very best outcomes for local people.

12. Ambition for net zero NHS

Members may be aware that in October 2020, the NHS became the world's first national health system to commit to net zero emissions, following the declaration of a public health emergency by the World Health Organisation (WHO). The NHS Strategy, approved unanimously by the NHS England and NHS Improvement boards, is the most comprehensive of any healthcare system and includes two ambitious (yet feasible targets):

- Net zero by 2040 for the emissions we control directly (the NHS Carbon Footprint), with an 80% reduction by 2028-2032;
- Net zero by 2045 for the broader emissions we can influence (the NHS Carbon Footprint Plus), with an 80% reduction by 2036-2039

Members will recall that the Board approved our sustainable Green Plan on 26 May 2021, and we officially launched this on the date of national Clean Air Day (17 June 2021). As such, we are very firmly on our way in pursuing these ambitious targets, working in partnership with others across Dorset.

13. Innovation Hub

I am delighted to announce that UHD has been awarded Innovation Hub status for Dorset, to speed up the spread and adoption of proven innovations. The Adopting Innovation programme is supporting four innovation hubs nationally, with the Dorset ICS and its partners successfully having secured the top award (£475,00) for two and a half years.

Our Hub will help to address inequalities (which have been exacerbated during the pandemic) and support the recovery of services across Dorset. It is another good example of the benefits that can be derived by working collaboratively as an ICS.

14. UHD Virtual Open Day – Saturday 11 September 2021

I am pleased to confirm that our first UHD virtual Open Day will be taking place on Saturday 11 September 2021, an event that will enable local people to gain a better insight into our hospitals and the care that we routinely provide for our patients

The event will include workshops, health talks and virtual tours, and for this year, for the first time, these will all run online. A range of departments will be involved including maternity, prosthetics, education, pharmacy, allied health professionals, human resources and estates. Our Annual Members Meeting will also be taking place that day via Teams.

We are looking forward to testing how well this virtual arrangement works, in that whilst it will be different to previous years, it is hoped that this may make the event even more accessible for the public. We are hoping that large numbers of people will join us on the day, including those who are interested in learning more about our hospitals, our ambitious transformation agenda, and of course, developing their careers within the NHS.

The link to the Open Day site will be on the homepage of the UHD website, www.uhd.nhs.uk. This will include all the timetables, information, films and links to the live elements which will run from 10am.

Debbie Fleming
Chief Executive

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER – COVER SHEET

Meeting date: 28 July 2021

Agenda item: 7.1

Subject:	Integrated Quality, Performance, Workforce and Finance Report

Prepared by:	Executive Directors, Donna Parker, Jacqueline Coles, David Mills, Fiona Hoskins, Matthew Hodson, Carla Jones, Louise Hamilton-Welsh, Jo Sims, 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 June 2021 and consider the content of recovery plans
Background:	The integrated performance report (IPR) includes a set of indicators covering the main aspects of the Trust's performance relating to safety, quality, experience, workforce and operational performance. It is a detailed report that gives a range of forums ability if needed to deep dive into a particular area of interest for additional information and scrutiny. All NHS organisations have received the '2021/22 priorities and operational planning guidance outlining the priorities for the year ahead' **Key priorities for 2021/22:** A. Supporting the health and wellbeing of staff and taking action on recruitment and retention B. Delivering the NHS Covid vaccination programme and continuing to meet the needs of patients with Covid-19 C. Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services, this includes the Think Big plan D. Expanding primary care capacity to improve access, local health outcomes and address health inequalities E. Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay F. Working collaboratively across systems to deliver on these priorities. We continue to work together with the Dorset system to produce and implement our organisational and system operational plans and objectives that aim to address these priorities and the performance related requirements.

Key points for Board members:	**Areas of Board Focus** 1. Attendances to ED are increasing, emergency admissions and ambulance conveyances continued to increase in June, challenging our front door wait to be seen times with corresponding pressures on our key Urgent & Emergency Care performance standards. Understanding the current trends, particularly the increase in ambulance conveyances and any changes to patient behaviours and access to all services is a focus of our internal and system-wide work. The increase in visitors to Dorset over the summer (already seen in June) presents a significant challenge along with capacity. 2. Additional bed capacity remains in situ to support the increased occupancy as well as elective recovery. This, together with avoidance of unnecessary admissions through a focus on Same Day Emergency Care and 'front door' pathways that support timely pathways to ongoing primary and community care, is key. Furthermore, a focus on reducing long lengths of stay and those patients who no longer need to be in hospital is paramount to reducing our predicted bed capacity gap. These are putting additional pressure on workforce to staff escalated bed capacity, driving increased costs and has a potential impact on quality including elective care recovery and risk of patient deconditioning. 3. Focus has remained on urgent and cancer care during June with more elective routine activity being undertaken in all specialties where it was safe to do so. Plans to reduce the number of patients on routine waiting lists waiting over 52 and 78 weeks for treatment have started to deliver improvement with 3737 patients waiting over 52 weeks at the end of June and 1,180 patients over 78weeks. This is 1,858 fewer patients over 52 weeks compared to March 21 (5,595). Recovery to pre-Covid levels requires investment to increase activity and this is currently being funded by achieving the Gateways as outlined in the Elective Recovery Fund (ERF). Recovery to pre Covid-19 levels will take some time to deliver due to workforce, patient's choosing to delay treatment and capacity limitations **<u>Operational Performance</u>** **Emergency Care** ***Emergency Departments*** The IPR provides the detailed performance against the new national Urgent & Emergency Care standards. The further increase in attendances, admissions and ambulance conveyances meant continued pressures on our front door and bed capacity through June. Headlines include: • Attendances were up by nearly 1475 on April and ambulance conveyances up 9% compared to 2019. • Admissions exceeded discharges resulting in a net gain of 59 patients • ED mean time on both sites became more challenged, increasing from 228 mins in May to 245 in June

- Positively there were no 12 hour waits from Decision to Admit (DTA) though the increase in meantime reflects longer stays in the department
- The increased conveyances and surges, as well as the need to ensure clinical review and prioritisation of all presenting patients, meant the number of 60min ambulance handover breaches increased to 117.

(colours based on change from last month)

		Jun-21		
Standard	**Aim**	**Poole**	**RBCH**	**Combined**
Operational (Field testing standards)				
Mean time in the dept	200 mins	240	250	245
Time to assessment	15 mins	7	18	13
Internal Care Standards				
Time to triage (*RBCH: to assessment*)	15 mins	7	18	13
Time to first clinician seen (*RBCH: to Dr seen*)	60 mins	119	157	139
Time waited for a bed (*RBCH: DTA to left dept*)	60 mins	147	67	102

The above pressures reflect a regional picture and there is concern across the Dorset System that this trend will continue through the summer, particularly with the increase in staycations and visitors to the area. In addition to overall attendances increasing in June, the proportion of patients outside of the Dorset area increased.

A deep dive by the new ED management team has commenced, supported by 'Big Room' events, which together with daily work with SWAST, continues to look to improve processes and pathways into and through the department. Areas for focus include:

- Arrival triage and assessment
- Rapid assessment and treatment model
- Clerking and assessment documentation
- Minors capacity
- Pathways to Same Day Emergency and/or Speciality/inpatient care.

System Executives have reviewed the current pressures being faced by our urgent care services and further urgent work is underway to understand what is driving these as well as to develop priority actions. A proposal for ongoing HALO support sited at both hospitals has also been recommended by the Dorset Urgent & Emergency Care Board. Ensuring patients are in the right place, including those patients who no longer need to be in the acute or community hospitals, will be a key area of focus.

Occupancy, Flow and Discharge

We continued to have all escalation beds open in June, however, despite this, occupancy remained high at above 90%.

The number of patients ready with No Reason to Reside (NRTR) as well as bed days occupied by patients with a longer length of stay (7/14/21+) remained high in June, with the latter exceeding the national standards as a proportion of all inpatients. Externally we continue to work with partners on the Home First programme and an external strategic partner has now been commissioned to support the development of new models. However, there is a recognition that current pressures are likely to need some urgent interim actions to reduce pressure on the acute and community hospitals.

Our internal work on 'Criteria to Reside' (C2R) continues and data completeness has now achieved 83%. Partners were invited into our

hospitals w/c 12 July to support an urgent focus on both front and back door discharge/community pathways. A Focus on Flow week is also taking place w/c 19 July to further support our C2R programme.

Internal bed capacity modelling is complete and a business case is being submitted to the Trust Board in July. Mitigation plans are also being progressed by the Care Groups and ward configurations being reviewed to offset potential demand and capacity gaps. However, winter projections currently remain challenged.

Surge, Escalation and Operational Planning

In line with the increasing national and local incidence of Covid, we do have a number of patients across UHD. At the time of writing, we have 20 confirmed inpatients, well below the levels experienced in Wave 2 (January/February) and within the 5% national planning requirements.

Due to current urgent care pressures and increasing Covid incidence across Dorset, we continue to maintain a system and internal resilience and capacity planning structure.

The challenges faced in emergency care in relation to ambulance handover volumes and delays, demands on services and bed occupancy in June mirror experience across the region but the Trust. So far, we have largely been able to maintain our elective care recovery activity, though this does remain at risk. Our combined internal and system actions to deliver improvement, capacity and appropriate pathways will be key to ensuring safe and responsive care and the additional demands.

Referral to Treatment (RTT)
92% of all patients should wait no more than 18 weeks for treatment

	January 2020	**May 21**	**June 21**	
Waiting List Size	44,508	48773	49099	**+4591 v January 20**
Referral to treatment 18 week performance		63.2%	**65.7%**	**+6.1% v Apr 21**
RTT incomplete pathways >52+ weeks		4153	3737	**-1,079 v Apr 21**

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 2022 than in January 2020. At the end of June 2021 there were 49,099 patients on the waiting list, 9.3% more than the combined January 2020 position of 44,508, this is a slightly worsened position from May 2021.

In parallel to the growth in the overall waiting list there is a decrease in the backlog of patients waiting over 18 weeks, which has resulted in an improvement in performance from 63.2% to 65.7%. Whilst the number of patients waiting over 18, 26, 40, 52 and 78 weeks has reduced, there has been a rise in patients waiting over 104 weeks. Patient choice to defer treatment remains a key influencing factor.

There are 3737 patients waiting over 52 weeks, a decrease of 416 patients

from last month and **1,858 less than March 2021**. Performance is ahead of the trust's planned 52ww trajectory of 4,656. >52ww represent 7.6% of the overall waiting list size and has delivered the ambition to deliver < 10% by the end of Q1 and on target to deliver < 7.5% by the end of Q2

Factors impacting on the RTT standard

Clinical Capacity & Response to COVID-19	The current RTT performance is a reflection of the number of patients waiting > 52 weeks which increased due to ceasing / reducing routine elective activity during 2020-21 in response to managing the COVID-19 pandemic and the need to work within new Infection Control guidance. The waiting list has risen slightly due to the transfer of the routine elective waiting list from Dorset Healthcare University NHS FT to UHD, this is part of the Dorset ICS recovery plan and in line with national recommendations to have a single system waiting list. Some patients are still reluctant to attend hospital for consultation, diagnostic test or treatment until they have had their vaccination and/or the pandemic is over. In recovering routine elective activity, some specialties productivity will remain lower than previous years due to restoring services safely in line with national and clinical infection control guidance which make each outpatient attendance, diagnostic test and procedure / treatment take much longer. 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 high number of 52 weeks is mainly due to lack of theatre / treatment capacity during 2020-21 however this has started to improve during Q1. The waiting list for patients waiting to be admitted for treatment is clinically reviewed and prioritised to reduce any potential harm for those patients waiting longer than expected for their procedure.

High level elective care recovery actions include:

- *A clinically led waiting list validation programme* of the active, follow up and planned waiting lists commenced in April 21, this programme of work is aimed at clinically prioritising patients and ensuring that episodes for patients who no longer require an appointment or treatment are closed. ENT, OMF, Orthopaedics, General Surgery and Gynaecology validation is now live.
- *Creating additional capacity* to see and treat our longest waiting patients, this includes use of the independent sector, using other NHS and private providers, insourcing using a partner organisation and running waiting list initiatives where possible.
- *Think Big* is a project to enable high volumes of outpatients to be seen safely, this plan has system approval to proceed and plans to commence in Q3.
- *Use of digital technology* to support non-face to face outpatient activity.

DM01 (Diagnostics report)
1% of patients should wait more than 6 weeks for a diagnostic test

June	Total Waiting List	< 6weeks	>6 weeks	Performance
UHD	8887	8728	159	**1.8%**

The DM01 standard has achieved 98.2% of all patients being seen within 6 weeks of referral, 1.8% of diagnostic patients have waited > 6 weeks. Radiology have achieved > 99% of all patients being seen < 6 weeks from referral. Echocardiography continues to improve as does Endoscopy increasing from 87.1% in May to 91.4% in June. The current performance is a remarkable achievement and testament to all the previously reported plans delivering during Q3 and continued in Q4.

High level diagnostic recovery actions include:

- Continuation of additional temporary endoscopy capacity on the RBH site and reviewing all endoscopy activity in the Dorset system
- Working collaboratively across both sites to standardise and reduce waiting times for cardiology, ultrasound, MRI and CT
- Outsourcing Ultrasound to the Independent Sector
- Insourcing radiological reporting to provide additional capacity.
- Sharing capacity across sites to reduce the waiting times in endoscopy and echo cardiology.

Cancer Standards

	Measure	Target	Q1 20/21 FINAL	Q2 20/21 FINAL	Q3 20/21 - FINAL	Q4 20/21 - FINAL	Apr 21 - FINAL	May 21 - FINAL	Jun-21
UHD	Cancer Two Week Wait	93%	96.7%	97.3%	N/A	N/A	N/A	N/A	N/A
	Cancer Plan 62 Day Standard (Tumour)	85%	79.3%	80.0%	78.6%	77.8%	80.9%	76.9%	78.4%
	62 Day Screening Standard (Tumour)	90%	73.3%	73.3%	94.1%	88.1%	88.0%	95.0%	84.6%
	31 Day First Treatment (Tumour)	96%	96.2%	94.4%	97.0%	96.7%	96.2%	97.6%	97.4%
	Subsequent Treatment - Surgery	94%	89.4%	86.7%	95.4%	90.5%	87.9%	90.9%	96.6%
	Subsequent Treatment - Radiotherapy	94%	98.8%	100.0%	98.7%	99.0%	98.3%	100.0%	100.0%
	Subsequent Treatment - Anti Cancer Drugs	98%	100.0%	100.0%	100.0%	99.7%	100.0%	100.0%	96.6%
	Faster Diagnosis	75%	76.3%	77.4%	80.7%	79.1%	77.1%	77.6%	74.7%
	Over 104 days (treated in month)	N/A	18	23.5	26	16.5	5	16.5	8.5

The rate of 2 week wait referrals continues to be high with notable increases in certain tumour pathways compared to the previous year, this impacts on the overall size of the PTL. Tumour pathways with greatest pressure on 2 week wait and size of PTL include Head and Neck and Upper GI.

Breast 2ww referrals remain high throughout June 2021. This has been further challenged by workforce capacity needed to run additional clinics. The capacity across both sites has been combined and is reviewed regularly by the Clinical team. 28-day FDS target continues to be met. Additional capacity in the week and super Saturdays are planned for July and August. DCP Task and Finish Meeting for Dorset-wide breast service held on 8th July.

The reported position for May improved against the National KPI's for the key standards – the 31day standard achieved at 97.6%, the 28-day faster diagnosis standards achieved at 77.6%. 62-day standard - UHD continues to perform above the current national average recognising this is still below the national threshold.

The number of reported backstops for June is expected to be 8.5 which is a significant improvement compared with the previous 2 months.

Factors impacting on standard

Demand	• Referral numbers continue to put additional pressure on several services at all stages of the pathway
Clinical Processing Capacity	• Patient choice continues to impact across all specialties - especially causing delays at diagnostic stage in some pathways • Specific challenges in several pathways - due to capacity to manage the increased demand - especially head and neck and breast.

High level actions ongoing

- Pathway analysis supported by Wessex cancer alliance to identify opportunities - to maximise capacity and improve flexibility - initially focusing on colorectal and head and neck
- ICS wide group reviewing Breast and skin pathways
- Commencing work to move towards a Dorset wide cancer PTL as per National guidance
- One stop opportunities at the start of the pathway to improve time to diagnosis- sarcoma/ lump clinic
- Improving IT support and intra-operability to assist efficacy of processes- working across Dorset
- Escalating issues across the care groups to identify mitigating actions and plan for improvements – where constraints and delays are identified
- Weekly breach and backstop meeting to ensure all patients are regularly reviewed and actions being taken as indicated clinically
- Continuing to pursue 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 on health inequalities
- Working with HEE to investigate the benefit of patient navigators within certain tumour sites –where complex diagnostics are required

Health Inequalities

The Dorset Elective Care Health Inequalities programme is progressing. The linked data set includes the Trust's elective activity, referral and waiting list data and data extracts are accessible. In collaboration with Optum analytics of the data is now underway and detailed analytical insights will be shared with the Trust in the summer. The participants of the programme will work together across organisational boundaries to target and **rapidly intervene** to improve care for **key cohorts at risk** of seeing their health worsen due to the **Covid-19 backlog.**

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

Infection Prevention and Control:

- Outbreak review meetings are near completion; and a report learning identified.
- Significant increase in community cases of COVID-19 in June, small number of hospital admissions at present.
- A refresh of National Guidance IPC guidance – no specific changes to note.
- Continued focus on social distance closed beds and national direction of

Covid-19.
- Ongoing work with regards to Fit Testing continues within the Task and Finish Group.
- Continue to work with the Dorset IPC Cell and SW IPC Region**.**

Clinical Practice Team:

Moving & Handling training
- Unable to meet the combined training requirements for clinical staff, approx.1300 staff now out of compliance. Performing a deep dive on the monthly compliance data to focus on areas with 60% or less compliance Risk Register entry to be reviewed and consider increasing to 12 numerous mitigations in place. To advertise for a Band 3 developmental post to support training.

Falls prevention & management
- A lack of observable side rooms identified as a theme and OPS Directorate to consider adding to their Risk Register.
- Flat lifting equipment remains a challenge across the UHD, devices moved relocated from RBH site to increase provision at the Poole. However, a unit has now failed leaving them with 1 unit in working order. Charities are now directly fundraising for upgrade FloJac systems.
- Bowel management is a consistent theme, SBAR and incident learning shared. To consider developing a training module/session. To highlight & promote the ability for nursing staff to administer standing doses.

Tissue Viability
- New FT Band 7 Tissue Viability Lead due to commence in post September 2021. Advised care groups that TV cover over July and August will be reduced due to annual leave.
- Involved in a national group looking to benchmark pressure ulcer data and develop metric parameters by Trust and eventually by specialty re per 1,000 bed days.
- To focus on supporting Poole based ward areas and provide stock access to barrier products to improve the care of patients with continence issues – aim to prevent excoriation and combination pressure ulceration
- Reinforce the need to perform skin inspections within 6 hrs of admission as any pressure ulceration noted after that window is recorded as “NEW” as per NHEI reporting guidance

Patient Experience:

Trend in complaints received and responded to: The Trust has seen as increase in the number of complaints received 2021/22 compared to the same period last year. This aligns with the position across the South West and nationally; a lower number of complaints received during the first peak of the pandemic when public support was at its greatest, with a subsequent increase back to pre-pandemic levels.

This month, the Trust has responded to a higher number of complaints compared to the number of complaints received; starting to address the backlog of complaints open and awaiting response.

Themes from PALS and Complaints: Patients and families continue to report a lack of communication from staff regarding inpatient care and discharge planning. This includes difficulty getting through to the ward by

'phone and patients being discharged with no prior communication with the next of kin.

This month, patients reported confusion regarding validation letters for some surgical specialties. However, by the end of the month these issues had started to be addressed.

Volunteer recruitment: planning in place to recruit additional volunteers, at pace, to support the Think Big outpatient transformation.

International Recruitment:
The commitment to recruit 200 IR Nurses by March 2022 is on trajectory with 89 nurses arrived and 42 offered and a further 16 scheduled for interview in July.

Safeguarding:
The trust received notification of 7 section 42 enquiries (2 on the Poole site, 5 on the Bournemouth site) This is a decrease on the previous months. An investigation into each concern via the nominated enquiry process is underway to understand details of the concern and identify any themes and learning.
Initial review has identified that the alleged unsafe discharge is the common theme in 6 of the 7 concerns.

Shelford Audit:
The Shelford Safer Nursing Care Tool is being used for the first UHD wide Establishment review – 20 days of data collection will conclude on 30 July. The audit will see ward areas scoring the acuity and dependency of the patients once a day. This will then support the annual template reviews.

Workforce

Key Performance Indicators to June 2021:

		21/22	20/21	Variance
Turnover		9.2%	10.4%	-1.1%
Vacancy Rate		-	0.9%	-
Recent data currently unavailable				
Sickness Rate		4.8%	4.8%	0.0%
Appraisals	Values Based	10.1%	47.1%	-37.0%
	Medical & Dental	52.7%	56.1%	-3.4%
Statutory and Mandatory Training		87.8%	86.7%	1.1%

Performance:
Turnover has increased slightly from last month and is currently being reported at 9.4%. We are seeing an increase in the number of staff retiring. Comparison of this indicator to the same period last year shows a reduction of 1%. However, this is likely to be a Covid effect.

Vacancy Rate: Accurate vacancy reporting relies on the ability to compare reliable funded establishment data against accurate filled posts down to

ward level, identifying the gap. We are working on uniting the processes and cleansing the data to achieve this for UHD.

Overall Sickness levels remain relatively stable at 4.8%. Staff continue to be supported to maintain their health and wellbeing and a programme to support staff with Long Covid began in July. We have seen an increase in short term absence due to the need for staff to isolate as a result of trac n trace contact/family members; however, new guidelines should support a better balance in this from 19th July.

Appraisal levels for Medical Staff remain relatively stable. Values Based appraisal has risen by just under 8% this month.

Statutory and Mandatory training compliance remains fairly stable and continues in the high 80s.

CPO Headlines:

- Tier 3+ implementation has now almost concluded.
- We are working with staff side to agree the outstanding ER issues which will support further integration e.g. adopting new joint UHD policies for all staff not just new staff.
- The Operational Team's workload continues to be high in regard to organisational change and employee relations case work.
- Demand for Occupational Health and Enhanced Wellbeing services remains high and this is being closely monitored.
- Covid restrictions are causing delays in access for some mandatory and statutory training modules. Whilst the training department has worked hard with subject matter experts to digitalise training wherever possible, face to face training is still required for some areas.
- 90+ international nurses have joined the trust since November of last year. A further 42 nurses have been offered posts. We are doing all we can to ensure these new members of staff are appropriately supported, but with an increase in student placements, wards are under increasing pressure.
- In Temporary Workforce - TempRe is on track to go live in August to centralize **all** non-nursing agency booking on a single platform for UHD. Locum's Nest has now been fully rolled out to all Care Groups. With a very high demand in HCSW bank shift requests, up 40% since April, we are prioritising growing this bank pool.

Finance

The Trust has set a financial break-even budget for the first half of the year (to 30 September) supported by the continuation of national FINANCIAL INDICATORS top-up funding and funding to cover specific COVID costs. However, the Trust has set an indicative budget for the second half of the year based upon the previous funding regime and Long Term Plan allocations. This represents a budget deficit of £32.3 million albeit this will be revisited following receipt of the planning guidance and associated allocations for the second half of the year, which is expected within the coming months.

	The national planning framework includes an Elective Recovery Fund (ERF) to support the necessary increases in capacity to see and treat those patients still awaiting planned care. The Trusts budget does not include the cost of this recovery and does not include the associated income from the Elective Recovery Fund. This will be reported within the monthly financial position as a variance against both expenditure and income budgets. At the end of June, the Trust is reporting a consolidated deficit of £128,000 being a favourable variance of £17,000. This reflects the fact that ongoing COVID-19 costs are below the budgeted levels. Additional expenditure of £3.918 million has been incurred in the Trusts elective recovery programme and, pending national validation, income has been assumed from the Elective Recovery Fund to off-set this in full. The Surgical Care Group is £186,000 behind plan as at 30 June, mainly due to additional medical staffing costs, partially offset by reduced activity particularly prosthetic in Orthopaedics, . The Medical Care Group is £51,000 ahead of plan, mainly due to an over achievement in cardiac private patient income, with the Specialties Care Group ahead of plan by £418,000 principally due to vacancies within Pathology and Pharmacy. As at June the Trust is forecasting delivery of £1.778 million CIP of which 59% is non-recurrent. All of the identified CIP is Green rated and therefore considered highly likely to deliver. This would leave a recurrent shortfall of £2.501 million at the end of the year. As such the Trust is looking to escalate the programme into recovery with increased monitoring and support provided. The Trust has set a very challenging capital programme for the year, with many priority schemes deferred due to the restrictive capital allocation for the Dorset Integrated Care System. This presents a considerable risk for the Trust and will require very careful management throughout the year. As at 30 June capital spend is £7.027 million, being £1.738 million above plan. This overspend relates to the phasing of the capital programme and will be closely monitored. The Trust is currently holding a consolidated cash balance of £76.2 million, which is fully committed in support of the medium-term strategic reconfiguration programme.
Options and decisions required:	The Board is asked to discuss the report.
Recommendations:	Members are asked discuss the report and to note: • The areas of Board focus • The increase in attendances & admissions and the impact this has on the front door. • The increase impact on our workforce
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:	**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 ensure that all resources are used efficiently to establish financially and environmentally sustainable services and deliver key operational standards and targets. **To 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 well governed and well managed organisation** that works effectively in partnership with others, is strongly connected to the local population and is valued by local people. **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)	**Risks scoring ≥12:** **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** (1343) – 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) **UHD 1460** – UEC national metrics **UHD 1429** – Ambulance handovers **UHD 1053 –**Long Length of Stay / Discharge to Assess /NRTR **UHD 1430** – ED workforce **UHD 1074** - Risks associated with breaches of 18 week Referral to Treatment and 52 week wait standards **UHD 1292** – Outpatient Follow-up appointment backlog. Insufficient capacity to book within due dates **UHD 1476** – Backlog of overdue planned follow up appointments **UHD 1386** – Cancer waits increasing due to increased referrals. **UHD 1276** – Delayed patient care due to delays in surgery for #NOF patients **UHD 1347** – Financial Control Total 2020/21.This entry highlights the potential risk of the Trust failing to achieve the required break-even outturn position, resulting in a revenue deficit and an unplanned reduction in cash available to support the capital programme. **UHD 1416** – GIRFT & Model Hospital. This entry highlights the risk of not achieving the efficiency and productivity opportunities identified through the Getting it Right First Time (GIRFT) programme and Model Hospital metrics resulting in continued unwarranted variation, reduced productivity and higher cost of service provision
CQC Reference:	All 5 areas of the CQC framework

Committees/Meetings at which the paper has been submitted:	**Date**
Trust Board (Full report)	July 2021
Quality Committee (Quality)	July 2021
Finance & Performance Committee (Operational / Finance Performance)	July 2021
Trust Management Group	July 2021

University Hospitals Dorset
NHS Foundation Trust

INTEGRATED PERFORMANCE REPORT




June 2021

Performance at a Glance - Key Performance Indicator Matrix

			standard	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	ytd	ytd var	trend
SAFE																	
Quality	Presure Ulcers (Cat 3 & 4)			12	6	10	8	12	12	13	16	11	15	12	38	5	
	Inpatient Falls (Moderate +)			5	2	3	5	4	4	5	2	4	6	2	12	0	
	Medication Incidents (Moderate +)			1	2	5	4	9	2	4	4	1	0	1	2	-1	
	Patient Safety Incidents (NRLS only)			1379	1341	1654	1581	1537	1492	1239	1006	1029	752	821	2602	714	
	Hospital Acquired Infections	MRSA		0	0	0	0	0	0	0	0	0	0	0	0	0	
		MSSA		1	2	3	9	8	4	6	4	3	2	4	9	3	
		C Diff		7	6	1	3	1	2	9	3	4	9	8	21	-8	
		E. coli		3	12	5	8	2	11	3	3	4	4	9	17	-3	
EFFECTIVE																	
Mortality	SMR Latest Jan 21	(source Dr Foster)		104.042	97.2055	111.664	113.307	96.5075	171.543	119.6							
	Patient Deaths	YTD		207	185	265	244	249	469	299	217	165	185	170	520	-32	
	Death Reviews	Number		100	81	99	84	86	151	104	63	21	9	4	34		
	Deaths within 36hrs of Admission			30	35	40	36	49	47	39	37	30	29	33	92	14	
	Deaths within readmission spell			15	13	15	22	25	36	18	16	12	14	10	36	-7	
CARING																	
	Complaints Received			57	48	51	56	62	53	53	51	60	68	62	190	-95	
	Complaint Response in month			57	48	51	48	49	43	59	59	47	26	64	137	-3	
	Section 42's			0	2	0	0	0	0	1	0	0	0	7	7	-2	
	Friends & Family Test			90%	91%	91%	91%	91%	91%	91%	93%	90%	89%	89%	90%	-	
WELL LED																	
Safety	Risks 12 and above on Register			36	38	39	31	32	27	31	34	35	40	24	99	15	
	Red Flags Raised*			31	47	51	43	73	129	51	28	41	45	56	142	114	
	*different criteria across RBCH & PHT																
	Overall CHPPD			9.5	8.8	9.0	9.4	9.4	8.3	9.4	9.3	5.7	5.3	5.2	5.5	-2.7	
	Patient Safety Alerts Outstanding			0	0	0	0	0	0	0	0	0	0	0	0	0	
People	Turnover			10.40%	10.70%	10.40%	10.20%	10.00%	9.80%	9.40%	9.20%	9.00%	9.20%	9.40%	9.2%	-1.1%	
	Vacancy Rate *(only up to Oct 2020)*			1.0%	0.7%	1.3%	-	-	-	-	-	-	-		-	-	
	Sickness Rate			4.2%	4.2%	4.2%	4.4%	4.5%	7.1%	4.9%	7.1%	4.7%	4.7%	4.8%	4.8%	0.0%	
	Appraisals	Values Based		41.6%	53.5%	57.3%	61.5%	63.9%	63.7%	63.1%	62.9%	4.6%	9.0%	16.7%	10.1%	-37.0%	
		Medical & Dental		52.0%	45.9%	37.5%	29.9%	50.3%	61.6%	62.7%	56.8%	55.4%	52.5%	50.3%	52.7%	3.4%	
	Statutory and Mandatory Training			86.52%	86.96%	88.37%	85.90%	85.80%	87.20%	86.50%	86.40%	87.20%	87.94%	88.20%	87.8%	1.1%	

RESPONSIVE

Quality	Patient with 3+ Ward Moves (Non-Clinically Justified Only)			8	20	25	17	29	36	10	17	14	8	9	31	11	
	Patient Moves Out of Hours (Non-Clinically Justified Only)			58	64	84	106	103	187	75	70	67	72	98	237	5	
	ENA Risk Assessment	Falls		62%	61%	61%	61%	58%	51%	59%	59%	65%	62%	62%	63%	3%	
	infection eNA assessment went live at RBCH during April 20	Infection*		74%	73%	70%	64%	73%	54%	62%	64%	70%	66%	74%	67%	-9%	
		MUST		64%	64%	63%	65%	61%	57%	63%	63%	69%	66%	66%	67%	4%	
		Waterlow		61%	61%	61%	61%	60%	52%	59%	60%	65%	62%	62%	63%	4%	
RTT	18 week performance %		92%	49.0%	56.2%	60.4%	63.4%	64.8%	63.0%	59.3%	58.2%	59.6%	63.2%	65.7%			
	Waiting list size		44,508	41,172	43,123	44,320	44,349	44,117	44,615	45,524	47,133	47,984	48,773	49,099			
	Waiting List size variance compared to Mar 2019 %, and Jan 2020 for 21/22		0%	-3%	1.3%	4.1%	4.1%	3.6%	4.8%	6.9%	10.7%	7.8%	9.6%	10.3%			
	No. patients waiting 26+ weeks			16,950	17,001	14,220	12,131	10,738	10,904	11,672	12,408	12,692	12,682	11,972			
	No. patients waiting 40+ weeks			6,395	6,921	7,197	7,799	8,031	7,258	7,006	6,727	6,474	6,151	5,962			
	No. patients waiting 52+ weeks		0	2,050	2,636	2,998	3,242	3,439	4,273	5,325	5,595	4,816	4,156	3,737			
	No. patients waiting 78+ weeks			0	70	92	149	291	542	726	979	1,176	1,268	1,180			
	No. patients waiting 104+ weeks			0	0	0	0	0	0	0	0	9	24	66			
	Average Wait weeks		8.5	20.8	20.6	19.5	18.3	18.6	18.3	18.3	20.1	19.5	19.5	20.1			
Theatre	Theatre utilisation - main		98%	67%	71%	71%	71%	73%	69%	67%	73%	73%	74%	75%			
	Theatre utilisation - DC		91%	70%	73%	59%	61%	63%	60%	62%	67%	59%	60%	61%			
	NOFs (Within 36hrs of admission - NHFD)		85%	40%	10%	26%	29%	25%	42%	67%	63%	20%	29%	23%			
Outpatients	**Referral Rates**																
	GP Referral Rate year on year +/-	*(20/21 baseline)*	-0.5%										200.1%	127.3%			
		(19/20 baseline)	-0.5%	-45.8%	-37.8%	-34.4%	-32.0%	-28.2%	-29.5%	-29.0%	-22.4%	-12.6%	-10.2%	-8.6%			
	Total Referrals Rate year on year +/-	*(20/21 baseline)*	-0.5%										169.1%	120.5%			
		(19/20 baseline)	-0.5%	-45.3%	-37.1%	-32.2%	-28.7%	-24.5%	-22.8%	-22.2%	-17.2%	-8.9%	-8.0%	-3.9%			
	Outpatient metrics																
	Overdue Follow up Appts			13,652	13,941	13,722	13,099	13,941	14,883	15,775	15,669	15,404	15,266	15,330			
	Follow-Up Ratio		1.91	1.46	1.44	1.44	1.48	1.44	1.63	1.54	1.44	1.40	1.36	1.37			
	% DNA Rate		5%	5.7%	6.6%	7.0%	6.6%	6.0%	5.5%	5.0%	5.0%	5.7%	5.8%	6.3%			
	Patient cancellation rate			9.2%	9.9%	10.3%	9.5%	10.4%	12.1%	8.8%	5.4%	8.3%	9.1%	10.5%			
	30% reduction in face to face attendances																
	% telemedicine attendances		25%	52.9%	44.5%	42.0%	43.1%	39.4%	52.1%	52.8%	42.5%	37.3%	34.1%	31.3%			
DM 01	**Diagnostic Performance (DM01)**																
	% of <6 week performance		1%	19.5%	16.9%	9.8%	1.4%	2.7%	6.4%	5.9%	2.9%	3.7%	2.6%	1.8%			
Cancer	2 week wait (RBH not being monitored)			99.3%	95.4%	-	-	-	-	-							
	62 day standard		85%	76.6%	76.1%	77.9%	80.3%	77.5%	78.5%	71.6%	83.2%	76.1%	76.9%	78.4%	*(June predicted)*		
	28 day faster diagnosis standard		75%	80.3%	72.9%	76.6%	86.7%	78.6%	72.5%	80.2%	83.6%	75.9%	77.6%	74.7%	*(June predicted)*		
Emergency Dept	Arrival time to initial assessment		15	5.7	5.7	5.1	5.0	6.0	6.0	5.0	6.0	9.0	9.0	13.0			
	Clinician seen <60 mins %			31.0%	36.2%	39.9%	43.7%	41.8%	50.5%	52.9%	45.2%	30.6%	27.0%	18.3%			
	PHT Mean time in ED		200	227	206	210	230	235	266	235	205	217	229	239			
	RBCH Mean Time in ED		200	211	217	226	219	259	258	222	206	223	228	250			
	Patients >12hrs from DTA to admission		0	0	0	0	7	8	3	1	0	0	0	0			
	Patients >6hrs in dept			1833	1454	1540	1488	2126	2052	698	1072	1674	2110	2735			
	ED attendance Growth (YTD)	*vs 20/21*										94.3%	17.0%	56.1%			
		vs 19/20		-26.0%	-23.2%	-15.7%	-21.2%	-21.8%	-22.6%	-31.4%	-21.1%	-3.0%	-15.0%	9.0%			
SWAST SCAST	Ambulance handover growth (YTD)	*vs 20/21*										43.0%	35.7%	22.9%			
		vs 19/20				-6.7%	-7.5%	-7.0%	-4.7%	-11.9%	-4.4%	7.8%	8.8%	8.9%			
	Ambulance handover 30-60mins breaches			313	228	249	213	261	296	126	190	227	264	341			
	Ambulance handover >60mins breaches			56	52	48	57	103	203	12	20	42	67	117			
	Emergency admissions growth (YTD)	*vs 20/21*										33.2%	17.0%	2.2%			
		vs 19/20		-11.9%	-10.5%	-12.1%	-15.4%	-16.4%	-13.1%	-19.3%	-13.4%	-16.2%	-15.0%	-15.1%			
Patient Flow	Bed Occupancy		85%	85.9%	86.0%	85.4%	85.2%	87.4%	84.6%	82.3%	85.1%	90.5%	90.3%				
	Stranded patients:																
	Length of stay 7 days			380	394	385	311	443	311	347	338	374	390				
	Length of stay 14 days			197	214	219	155	242	155	184	178	195	216				
	Length of stay 21 days		108	108	126	132	86	144	86	105	103	115	132				
	Non-elective admissions			6089	6279	5673	6034	5231	6034	6130	6355	6463	6366				
	> 1 day non-elective admissions			3796	3932	3554	3686	3521	3686	3737	3873	4025	3885				
	Same Day Emergency Care (SDEC)			2291	2346	2118	2344	1710	2344	2387	2481	2437	2478				
	Conversion rate (admitted from ED)		30%	34.40%	36.10%	38.30%	36.90%	42.30%	36.90%	37.00%	33.90%	32.50%	30.40%				

Quality - SAFE

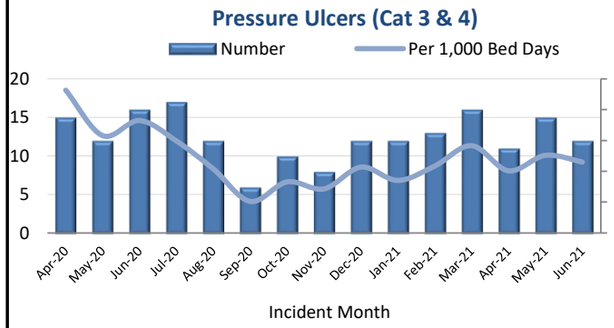
Commentary on high level board position

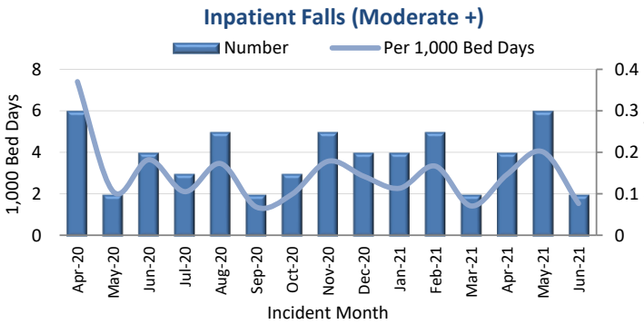
- 3 Serious Incidents were reported in June 2021. See full SI report for details.
- No Never events reported in June 21. YTD = 0
- Category 3 have reduced slightly this month, there are no Cat 4's reported. Two patients were on the End of Life Care pathway, three patients had presented with pre-exiting PU's on admission that progressed. Mixed aetiology (moisture + pressure) accounted for two of the incidents.
- Focus remiains on undertaking a skin inspeciton and risk assessment wihtin 6 hours of admission as any PU damage noted after that window is recorded as developing post admission. Two moderate + falls incidents recorded this month, the theme of availability of observable bed spaces is being highlighted.

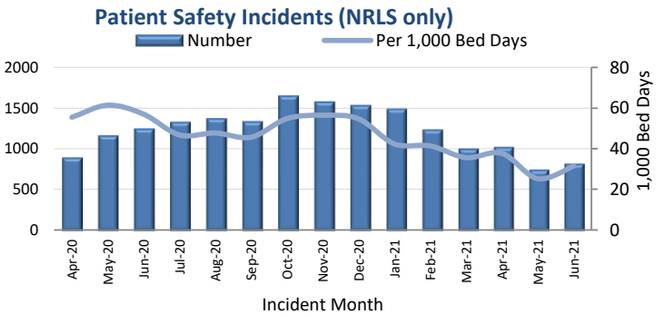
High level Board Performance Indicators

		21/22 YTD	20/21 YTD	Variance
Presure Ulcers (Cat 3 & 4)	Number	38	43	5
	Per 1,000 Bed Days	0.46	0.75	0.30
Inpatient Falls (Moderate +)	Number	12	12	0
	Per 1,000 Bed Days	0.14	0.21	0.07
Medication Incidents (Moderate +)	Number	2	1	-1
	Per 1,000 Bed Days	0.02	0.02	-0.01
Patient Safety Incidents (NRLS only	Number	2,602	3,316	714
	Per 1,000 Bed Days	31.28	58.04	26.76
Hospital Acquired Infections	MRSA	0	0	0
	MSSA	9	12	3
	C Diff	21	13	-8
	E. coli	17	14	-3

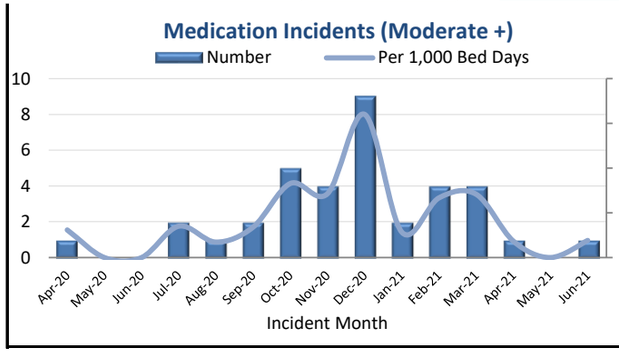
High Level Trust Performance

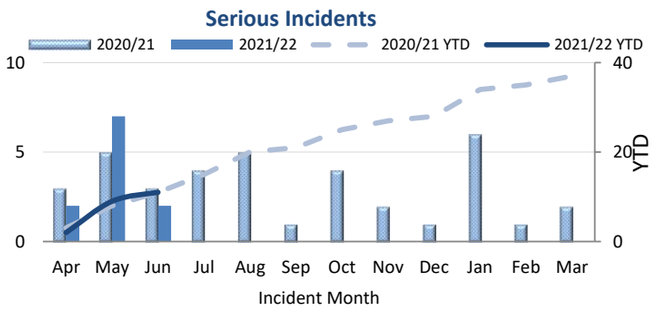


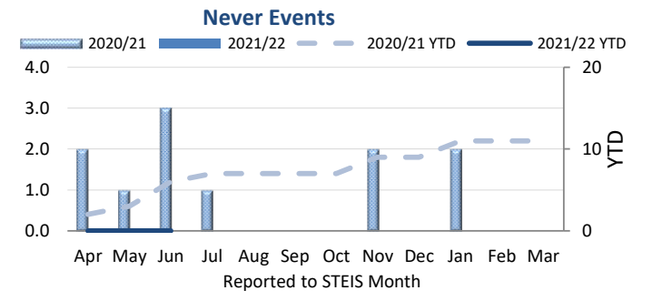




0 (May 21) MRSA 0 Jun 21) | 2 (May 21) MSSA 4 (Jun 21) | 9 (May 21) C Diff 8 (Jun 21) | 4 (May 21) E. coli 9 (Jun 21)







Quality - RESPONSIVE

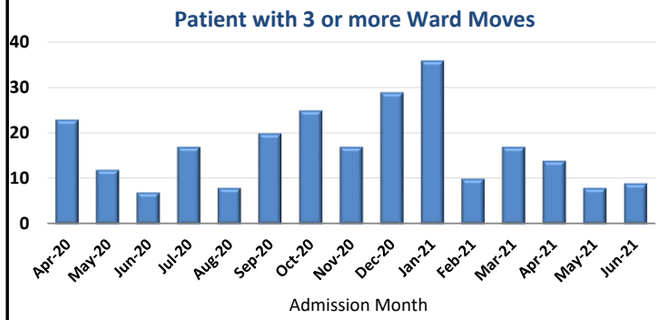
Commentary on high level board position

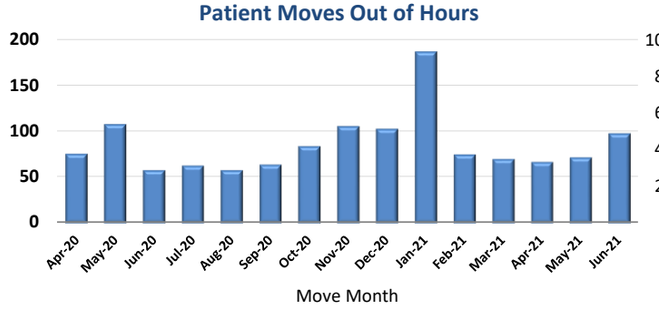
- Reporting on mixed sex accomodation remains on hold nationally, the Trust however continues to aspire to maintain this standard
- eNA compliance completion within 6hrs of admission remains a challenge for admission areas and has remained static at circa 60%, improvemetn continues steadily on the Poole site.

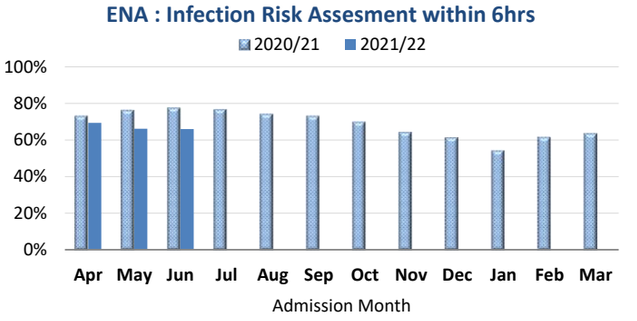
High level Board Performance Indicators

	21/22 YTD	20/21 YTD	Variance
Patient with 3+ Ward Moves (Non-Clinically Justified Only)	31	42	11
Patient Moves Out of Hours (Non-Clinically Justified Only)	237	242	5
Mixed Sex Acc. Breaches Suspended Apr-20 onwards due to Covid	0	0	N/A
ENA Risk Assessment			
Falls	63%	60%	3%
Infection	67%	76%	-9%
MUST	67%	63%	4%
Waterlow	63%	59%	4%

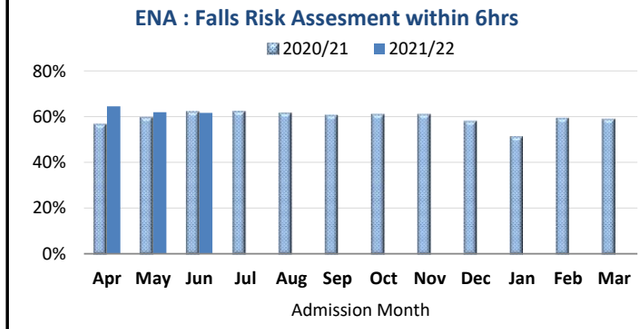
High Level Trust Performance

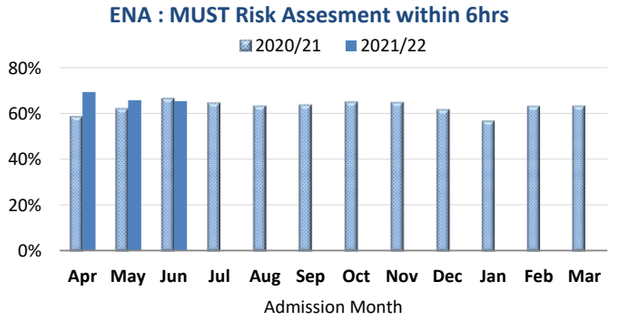






61.9% (May 21) Falls 61.7% (Jun 21) | 66.2% (May 21) Infection 66% (Jun 21) | 65.8% (May 21) MUST 65.4% (Jun 21) | 62.3% (May 21) Waterlow 61.8% (Jun 21)





Quality - EFFECTIVE AND MORTALITY

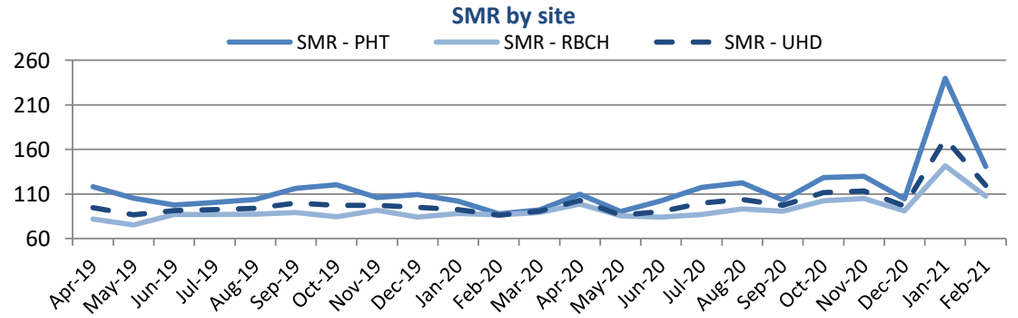
Commentary on high level board position

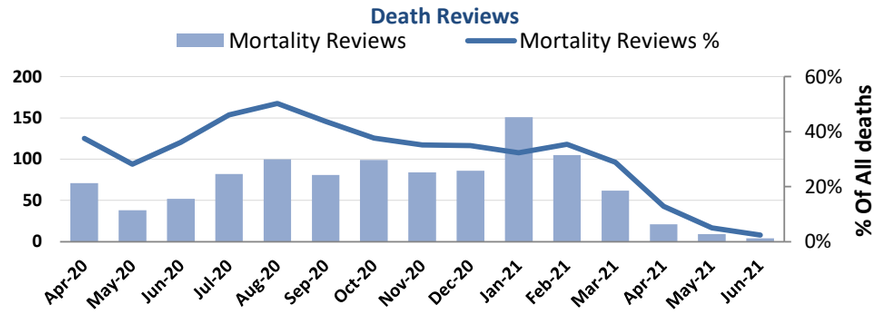
- Please see separate briefing regarding Mortality

High level Board Performance Indicators

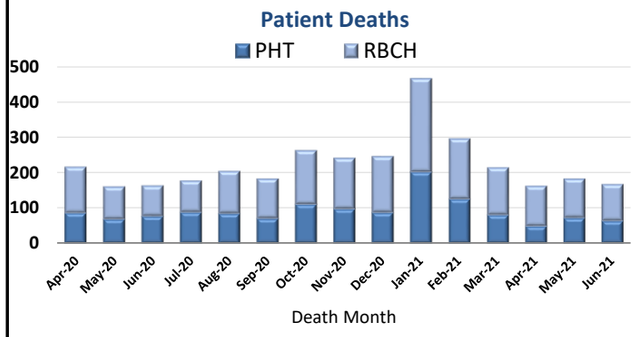
			21/22	20/21	Variance
SMR (Source: Dr Foster for all sites)	Latest	(Feb-21 - UHD)	119.6	86.4	
Patient Deaths		YTD	520	548	-28
Death Reviews Note: 3 month review turnaround target		Number	34	161	N/A
		Percentage	7%	34%	
Deaths within 36hrs of Admission			92	100	-8
Deaths within readmission spell Patient readmitted within 5 days			36	45	-9

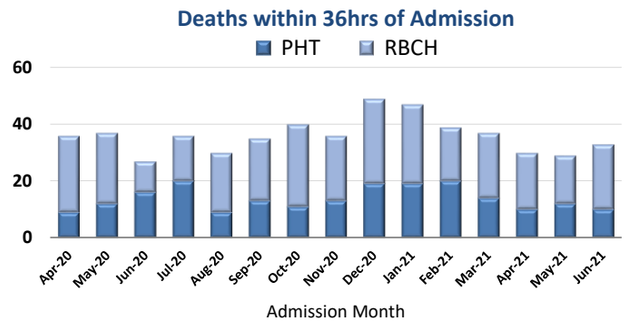
High Level Trust Performance

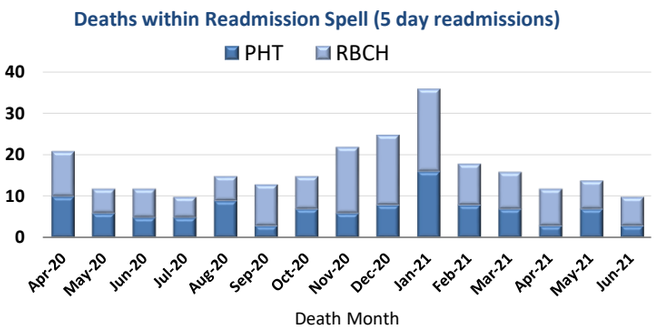




172.1 (Jan 21) | SMR | 119.6 (Feb 21) | 185 (May 21) | Patient Deaths | 170 (Jun 21) | 35.1% (Feb 21) | Deaths Reviewed | 29.3% (Mar 21)







Quality - CARING

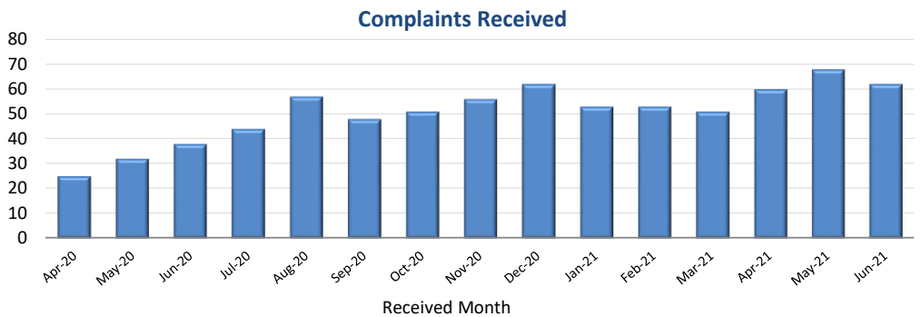
Commentary on high level board position

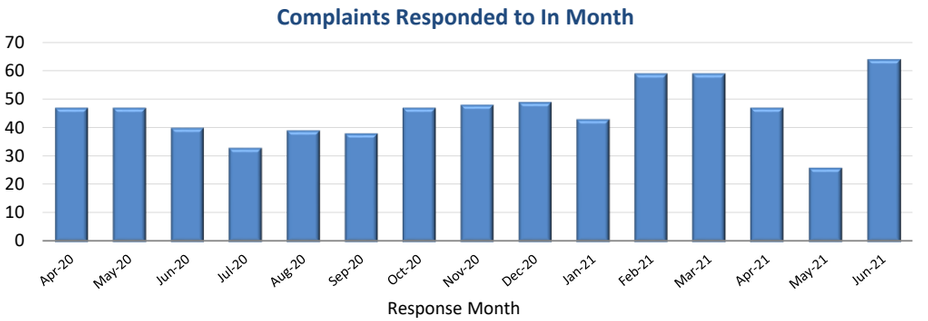
- During June, 2,388 patients completed the Trust's FFT; 89% (2,125 patients) rated our hospitals as good/very good, with a high number of positive comments about our staff:
  - *The whole team were very professional and put me at ease from start to finish, I couldn't fault them at all (Endoscopy, PH)*
  - *The staff are SO lovely. So welcoming at the desk, so kind, couldn't do enough for you. They seem really happy to work here (X-Ray, RBCH)*
- The 21/22 YTD complaints received exceeds the 20/21 position; this aligns with the picture across the south west and no specific trends have been noted
- This month, the Trust has responded to a higher number of complaints compared to the number of complaints received; starting to address the backlog of complaints that are open and require response
- **Top themes from PALS and Complaints:**
  *Lack of comunication between ward staff and patient's family/next of kin, including lack of notification of discharge
  *Delays in appointments for Child Development Centre
  *Confusion regarding validation letters for some surgical specialties

High level Board Performance Indicators

	21/22 YTD	20/21 YTD	Variance
Complaints Received	190	95	-95
Complaint Response Compliance	TBC		
Complaint Response in month	137	134	-3
Section 42's	7	5	-2
Reported quarterly (figures are previous FY)			
Friends & Family Test	89%	N/A	-
New guidelines from June 2020			

High Level Trust Performance

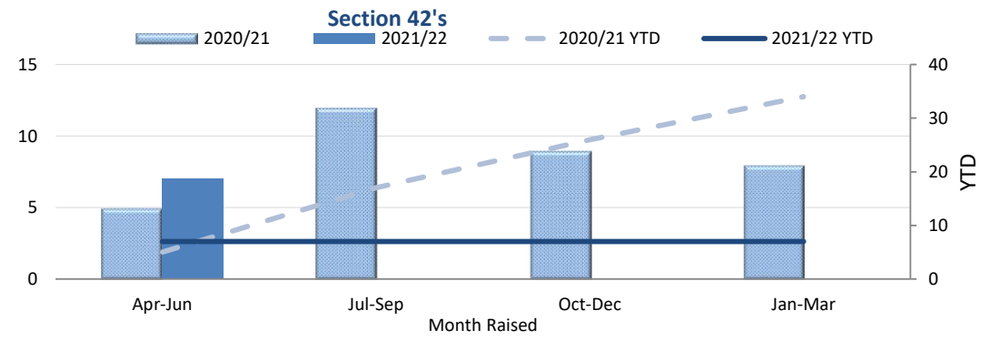


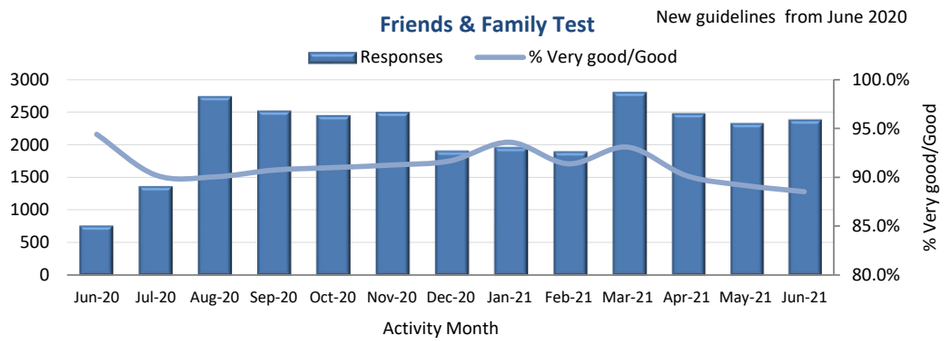


68 (May 21) | Complaints Received | 62 (Jun 21)

26 (May 21) | Complaint Responses | 64 (Jun 21)

89.2% (May 21) | FFT % V.Good/Good | 88.5% (Jun 21)





Quality - WELL LED

Commentary on high level board position

- The new Board Assurance Framework for 2021/22 has been produced and was approved at the Board of Directors meeting in June 21. The Q1 report will be presented to the Quality Committee on the 26/7/21.
- Risk register update (as at the 10/7/21):
  - Current risks rated at 12 and above on the risk register - 46
  - Risk(s) increased to 12 and above for review - 2
  - Reduced, closed or suspended risk(s)rated at 12 and above to note -2
  - Potential new risks for review at Quality Committe on the 28/7/21 - 1

A Board Strategy and Development session has been arranged for the 28/7/21 to review the Trust Risk Maturity and Risk Appetite.

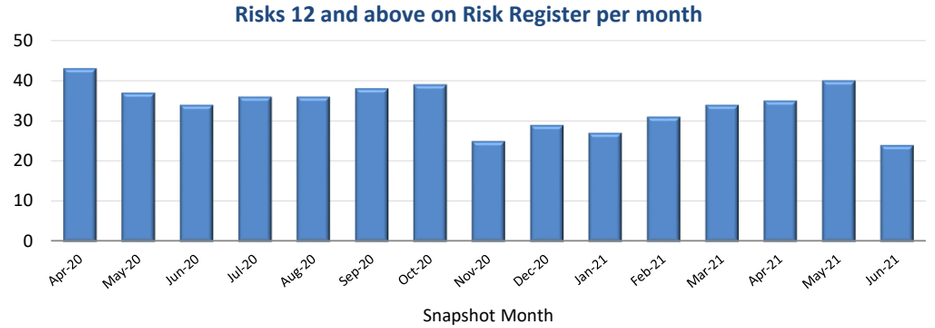
A new Patient Safety Alert requiring the removal of all air flowmeters for pipped air by the 16/11/21 was issued on the 16/6/21 . An Action plan is being developed by the Oxygen and Medical Gas Group.

- The red flag criteria have been aligned in consultation with clinical areas as part of the Safecare system review across UHD. The increase in Red Flags for June 2021 were as a result of an increase in the number of patients presenting with challenging behaviour requiring 1-1 enhanced care and movement of staff to maintain safety across sites.
- The overall CHPPD data for June is consistent with previous months

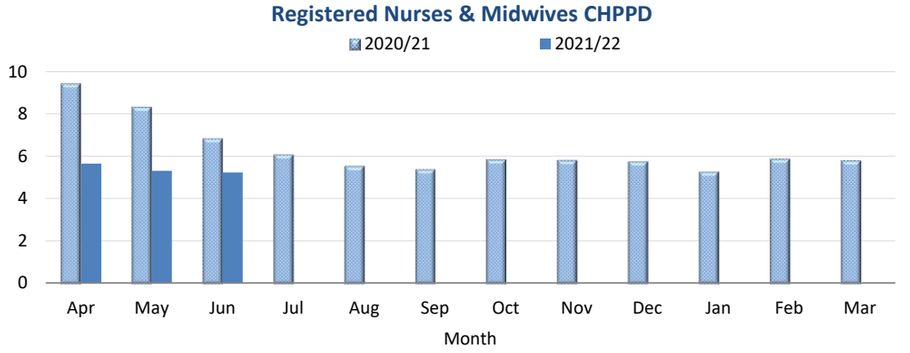
High level Board Performance Indicators

	21/22 YTD	20/21 YTD	Variance
Risks 12 and above on Register	99	114	-15
Red Flags Raised* *criteria now aligned across UHD	142	28	114
Registered Nurses & Midwives CHPPD	5.4	8.1	-2.7
Patient Safety Alerts Outstanding	0	0	0

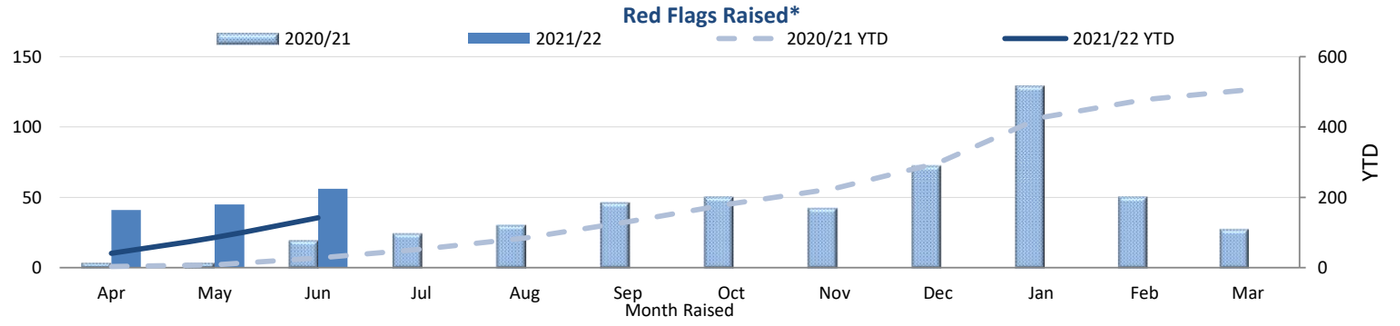
- **High Level Trust Performance**



40 (May 21) | Risks 12+ | 24 (Jun 21)



5.3 (May 21) | RN & RMN CHPPD | 5.2 (Jun 21)



Workforce

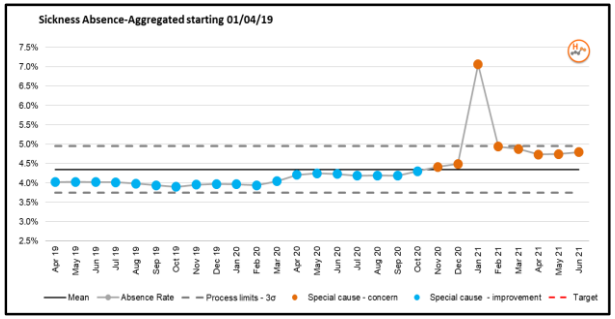
Commentary on high level board position

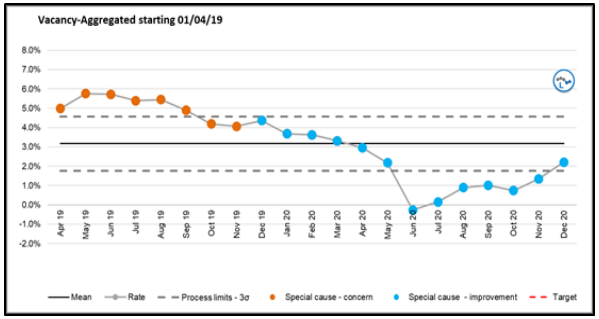
- **Turnover** has increased slightly from last month and is currently being reported at 9.4%. We are seeing an increase in the number of staff retiring. Comparison of this indicator to the same period last year shows a reduction of 1%. However, this is likely to be a Covid effect.
- **Vacancy Rate**: Accurate vacancy reporting relies on the ability to compare reliable funded establishment data against accurate filled posts down to ward level, identifying the gap. We are working on uniting the processes and cleansing the data to achieve this for UHD.
- **Overall Sickness** levels remain relatively stable at 4.8%. Staff continue to be supported to maintain their health and wellbeing and a programme to support staff with Long Covid began in July. We have seen an increase in short term absence due to the need for staff to isolate as a result of track n trace contact/family members, however, new guidelines should support a better balance in this from 19th July.
- **Appraisa**l levels for Medical Staff remain relatively stable. Values Based appraisal has risen by just under 8% this month.
- **Statutory and Mandatory training** compliance remains fairly stable and continues in the high 80s.

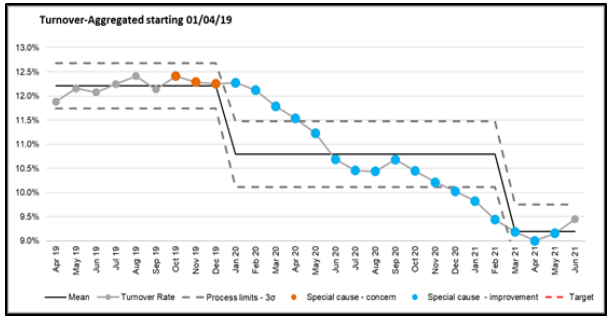
High level Board Performance Indicators

		21/22	20/21	Variance
Turnover		9.2%	10.4%	-1.1%
Vacancy Rate		-	0.9%	-
Recent data currently unavailable				
Sickness Rate		4.8%	4.8%	0.0%
Appraisals	Values Based	10.1%	47.1%	-37.0%
	Medical & Dental	52.7%	56.1%	-3.4%
Statutory and Mandatory Training		87.8%	86.7%	1.1%

High Level Trust Performance





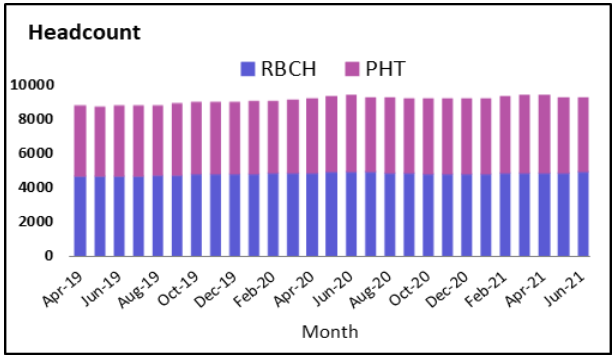


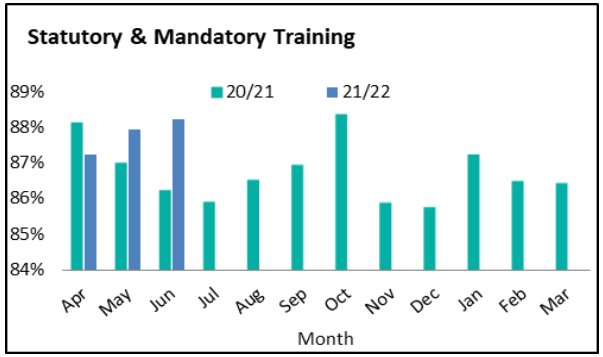
52.5% (May21) | Appraisals (Medical) | 50.3% (June 21)

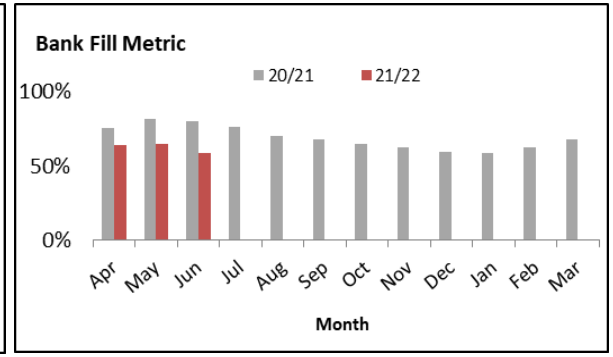
9.0% (May 21) | Appraisals (Values) | 16.7% (June 21)

9.2% (May 21) | Turnover | 9.4% (June 21)

4.7% (May 21) | Sickness | 4.8% (June 21)







Emergency

Commentary on high level board position

The UHD Emergency front doors continue to see significant growth in June compared to April, with 1475 additional attendances presenting to the Emergency Department, an average of 50 more per day (June vs April). While YTD growth is 0.9% compared to 19/20 this is offset by lower attendances in April, June 2021 saw 6.1% growth over June 2019. The profile of attendances has also seen a change with Ambulance arrivals 8.9% higher than 2019, almost 13 per day. With incidence of Covid in the community increasing, we are also now seeing Covid inpatients in the hospitals.

Performance against key metrics has deteriorated since last month, with a number of recovery actions being instigated including a deep dive review by the new leadership team. Medical staffing remains a concern and recruitment of middle grades a particular challenge. Ambulance handover times have extended with 117 taking more than an hour. As previously reported, the challenges are reflected across the SW region and ensuring clinical prioritisation across all patients presenting at the hospitals is key. There remains a daily meeting with SWAST to review positions and plans and agree escalations, and a fortnightly meeting with the CCG to review these and performance.

There is ongoing work with the wider system to develop plans for the rest of the summer and unprecedented pressures in Emergency Care with high volumes of visitors to the South Coast.

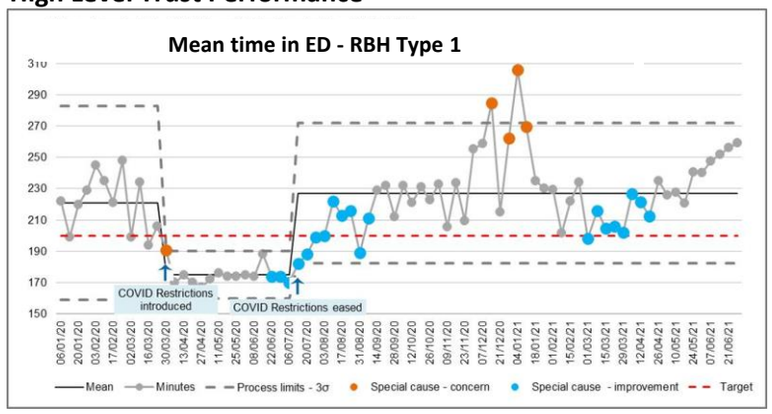
High level Board Performance Indicators

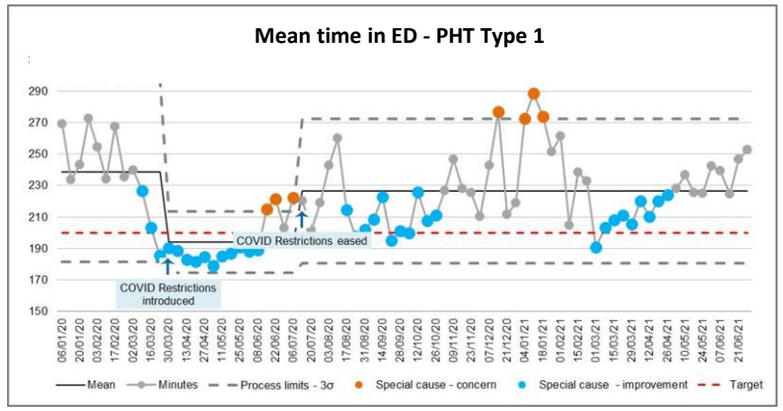
Type 1 ED	Standard	Merged Trust
Emergency Dept		
Arrival time to initial assessment	15	13
Clinician seen <60 mins		18.3%
PHT Mean time in ED	200	239
RBCH Mean Time in ED	200	250
Patients >12hrs from DTA to admission	0	0
% Patients >6hrs in dept		18.9%
YTD ED attendance Growth vs 20/21 (vs 19/20)		56.1% (0.9%)
Ambulance Handover		
YTD Ambulance handover Growth vs 20/21 (vs 19/20)		22.9% (8.9%)
Ambulance handover 30-60mins breaches		341
Ambulance handover >60mins breaches		117
Emergency Admissions		
YTD Emergency admissions growth vs 20/21 (vs 19/20)		33.8% (-0.3%)

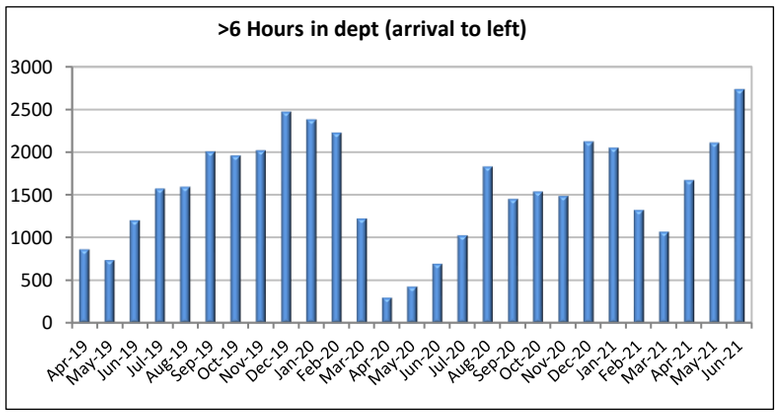
9 mins May-21 → Mean time to initial assessment → 13 mins Jun-21

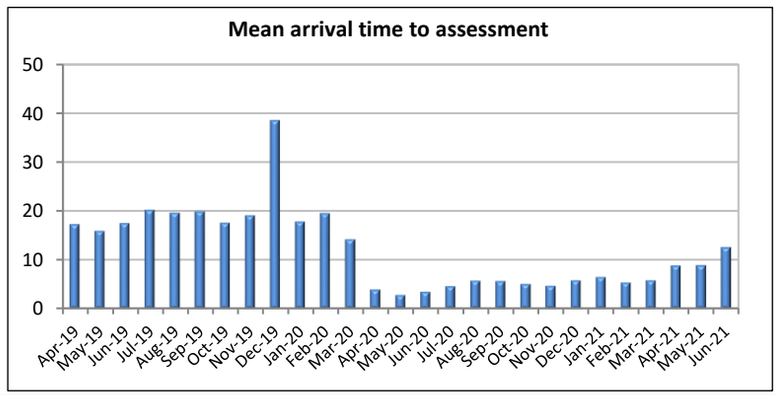
228 mins May-21 → Mean time in Dept. RBH & PHT → 245 mins Jun-21

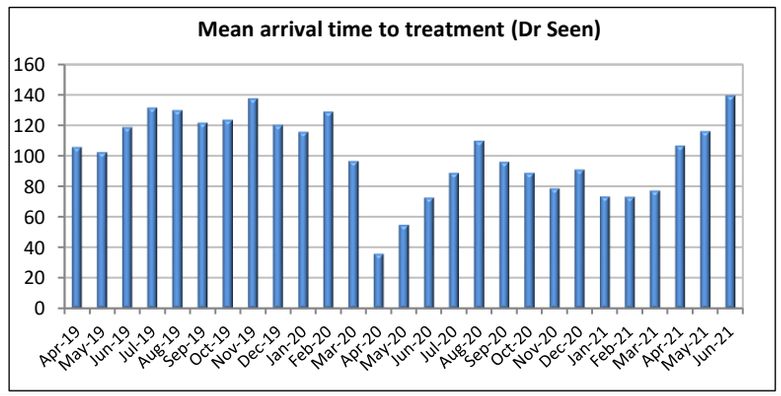
High Level Trust Performance

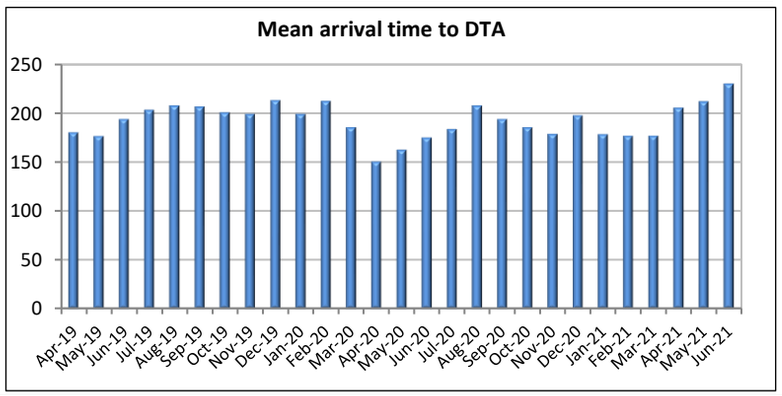












Patient Flow

Commentary on high level board position

Patient Flow

Bed occupancy continued to be challenged in June, averaging at above 90% with some days at 92-95% despite escalation capacity. A net increase of 59 patients was seen through June and the mean wait for a bed for an ED patient was increasingly challenged. Increased levels of 7/14/21+ patient beddays is expected to have contributed as some marginal improvements have been seen in some overall lengths of stay in some specialities.

Bed waits (for ED admissions) are monitored as we refine collection of data relating to the new national indicator relating to 'Clinically Ready to Proceed'. Waits have generally been higher on the Poole Hospital site and we continue to focus our bed capacity modelling and mitigation work on identifying areas for improvement.

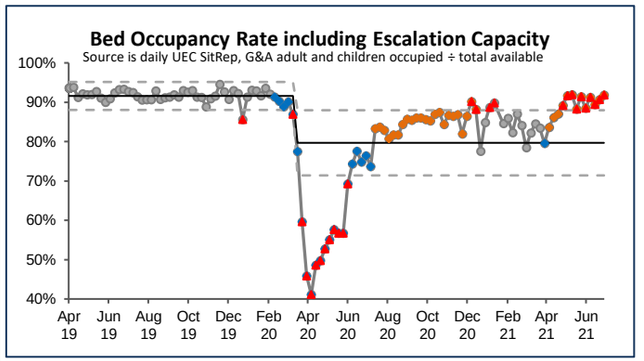
Paediatric occupancy saw a reduction through June, whilst adult occupancy remained high. We are planning in readiness, should we see an impact of increasing non Covid viruses/conditions in children.

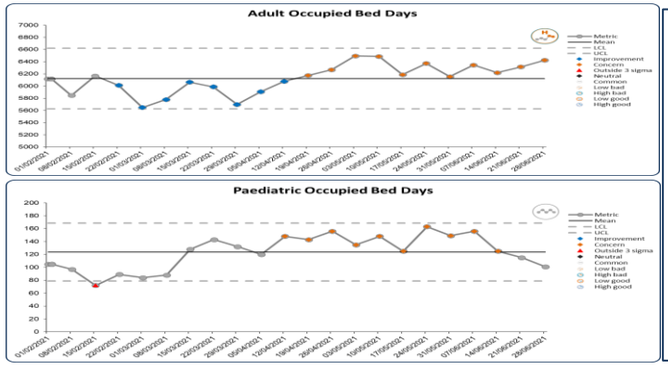
Overall, admissions were similar to 2019 levels, including electives. Some early improvement on 0 day Length of Stay/Same Day Emergency Care admissions has been seen and an ongoing focus on this aims to support pressures and bed capacity gaps.

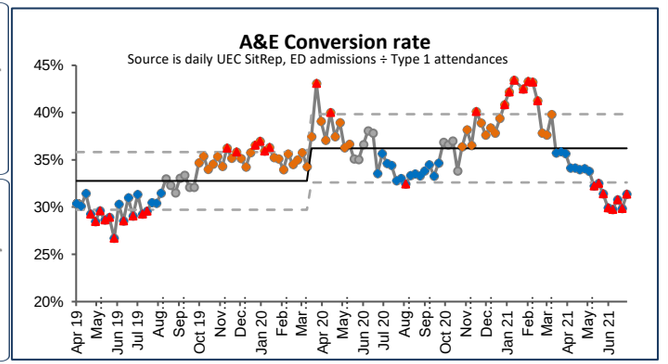
High level Board Performance Indicators & Benchmarking

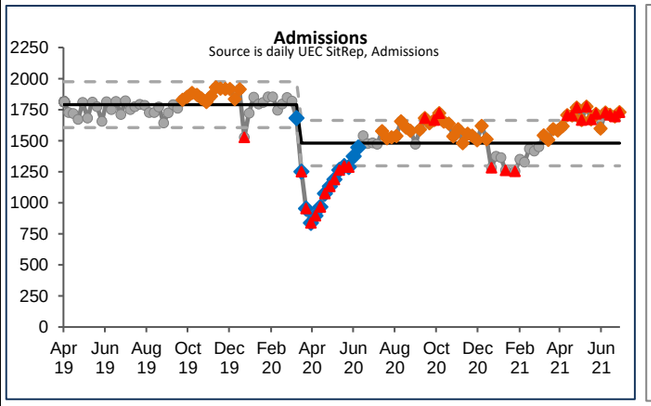
July 2021	Standard	Merged Trust
Patient Flow		
Bed Occupancy		
(incl. escalation in capacity)	85%	91.8%
(excl. escalation in capacity)		93.9%
Occupied Bed Days		5,590
Admissions v Discharges		1,427 v 1,392
Net admissions	<= 0	+35
Non-elective admissions		1,238
> 1 day non-elective admissions		806
Same Day Emergency Care (SDEC)		431
Conversion rate (admitted from ED)	30%	30.6%
Mean bed wait: minutes *w/c 28 June*		104

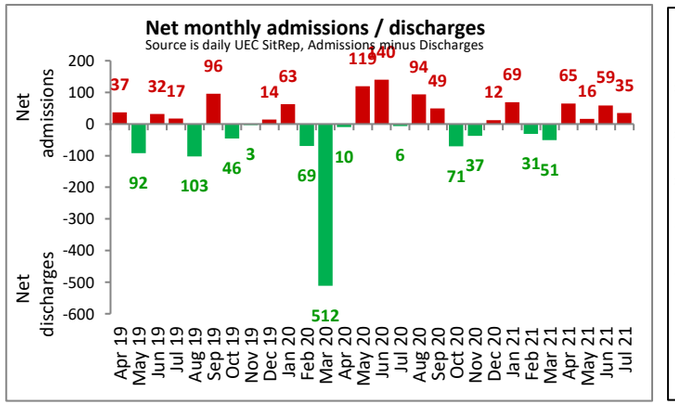
High Level Trust Performance (weekly)

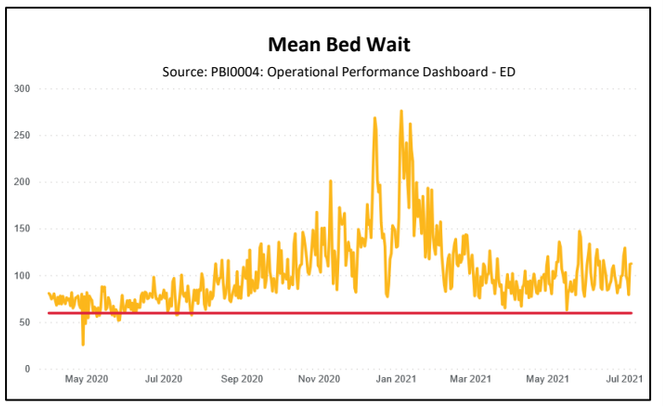












Length of Stay and Discharges

Commentary on high level board position

Patient Flow

The average number of beds per day occupied by patients with a stay greater than 7 days increased in June compared to May, an average of 390 in June vs 374 in May. Bed occupancy for patients with LOS over 21 days has increased, an average of 132 beds in June vs 115 in May.

Whilst occupied beddays for 7/14/21+ day patients remained static overall, we are above the national standards. Discharges on D2A pathways remained similar in June with support from community services, but patients awaiting large packages of care remains an issue for delays. Recognising the pressures and demand moving into Q2, D2A Cluster workshops have developed a revised way of working. In addition, Executive-led system discussions are exploring further solutions to the increased patients with No Reason to Reside.

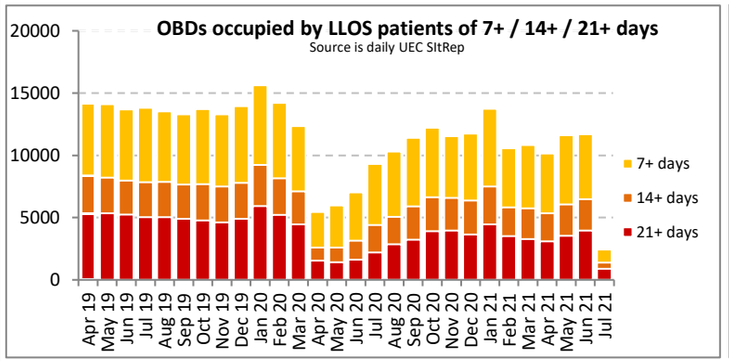
Internal processes account for c32% of the overall number of patients no longer meeting the Criteria to Reside (C2R) in June, this is an improvement on May performance (37%). Improvement in the data completeness has continued (83%) though more work is needed to capture the reason. Phase II of the C2R roll out is being championed by Care Groups to

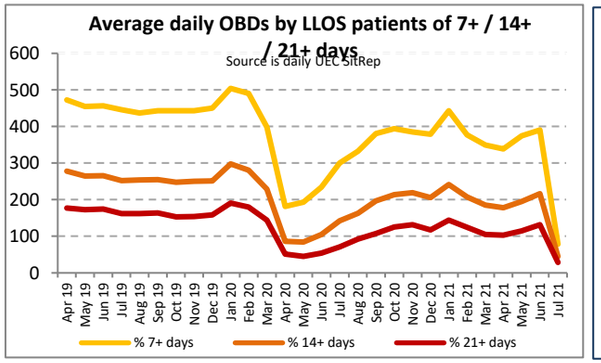
High level Board Performance Indicators & Benchmarking

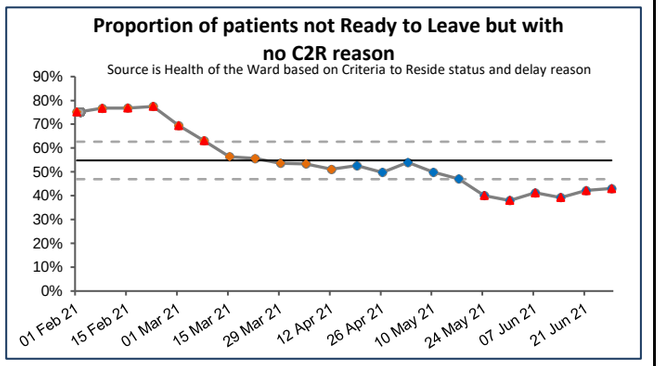
July 2021	Standard		Merged Trust	
Length of Stay and Discharges				
Stranded patients:				
Length of stay 7 days		*42%*	78	*43.5%*
Length of stay 14 days		*21%*	45	*24.8%*
Length of stay 21 days	108	*12%*	29	*15.8%*

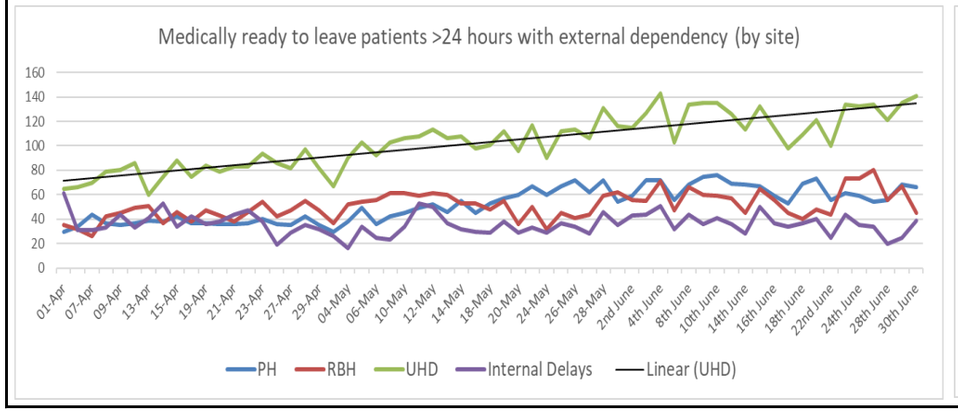
Criteria to Reside (excludes Ready to Leave)	Physiology	5%
	Function	17%
	Treatment	25%
	Recovery	9%
	Not Recorded	44%
Proportion of patients who are Ready to Leave		20%

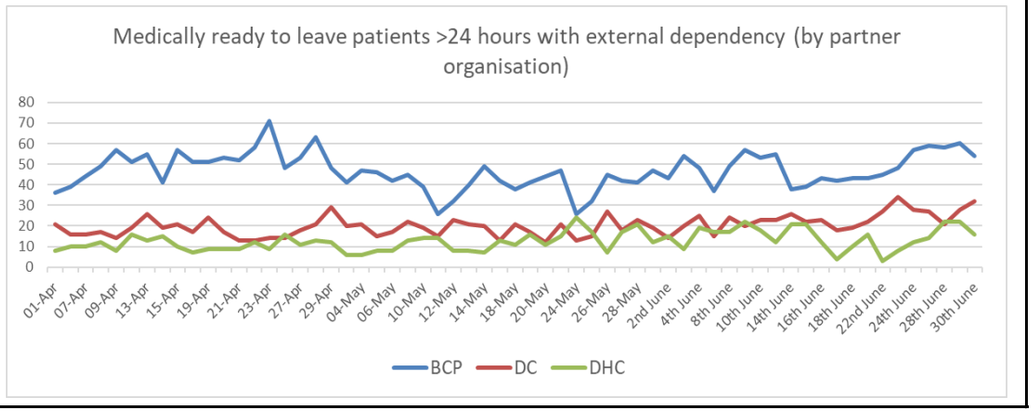
High Level Trust Performance (weekly)











Escalation Report

Jun-21

Trauma Orthopaedics -31.5% 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

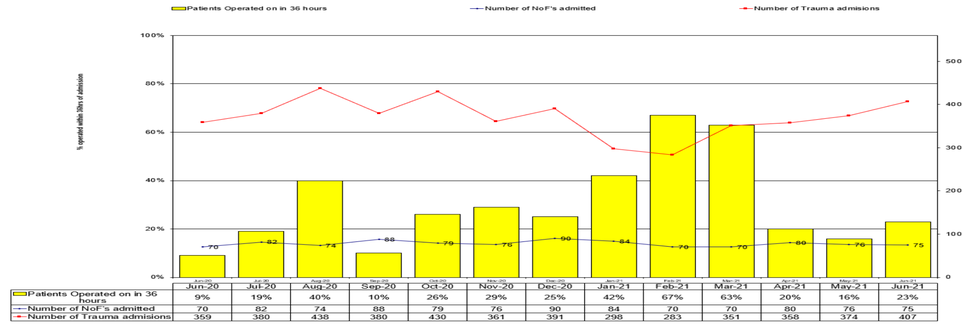
NHFD Best Practice Tariff Target: 85% of fractured neck of femur (NOF) patients to be operated on within 36 hours of admission
June 2021 Compliance: 23%

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)
June 2021 Compliance: 47.2%
Internal Target: 95% of other trauma patients to theatre within 48 hours of admission or being deemed fit for surgery.
June 2021 Compliance: 93%

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	2
Other NoF/trauma patients prioritised	36
Loss of weekend capacity due to theatre staffing	0
Awaiting x-ray/scan availability	1
Required medical review pre-op	1
Patient refused surgery	0
Awaiting specialist surgeon	1
Total breached NoFs	57

Demand on Trauma Directorate during June 2021



	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Patients Operated on in 36 hours	9%	19%	40%	10%	26%	29%	25%	42%	67%	63%	20%	16%	23%
Number of NoF's admitted	70	82	74	88	79	76	90	84	70	70	80	76	75
Number of Trauma admisions	359	380	438	380	430	361	391	298	283	351	358	374	407

Escalation Activity in June 2021

The gradual rise in trauma admissions continues with 407 patients admitted this month, including 75 patients with a fractured NoF. The number of # NoF patients achieving their 36 hour target has increased month due the more steady admission pattern. The majority of NoF's breached their 36 hr target due to other trauma patients or NoF's that had been in longer taking priority. We had several complex cases prioritised on our consultant lists and referrals from clinic with older fractures that required prioritising.

We had 11 patients treated with a THR for their fractured neck of femur this month and as such some patients were delayed as we do not always have a surgeon available who can do a THR. We spent the majority on the month in stage 2 of escalation (greater than 34 patients awaiting surgery) with 3 days in stage 3 (greater than 45 patients waiting)

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 3 additional conultant posts approved at september HEG, 2 in post with a third to join in October.

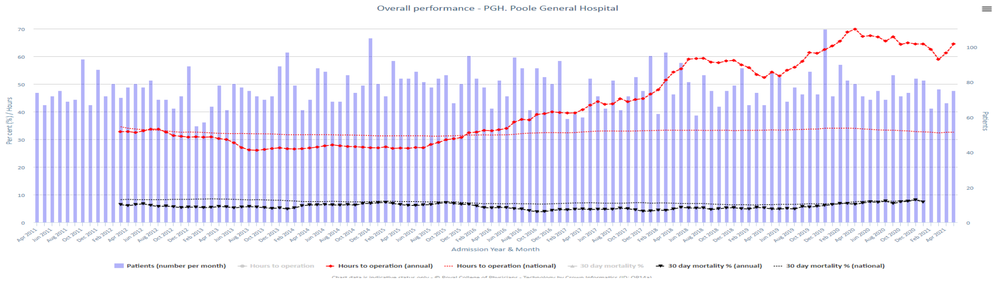
Complexity of Case Load

Soft Tissue	No. of pts
Patients requiring returns to theatre	11
Additional theatre slots required	4
Complex Surgery	No. of pts
Total Hip Replacements for NoFs	11
Revisions carried out	0

11 patients required 2 trips to theatre this month, equating to an additional 11 theatre visits, which is approximately 4 theatre sessions (of multiple trips to theatre) if 3 soft tissue cases are done on a session.

We have lost approximately 57 theatre sessions (a week's worth of operating), this month which includes the third list running at a weekend which has proved to be vital when available and the 3rd session in theatre 4 most Monday, Wednesday and Fridays, though we were given 4 extra sessions

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	Trochanteric fractures (excl. reverse oblique) treated with SHS	Subtrochanteric fractures treated with an IM nail
Poole General Hospital	PGH	921	21.7	8.2	81.6	52.9	18.3	24.4	97.7	26.4	49.0	88.5
Queen Elizabeth Hospital, Edgbaston	QEB	867	59.0	99.8	71.9	0.0	23.2	0.0	57.7	19.6	56.1	87.8
Norfolk and Norwich Hospital	NOR	842	71.6	66.3	71.3	0.0	28.9	0.0	99.1	14.2	72.6	92.3
Leicester Royal Infirmary	LER	821	64.8	68.2	23.3	79.5	77.5	55.7	98.7	19.8	81.7	90.6

June Update on virtual fracture clinic

	2019/20				2020/21			
Month	Referrals	% Triaged to 'Virtual' Management Plan	Number Triaged to 'Virtual' Management Plan	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	1040	51.1%	473
Aug-19	926	38.3	352	Aug-20	1038	47.8%	448
Sep-19	988	41.1	375	Sep-20	1100	49.3%	452
Oct-19	899	39.4	365	Oct-20	934	50.3%	467
Nov-19	924	38.4	355	Nov-20	743	53.2%	478
Dec-19	832	40.2	332	Dec-20	563	55.6%	403
Jan-20	860	40.2	314	Jan-21	518	52.5%	383
Feb-20	889	39	365	Feb-21	852	50.0%	400
Mar-20	716	50.4	361	Mar-21	1117	52.1%	438
Apr-20	484	63.6	308	Apr-21	1039	50.6%	452
May-20	716	55.9	400	May-21	972	43.7%	425
Jun-20	861	50.8	438	Jun-21	1012	44.6%	451

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

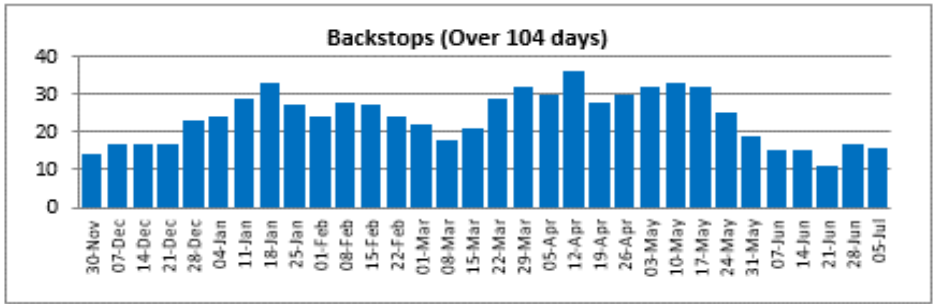
Cancer - Actual May 2021 and Forecast June 2021

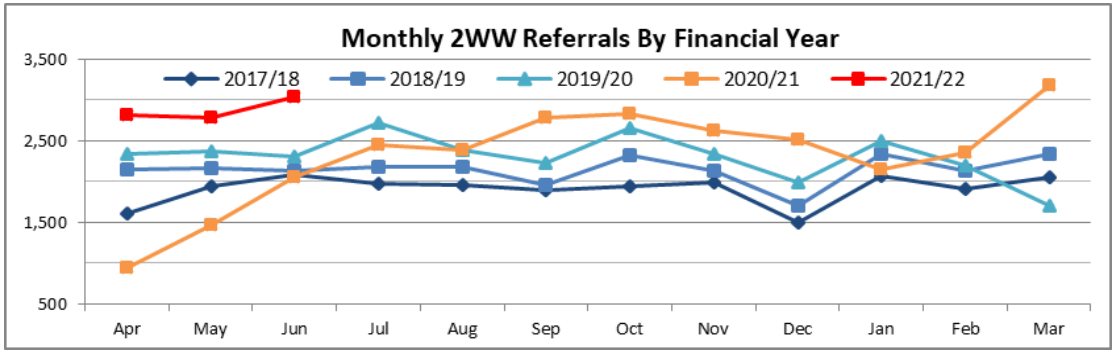
Commentary on high level board position

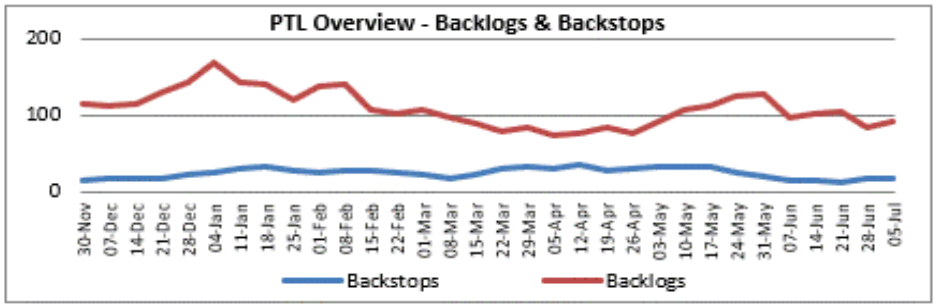
The number of referrals received since March 2021 have exceeded previous months year on year (highlighted on graph in red). The total number on the UHD PTL is above 3000 which is the 15th largest PTL nationally (head & neck is the 4th largest). This increase in referrals continues to challenge all performance standards. However of the 40 trusts with the largest PTL's nationally, UHD have the 3rd lowest % of backstop patients. Within wessex, UHD has the 2nd best performing backstop position at 0.53% (however, for context, UHD PTL is approaching double the size of any other Wessex trust). 28 day FDS has been achieved in April, May and is expected to be achieved at month end in June. Work is ongoing with tumour sites that are still not achieving the 75% threshold. In terms of 62 days UHD continues to perform above the current national average recognising this is still below the threshold. Work with all clinical teams is ongoing to improve performance. Of note the 31 day standard has now been reached for 3 consecutive months.

High level Board Performance Indicators & Benchmarking

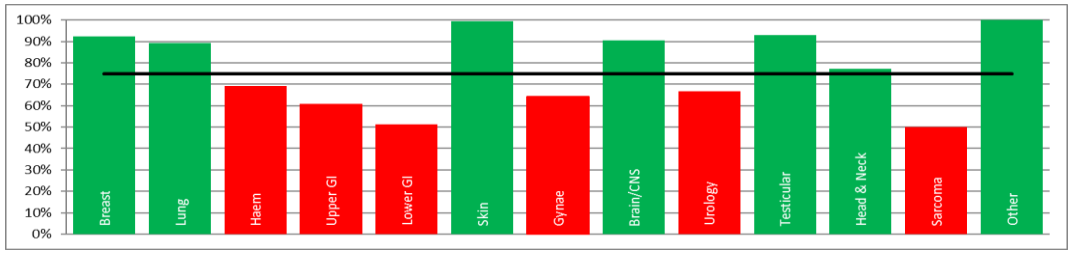
Cancer Standards	Standard	UHD May-21	Predicted Jun-21
31 day standard	96%	97.6%	97.4%
62 day standard	85%	76.9%	78.4%
28 day faster diagnosis standard	75%	77.6%	74.7%



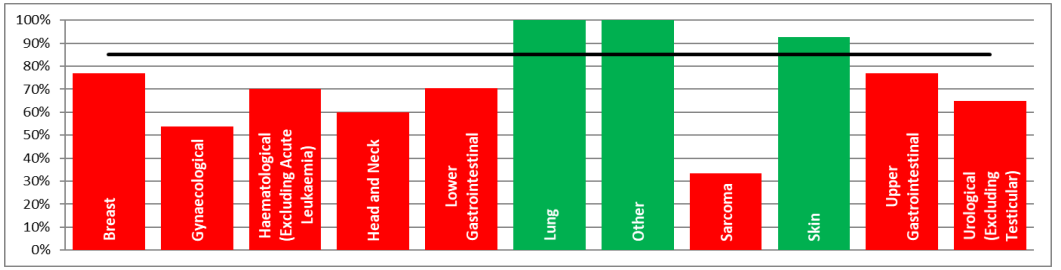


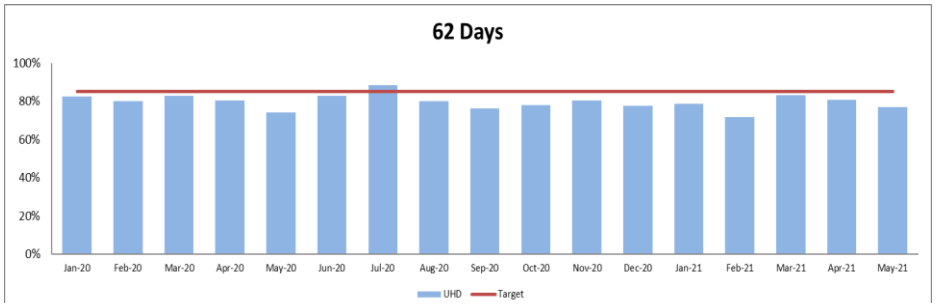


Target 75% | 28 | **UHD: May 2021: 77.6%**



Target 85% | 62 | **UHD: May 2021: 76.9**





Elective & Theatres

Commentary on high level Board position

18 Weeks Referral to Treatment
At the end of June 2021, the Trust's 18 week RTT performance is **65.7%** against the 92% standard an **improvement of 2.5%** compared to May.

- 3,737 patients waited over 52 weeks for treatment, **a reduction of 416** resulting in an improved position of 7.6% (8.5% in May) of the waiting list now over 52 weeks.
- specialty level improvement trajectories are in place and governed by the OPAD programme to ensure delivery of reducing the number of patients waiting > 52 weeks remains on track
- 1,180 patients are waiting over 78 weeks, this is a **reduction of 88** compared to May. 66 patients waiting over 104 weeks, some of the longest waiting patients have chosen to delay their treatment due to the COVID-19 pandemic
- waiting list size has grown due to lost capacity during the response to managing the pandemic and transfer of the routine waiting list/activity from Dorset Healthcare University NHS FT as part of the system recovery plan.

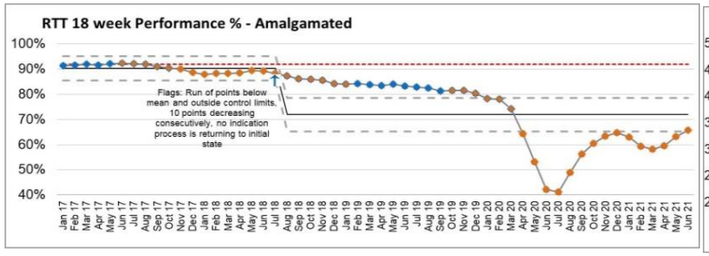
Theatre utilisation
The current theatre utilisation rate is improving slowly as routine elective activity is being restored.

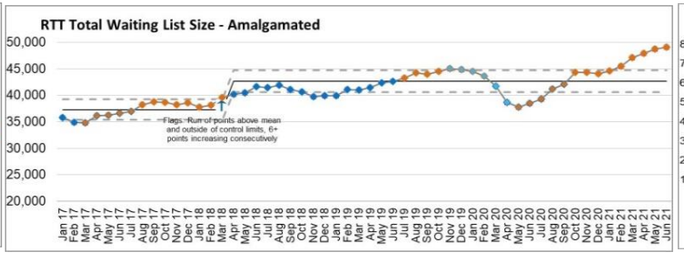
Trauma
23% of NOF patients were treated within 36 hours of admission, an improvement on 16% last month. The number of #NoF patients achieving their 36 hour target has increased this month due the more

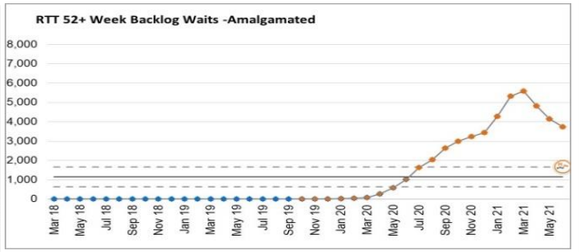
High level Board Performance Indicators & Benchmarking

	Standard	Merged Trust	% of pathways with a DTA
Referral To Treatment			
18 week performance %	92%	65.7%	
Waiting list size	44,508	49,099	26%
Waiting List size variance compared to Jan 20 %	0%	10.3%	
No. patients waiting 26+ weeks		11,972	53%
No. patients waiting 40+ weeks		5,962	63%
No. patients waiting 52+ weeks (and % of waiting list)	7.6%	3,737	70%
No. patients waiting 78+ weeks		1,180	84%
No. patients waiting 104+ weeks		66	36%
Average Wait weeks	8.5	20.1	
Theatre metrics			
Theatre utilisation - main	80%	75%	
Theatre utilisation - DC	85%	61%	
NOFs (Within 36hrs of admission - NHFD)	85%	23%	

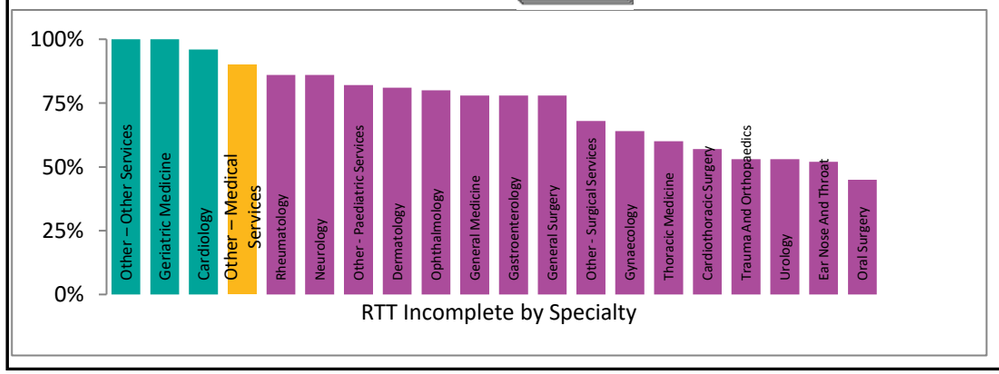
High Level Trust Performance



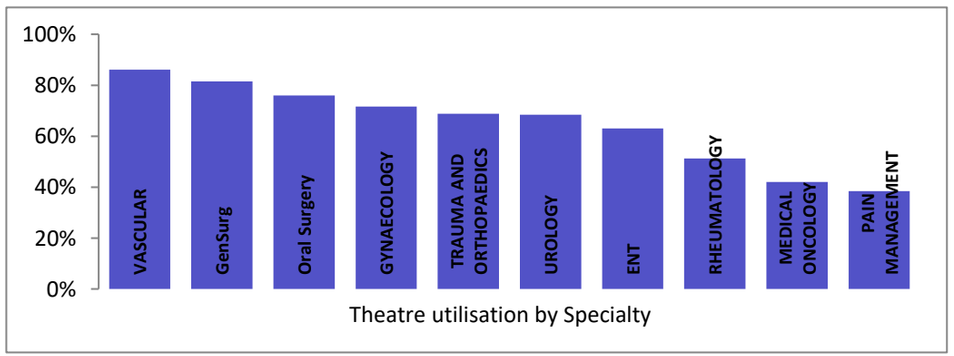




RTT Incomplete 65.7% <18weeks 18 WEEKS **(Last month 63.2%) Target 92%**



Theatre Utilisation 72% **(Last month 71%)**



Referral to Treatment (RTT)

What is driving under performance?

92% of all patient should be seen and treated within 18 weeks of referral.
Performance **65.7%** of all patients were seen and treated within 18 weeks at the close of June 2021.
The overall waiting list (denominator) was **49,099** which is higher than previous months and 9.6% above the January 2020 waiting list of 44,508 (unadjusted for inward transfers).

At the end of June 2021 3,737 patient pathways were reported as having exceeded 52 weeks.

June 2021 (compared with previous month)

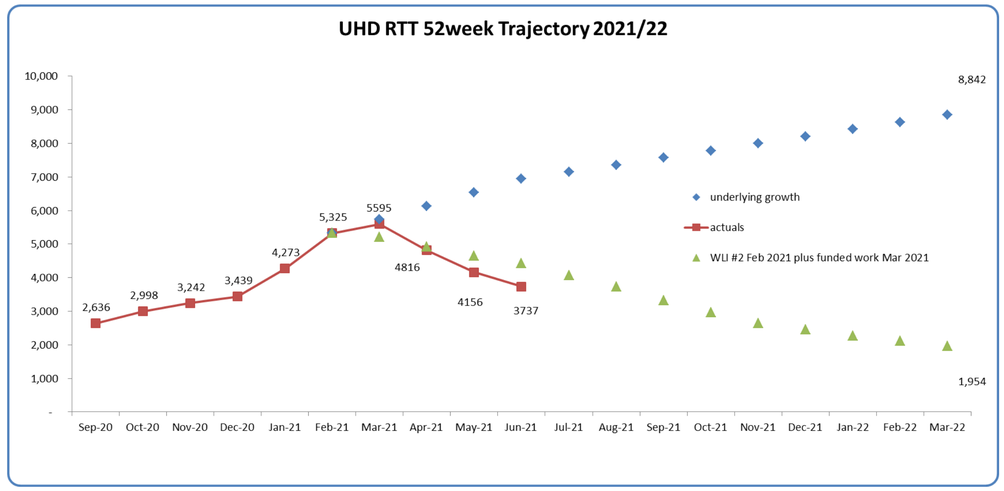
32,244 decrease > 18 weeks
11,792 decrease > 26 weeks
5,962 decrease > 40 weeks
3,737 decrease > 52weeks
1,180 decrease > 78 weeks
66 increase > 104 weeks

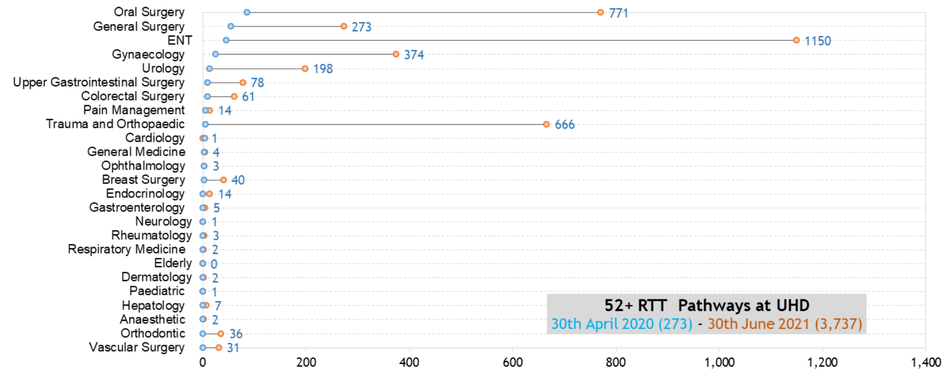
From October 2020 all trusts are required to provide patient level exception reports for all patients waiting > 78 weeks, and a RCA for any patient waiting > 104 weeks.

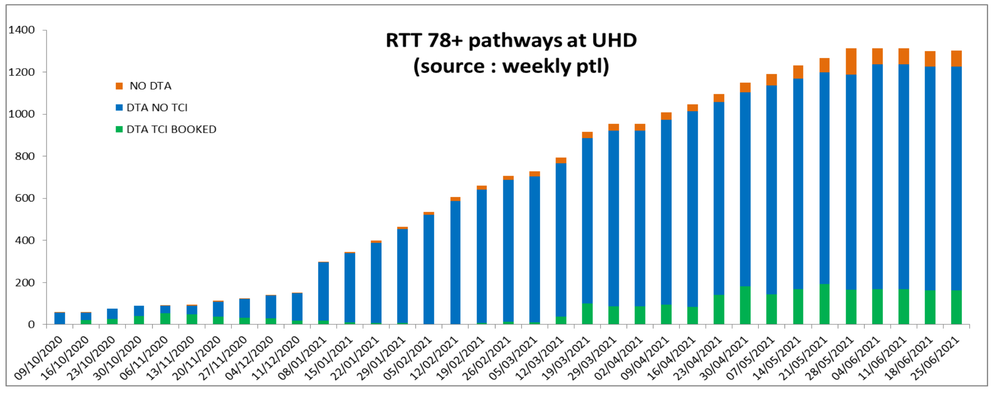
During the Trust response to managing the COVID-19 pandemic the priority was to undertake essential emergency/urgent services whilst adhering to national guidelines on social/physical distancing, shielding and self isolation. This led to a significant reduction in routine elective activity including out patient appointments and surgical procedures.

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 -19 pandemic leading to many patients being deferred for both outpatient appointments and routine elective surgery
- Patients choosing not to attend hospital due to concerns about COVID-19, many patients choosing to wait until the pandemic is over or they have been vaccinated.
- National requirements regarding testing, PPE and infection control processes restrict a full recovery of activity in many specialties.
- Clinical prioritisation of urgent and cancer pathways during period of reduced capacity / activity
- Workforce were redeployed to support the response to managing COVID-19, notably many theatre staff and clinicians were redeployed to support critical care
- Lack of capacity to book routine elective patients for treatment as shown by the number of patients waiting a TCI date in the RTT > 78 week chart.







What actions have been taken to improve performance ?

An Operational Performance, Assurance and Delivery (OPAD) programme was launched in October 2020 to oversee improvements in performance, activity and reducing the number of patients waiting a long time for treatment.

The OPAD programme accounts to the Chief Operating Officer through the Trust Operational and Performance Group.

The OPAD programme has several workstreams to support contiguous improvements with the main programmes of work being:

- Validation & clinical prioritisation of all waiting lists commenced in April; active FU Op and Planned PTLs
- Single PAS project to support merging teams to manage single UHD waiting lists
- Think Big Outpatient recovery at scale working across the Dorset ICS system
- 52/78 ww Trajectory planning to manage /monitor improvements
- Demand & Capacity planning
- Specialty PTL Reviews and action plans, focus on > 78 ww plans
- Access Policy and SOP review to include retraining of all staff in RTT processes
- Improving BI reports to support and monitor improvement
- Patient Pathway Coordination
- Review of admission processes and governance
- Operational Planning
- Supporting Dorset ICS with single PTLs and taking on activity from other providers e.g. transfer of DHUFT routine activity and wait list
- Health Inequalities and Elective Recovery programme

Care Groups are leading on speciality level improvement plans:

- Theatre Utilisation Group established across UHD
- Outpatient Transformation Programme (Dorset ICS)
- Creating additional capacity using local ISP providers and / or Insourcing companies
- Reviewing clinical and ICP guidance to ensure effective use of sessions
- Maximising potential and harmonising capacity across all sites

Health Inequalities
National planning guidance requires Health Inequalities to be a key gateway for access to the Elective Recovery Fund, this is being led by a sub group of Dorset ICS Elective Care Oversight Group to develop a system-wide approach to understanding and responding to health inequalities associated with elective and UEC recovery. The Dorset Information and Intelligence Service's (DiiS) population health database provides access to interactive and filterable analytics of our activity and waiting lists by a number of metrics including deprivation, as well as other vulnerabilities including risk of social isolation, unhealthy behaviours and active safeguarding flags. This system-wide programme involves partnering with Optum to undertake analytics of the data and generate insights which will be shared with the Trust over the summer. These insights will then be used to design interventions with clinicians that respond to the inequalities evident through the data insights.

Executive Lead Mark Mould | Trustwide Lead | Author Jacqueline Coles

Outpatients & Diagnostics

Commentary on high level board position

Outpatients

- DNA rates have stabilised; however patient cancellation rates remain high, some feedback that patients are more cautious about attending face to face appointments
- Non Face-to-Face attendances - drop of 2.8% compared to May 2021, but still remains comfortably above the national standard of 25%, telephone and video consultations are also helping to stabilise the DNA rate.

Diagnostics

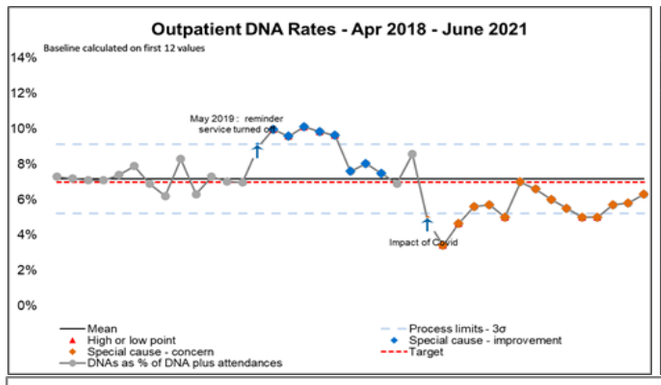
- Increase against May from 97.4% to 98.2% of all diagnostics tests required within 6 weeks
- Radiology continue to use ISPs for additional MRI, CT and Ultrasound capacity
- Endoscopy position has improved from 87.1% in May to 91.4% in June
- Echocardiography has improved from 97.0% to 98.6% in June
- Neurophysiology has improved from 96.8% in May to 98.9% in June

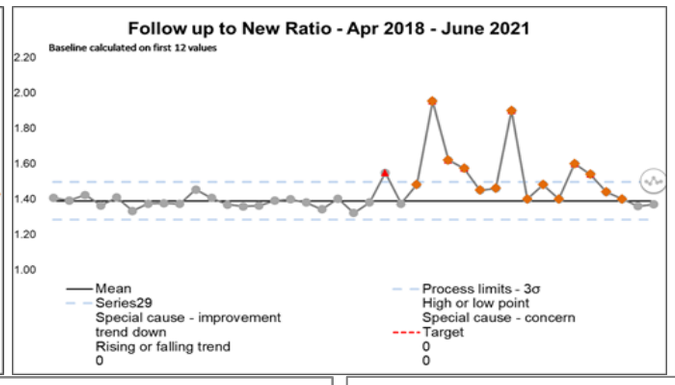
- In endoscopy, increase in fast track demand is displacing routine capacity. Additional work has been planned in July and August to try and offset the impact of essential scheduled ventilation work.
- Additional flexible cystoscopy lists have been undertaken throughout Q1, this has enabled recovery of the waiting list. Impact expected in July data. Demand is being managed.

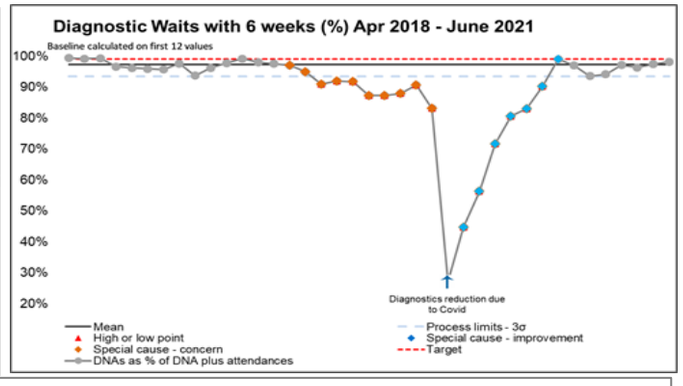
High level Board Performance Indicators & Benchmarking

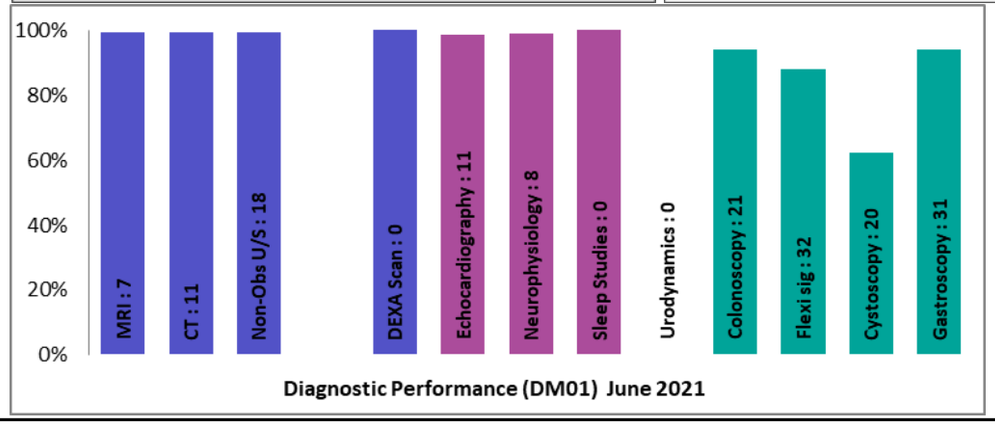
		Standard	Values	Merged Trust
Referral Rates				
GP Referral Rate year on year	*(values 20/21 v 21/22)*	-0.5%	13987 / 31790	127.3%
	(values 19/20 v 21/22)		34797 / 31790	-8.6%
Total Referrals Rate year on year	*(values 20/21 v 21/22)*	-0.5%	25931 / 57184	120.5%
	(values 19/20 v 21/22)		59479 / 57184	-3.9%
Outpatient metrics				
Overdue Follow Up Appointments				15,330
Follow-Up Ratio		1.91		1.37
% DNA Rate	*(New & Flup Atts / Total DNAs)*	5%	34697 / 2341	6.3%
Patient cancellation rate	*(New & Flup Atts / Total Pat Canx)*		34697 / 4068	10.5%
reduction in face to face attendances				
% telemed/video attendances	*(Total Atts / Total Non F-F)*	25%	34697 / 10857	31.3%
Diagnostic Performance (DM01)				
% of <6 week performance	*(Total / 6+ Weeks)*	1%	8887 / 159	1.8%

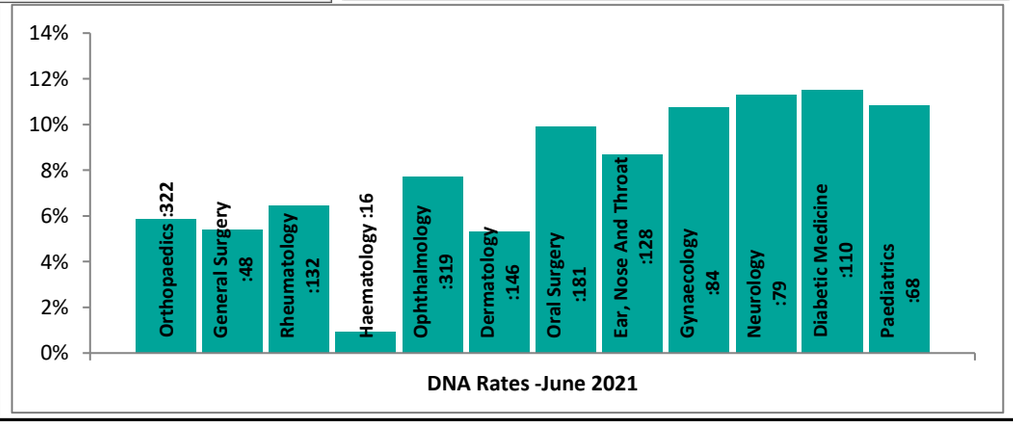
High Level Trust Performance











SCREENING PROGRAMMES

Commentary on High Level Board Position

Bowel Cancer Screening

Invitation Backlog Recovery

The programme is the first in the South West to recover the invitation backlog to within the programme standard. As a result of maintaining an increased invitation rate since October 2020, the 'delayed an invitation' backlog has steadily reduced. The programme is currently at 0 weeks for invitations (the programme standard is +/- 6 weeks), which means invitations are being sent to screening subjects on their due date.

The remaining risk for the programme comes from the high numbers in the 'invited not screened' group who have not yet engaged in their screening offer. However, that group of subjects is slowly starting to reduce and in the last month has dropped by 1200 subjects to 20,124.

Age Extension

As the programme has successfully achieved invitation recovery, age extension rolled out as planned at the end of May 2021, starting with 56 year olds. There were only six programmes nationally launching age extension at this time.

Key Performance Standards

*** Uptake Standard** (*Number of subjects aged 60 to 74 who adequately participated in screening within 6 months of the invitation):*

The uptake rate has averaged 75% since July 2020 (acceptable performance = >52%; achievable performance = >60%).

*** SSP Clinic Wait Standard** (*Proportion of patients with an abnormal FIT result offered an appointment with a Specialist Screening Practitioner (SSP) within 14 days):*

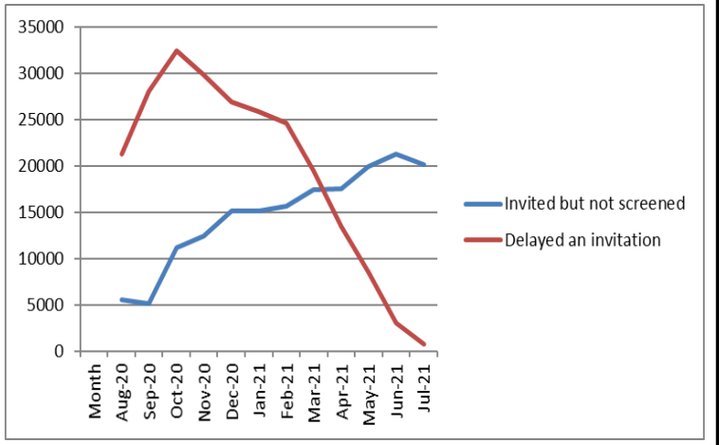
The clinic wait standard has been maintained at 100% (acceptable performance = 95%; achievable performance = 98%) for the last year via virtual clinics.

*** Diagnostic Wait Standard** *(Proportion of patients with an abnormal FIT result whose first offered diagnostic test date falls within 14 days of their SSP appointment)***:**

The diagnostic wait standard has been above 90% since August 2020 (acceptable performance = 90%; achievable performance = 95%).

The diagnostic wait standard is the key performance measure at risk if the programme has an influx of screening subjects from the 'invited not screened' backlog . To mitigate this, there is additional capacity available via the PHE funded insourcing weekends at the Poole site and lis ts in the mobile unit at the Bournemouth site.

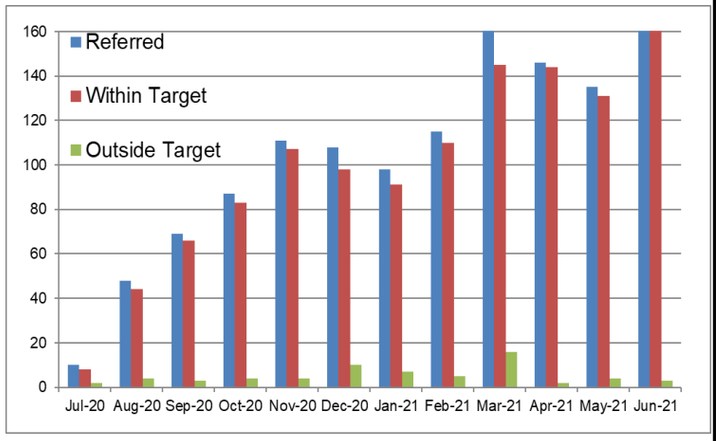
High Level Board Recovery Indicators



High Level Board Performance Indicators

Bowel Screening Standard	Target	Trust June Performance
SSP Clinic Wait Standard (14 days)	95%	100%
Diagnostic Wait Standard (14 days)	90%	98%

Diagnostic Wait Standard



SCREENING PROGRAMMES

Commentary on high level board position

Breast Screening
There is a recovery plan in place with a trajectory to meet the PHE deadline of March 2022.

Recovery has been planned around installation of new equipment. Static Unit (Room 1) equipment has now been installed. LBU replacement is underway.
Additional mammography screening equipment has been purchased and is in storage, pending installation for the THINK BIG project.
The recovery round length plan has been revised to include THINK BIG. Plan to call in the Bournemouth GP practices to this clinic, with the exception of one of the bigger practices which will continue to be screened on the Bournemouth van. The Bournemouth van will be utilised as a training van with longer appointment times (20 minutes) to aid recovery by March 2022 and future workforce capacity.
All other vans are now running at appointment times of 7.5 minutes. Vans are now situated in Ferndown, and Lyme Regis. The van at Lyme Regis will be moving to Swanage earlier than anticipated as the service is managing the numbers of screens quicker than originally anticipated. Potential issues with van Weymouth Hospital site. WCH Locality Manager has requested an earlier move date from Weymouth site. ASDA site in Weymouth is being considered and service is in early negotiations.
A business case has been submitted for both breast radiologists and mammographers , the recruitment to these posts is essential for recovery.
Recovery **could** be achieved by March 2022 (PHE target date). This is dependent on investment, extra staffing and no further peaks of Covid. The current plan commenced on April 1st to achieve the target however,

High level Board Performance Indicators & Benchmarking

Breast Screening	Standard	Merged Trust
Screening to Normal Results within 14 days	95.00%	99.00%
Screening to first offered assessment appointment within 3 weeks	95.00%	100.00%
Round Length within 36 months	90.00%	7.33%
Longest Wait time (Months)	36	48

Maternity

Commentary

Maternity incentive scheme submission made in July - all 10 safety actions achieved.

Training for Prompt reported and above 90% threshold.

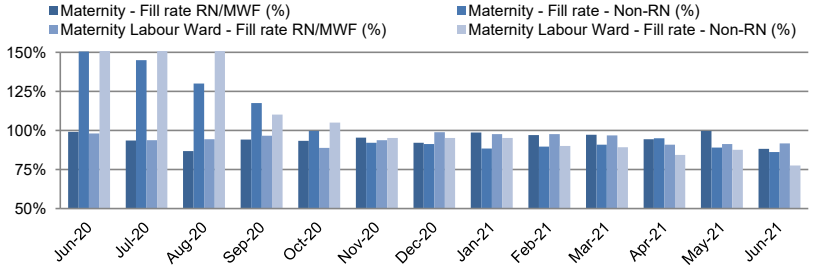
Obstetric workforce challenges have continued but were mitigated by the senior obstetric team.

The maternity team have been notified of our funding from the Ockenden bid and this will now be reviewed to prioritize workforce gaps and identify the shortfall in funding.

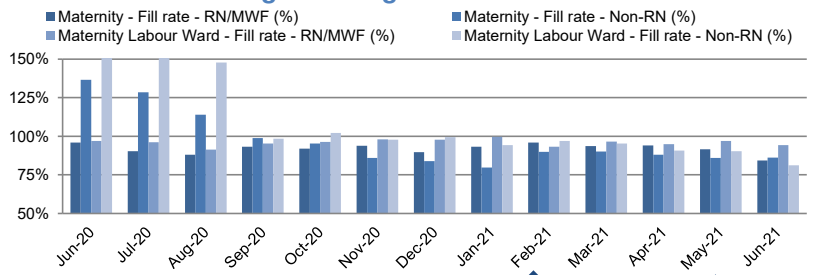
CQC Maternity Ratings	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Good	Requires Improvement	Good	Outstanding	Good	Outstanding

Screening Incidences			0
Serious Incidents Reported			0
HSIB Cases Reported			0
HSIB / NHSR /CQC Concerns			No
Coroner Reg 28			No
Maternity Safety Support Programme			No
FFT Maternity User Response		Number	%
	Good / Very Good	284	94%
	Poor / Very Poor	11	4%
	Neither	8	3%

Day average staff fill rate



Night average staff fill rate



Obstetric cover on Delivery Suite (Total shift gaps)

Day	May-21	Consultant	7	Registrar	17.5	SHO	5
Night	May-21	Consultant	2	Registrar	12.25	SHO	3

Latest Maternity Staff Survey 2019 responses

Proportion of midwives responding with 'Agree or Strongly Agree'

	Community Midwifery Team	Maternity clerical and secretarial team	Labour Ward	Maternity management and lead midwives	Post Natal & TCU	ANDA/Antenatal Clinic
21c) I would recommend my organisation as a place to work	71%	64%	70%	83%	93%	70%
21d) If a friend or relative needed treatment I would be happy with the standard of care provided by the organisation.	93%	91%	93%	92%	93%	75%

Clinical Supervision

Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours. (Reported Annually)

	Obstetric & Gynaecology
RBCH	89.06%
POOLE	87.5%

Training Compliance PROMPT June 2021

	Number Compliant April 2020 to date	Number of Staff @ May 2021	Percentage Compliant
Midwives Band 5	18	18	100%
Midwives Band 6	173	173	100%
Midwives Band 7	30	30	100%
Midwiifery Managers, Matrons &Other Band 8+	7	7	100%
Consultant Obstetricians	17	17	100%
Obstetric Trainees (Doctors)	25	25	100%
Obstetric Anaesthetics	27	27	100%%
HCAs/MCAs/MSWs	77	78	98.72%
ODP	13	13	100%

Maternity

Severe Incidents / HSIB

0 severe incidents on Datix

0 HSIB

0 Screening incidences

Perinatal Mortuary Review Panel

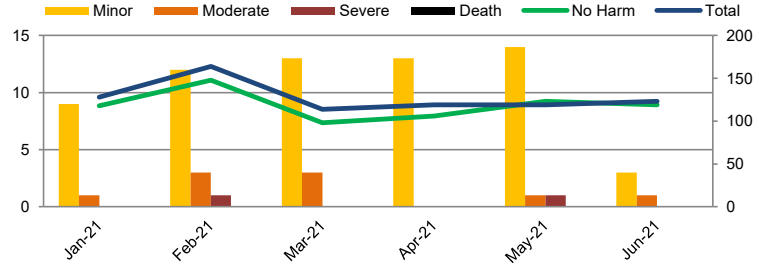
Perinatal Mortality Review panel 24th June 2021

1x case presented - UHD:
1x Stillbirth 32+1

2nd review of 1x case - UHD:
1x NND age 3 days

Summary of learning from cases:
Education to medical staff to have gold standard of care when confirming IUD to inform consultant as soon as possible (including out of hours).

Datix Incidents



No Harm	118	148	98	106	123	119
Minor	9	12	13	13	14	3
Moderate	1	3	3	0	1	1
Severe	0	1	0	0	1	0
Death	0	0	0	0	0	0
Total	128	164	114	119	119	123

Screening Incidents = 0

FINANCE

Commentary

The Trust has set a financial break-even budget for the first half of the year (to 30 September) supported by the continuation of national top-up funding and funding to cover specific COVID costs. However, the Trust has set an indicative budget for the second half of the year based upon the previous funding regime and Long Term Plan allocations. This represents a budget deficit of £32.3 million albeit this will be revisited following receipt of the planning guidance and associated allocations for the second half of the year, which is expected within the coming months.

The national planning framework includes an Elective Recovery Fund (ERF) to support the necessary increases in capacity to see and treat those patients still awaiting planned care. The Trusts budget does not include the cost of this recovery and does not include the associated income from the Elective Recovery Fund. This will be reported within the monthly financial position as a variance against both expenditure and income budgets.

At the end of June, the Trust is reporting a consolidated deficit of £128,000 being a favourable variance of £17,000. This reflects the fact that ongoing COVID-19 costs are below the budgeted levels. Additional expenditure of £3.918 million has been incurred in the Trusts elective recovery programme and, pending national validation, income has been assumed from the Elective Recovery Fund to off-set this in full.

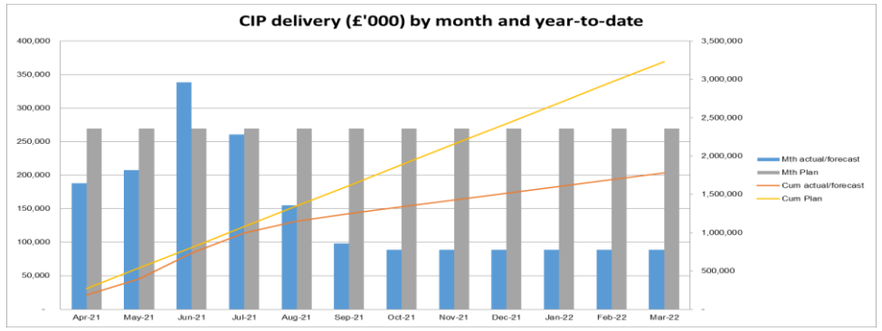
The Surgical Care Group is £186,000 behind plan as at 30 June, mainly due to additional medical staffing costs, partially offset by reduced activity particularly prosthetic in Orthopaedics, . The Medical Care Group is £51,000 ahead of plan, mainly due to an over acheivement in cardic private patient income, with the Specialties Care Group ahead of plan by £418,000 principally due to vacancies within Pathology and Pharmacy.

As at June the Trust is forecasting delivery of £1.778 million CIP of which 59% is non-recurrent. All of the identified CIP is Green rated and therefore considered highly likely to deliver. This would leave a recurrent shortfall of £2.501 million at the end of the year. As such the Trust is looking to escalate the programme into recovery with increased monitoring and support provided.

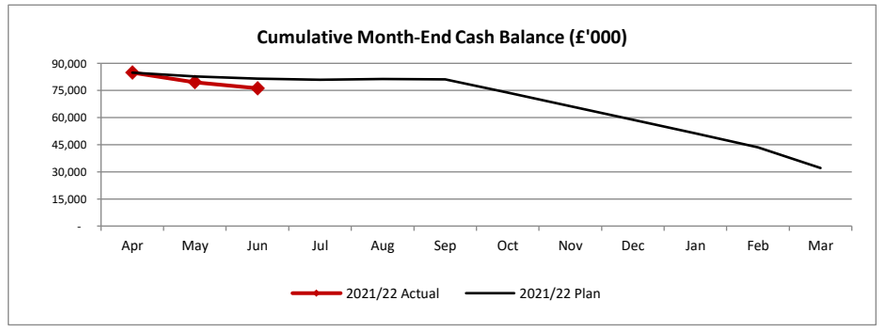
The Trust has set a very challenging capital programme for the year, with many priority schemes deferred due to the restrictive capital allocation for the Dorset Integrated Care System. This presents a considerable risk for the Trust and will require very careful management throughout the year. As at 30 June capital spend is £7.027 million, being £1.738 million above plan. This overspend relates to the phasing of the capital programme and will be closely monitored.

The Trust is currently holding a consolidated cash balance of £76.2 million, which is fully committed in support of the medium-term strategic reconfiguration programme.

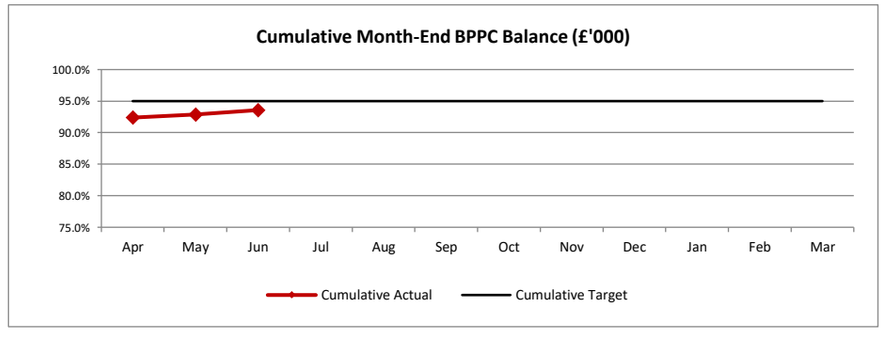
FINANCIAL INDICATORS	Year to date			Forecast
	Budget *£'000*	Actual *£'000*	Variance *£'000*	Variance *£'000*
Control Total Surplus/ (Deficit)	(145)	(128)	17	(0)
Capital Programme	5,289	7,027	(1,738)	0
Closing Cash Balance	81,602	76,195	(5,407)	0
Public Sector Payment Policy	95%	94%	-1%	0



REVENUE	Year to date		
	Budget *£'000*	Actual *£'000*	Variance *£'000*
Surgical	(32,232)	(32,418)	(186)
Medical	(40,479)	(40,428)	51
Specialties	(41,278)	(40,861)	418
Operations	(5,795)	(5,731)	65
Corporate	(13,474)	(13,386)	88
Trust-wide	132,799	132,528	(271)
Surplus/ (Deficit)	(460)	(296)	164
Consolidated Entities	75	118	43
Surplus/ (Deficit) after consolidation	(385)	(177)	208
Other Adjustments	240	49	(191)
Control Total Surplus/ (Deficit)	(145)	(128)	17



CAPITAL	Year to date		
	Budget *£'000*	Actual *£'000*	Variance *£'000*
Estates	2,197	3,926	(1,729)
IT	120	775	(655)
Medical Equipment	150	628	(478)
Strategic Capital	2,821	1,698	1,123
Total	5,289	7,027	(1,738)

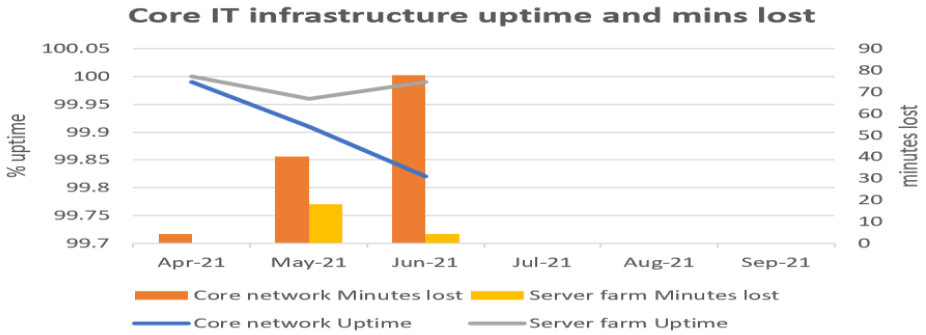


Informatics

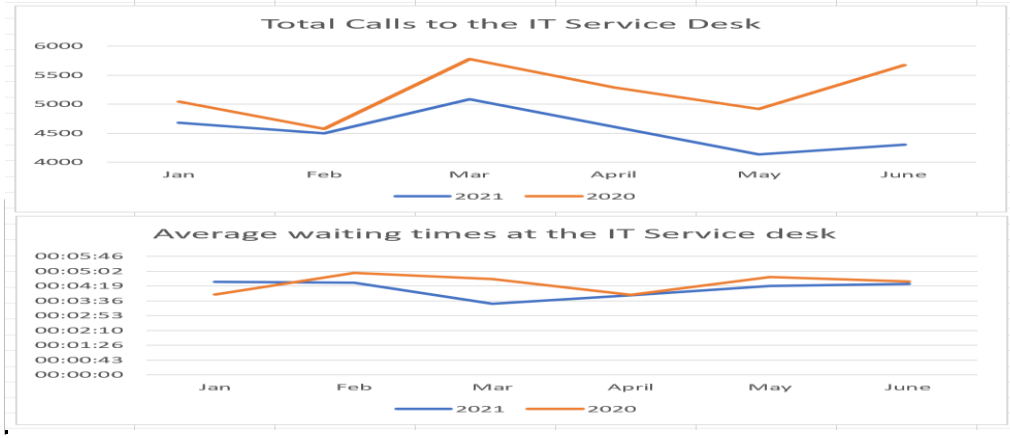
Overall Commentary: There are ongoing resource issues and challenges within Informatics to deliver the BAU service, the normal workload of IT projects and for this year there is increased organisational pressure coming into Informatics, e.g. CSR work, the move off site to Discovery court for Outpatients, the Yeomans way off site setup, the setup of community sites, the Think Big setup and accelerated move to paperless clinics. We need to develop more sophisticated Organisational Programme Management that takes into account that the number of projects that impact the same team in the same timeline.
Graph 1: At the beginning of June UHD suffered network outages adding to about 80 minutes of lost time, primarily for the RBH site relating to our externally provided inter-site links. PH suffered an Air Conditioning failure in one of the computer rooms on 15 June which primarily affected pathology services. Other outages were avoided in June as a result of the skilful planning and dedicated work of the IT infrastructure team. lead by Robin Lack with support from Bob Down while the CSR ground works were being carried out. **Graph 2.1, 2.2** the number of calls to the IT Service Desk has been successfully reduced compared to 2020 levels with the use of the online self-service IT portal for logging incidents and service requests but the call waiting times remain high indicating increased complexity. **Tables 3 and 4.** Project highlights: UHD staff accessed c.18,700 records in Dorset Care Record in June (an increase of c.5,800 from May). There are now 1400 users of Single Sign On. The Electronic Prescribing team are targeting a go live of Oct 2021 for RBH Inpatients. **Table 5** shows the number of systems (PCs, Servers) running unsupported software - we aim to mitigate all these systems by 31 Dec 2021. **Table 6** show the status of our Information Assets and how many have provided assurance of being fully managed as per the Data Security and Protection Toolkit - deadline for completion of this work is 31.12.21. **Table 7** shows our FOI compliance.

Business As Usual/Service Management

Graph 1: core Infrastructure availability



Graph 2.1 and 2.2 : Service Desk demand and average waiting time



Projects/Developments/Security/IG

Table 3: flow of Informatics projects since Nov 2018. c 150 closed projects per year.

Informatics Projects since November 2018						
Project Type	**Pending Approval**	**Not Started**	**Deferred**	**In Progress**	**Completed**	**Total**
eForm/Automation Project	0	16	11	42	146	215
Infrastructure Mandatory	0	23	0	5	3	31
Projects	4	53	17	95	243	408
Service Improvement Projects	0	0	0	0	3	3
Grand Totals	**4**	**92**	**28**	**142**	**395**	**657**

Table 4: Priority of current Informatics projects

	Escalated	Project Risk Score (risk of not doing it)												
Project status	**25**	**20**	**16**	**15**	**12**	**10**	**9**	**8**	**6**	**4**	**2**	**1**	**0**	**Grand Total**
In Progress	35	16	22	4	22	3	14	4	3	6	2	1	9	141
Not Started	5	11	19	4	25	1	6	2		3	1		15	92
Grand Total	**40**	**27**	**41**	**8**	**47**	**4**	**20**	**6**	**3**	**9**	**3**	**1**	**24**	**233**

Table 5: Cyber Security - Obsolete systems

	# Supported	% Supported	# Obsolete	% Obsolete	% Mitigated
Windows Devices	7504	96.2	296	3.8	0
Windows Servers	387	64.3	215	35.7	0

Table 6: Information Assets

	Information Assets by Entry Status		
	Draft Only	**Under Review**	**Fully Complete**
CG A	14	11	0
CG B	67	16	0
CG C	58	41	0
Corp	71	55	0
TBC	14	1	0
Total	**224**	**124**	**0**

Table 7: FOI compliance

	March	**April**	**May**	**June**	**Total**	**%**
Total Received	**52**	**85**	**62**	**68**	**267**	
In time	27	50	34	36	147	**55%**
Breach	22	22	13		57	**21%**
Outstanding	3	13	15	32	63	**24%**

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 28 July 2021

Agenda item: 8.1

Subject:	Annual Operating Plan 2021-2022

Prepared by:	Sandy Edington, Associate Director of Service Development Judith May, Associate Director of Operational Performance and Delivery
Presented by:	Mark Mould, Chief Operating Officer

Purpose of paper:	For discussion
Background:	This document is the UHD Operational Plan for 2021/22. It is anticipated that it may be updated in year. Appendix A Several drafts of the document have been presented at the Board in May and June and the comments received have been incorporated into this updated version.
Key points for Board members:	The narrative complements the agreements made within the Dorset ICS and more widely, regarding finance, activity and workforce numbers for 2021/22. It is intended that once approved this document will be developed into a designed version by the Communications team.
Options and decisions required:	For discussion
Recommendations:	The Board is asked to discuss the plan
Next steps:	Care Group / Directorate plans on a page to support the organisational operational plan

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	Supports the organisations strategic objectives
BAF/Corporate Risk Register: (if applicable)	1492-Resourcing pressures-staffing, 1584,1585 – Financial Control Total 21/22, 1074, 1386,1460,1131, 1387 – Flow and capacity
CQC Reference:	All domains

Committees/Meetings at which the paper has been submitted:	**Date**
Trust Management Group	18/5/21
Trust Board	26/5/21

University Hospitals Dorset
NHS Foundation Trust

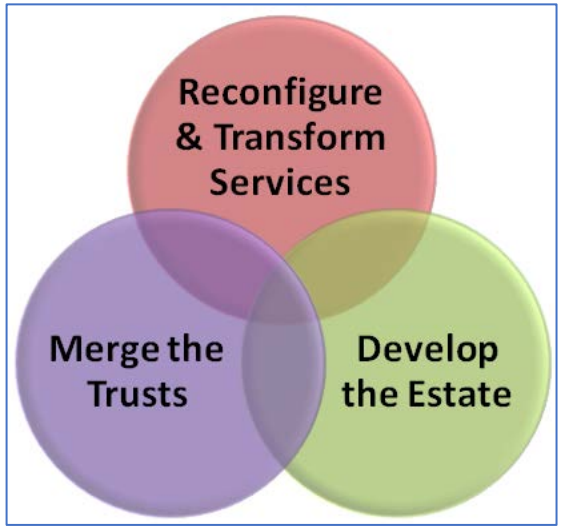
2021/22 Operational Plan: University Hospitals Dorset NHS Foundation Trust

July 2021

Final Version 1

1. Introduction

The key plans for University Hospital Dorset in 2021/22 are reflected in the model alongside and encompass the high level of change affecting the NHS, in particular arising from COVID, the need to plan for further surges and the need to recover our capacity as soon as possible.



Alongside this, the recent merger of Poole Hospital NHS FT and Royal Bournemouth and Christchurch NHS FT provides us with a generational opportunity to create or transform services on a larger scale with the potential to increase effeciencies and improve processes more radically. We are keen to take the best of both hospitals and “level up” so that UHD as an organisation is able to improve the services for local people even further.

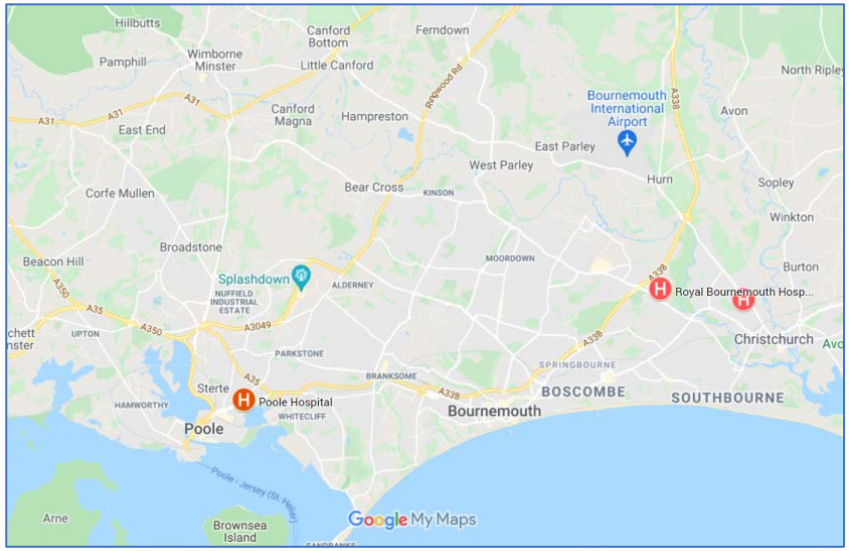
A key enabler for this is the capital development programme now underway, whereby the services on both sites will be physically transformed via our £147m estates programme, into state of the art facilities, fit for the 2nd decade of the 21st century and beyond.

All the planning assumptions used throughout this document are based on best intelligence as at 1st July 2021. As part of our active planning and management these are regularly reviewed and updated throughout the year.

Overview of the Trust

University Hospitals Dorset NHS Foundation Trust (UHD) was formed in October 2020 with the merger of Poole Hospital NHS FT and Royal Bournemouth and Christchurch Hospitals NHS FT and is situated in the east side of the county of Dorset.

The Trust has an annual turnover of £650m and employs over 9000 staff across 3 sites – Poole Hospital (PH), Royal Bournemouth Hospital (RBH) and Christchurch Hospital (XCH).



The Trust's services include the major medical and surgical specialties, routine and specialist diagnostic services and other clinical support services and deliver the following annual activity:

- 194,000 ED attendances
- 81,000 emergency admissions
- 83,000 daycase treatment
- 12,000 planned admissions
- 650,000 outpatient attendances
- Over 4000 births

We also operate urgent primary care services from the PH & RBH sites.

These services are provided primarily to a catchment population of approximately 500,000 in the East Dorset area.

Trust Vision, Mission and Values

As a newly merged organisation, the Trust has developed a new set of values together with a Vision and Mission, shown as follows:

Alongside this we have developed 5 strategic objectives which underpin this and future plans, including the annual objectives for 2021/22, which are at Appendix A. The strategic objectives are:

Key Clinical Activities in 2021/22:

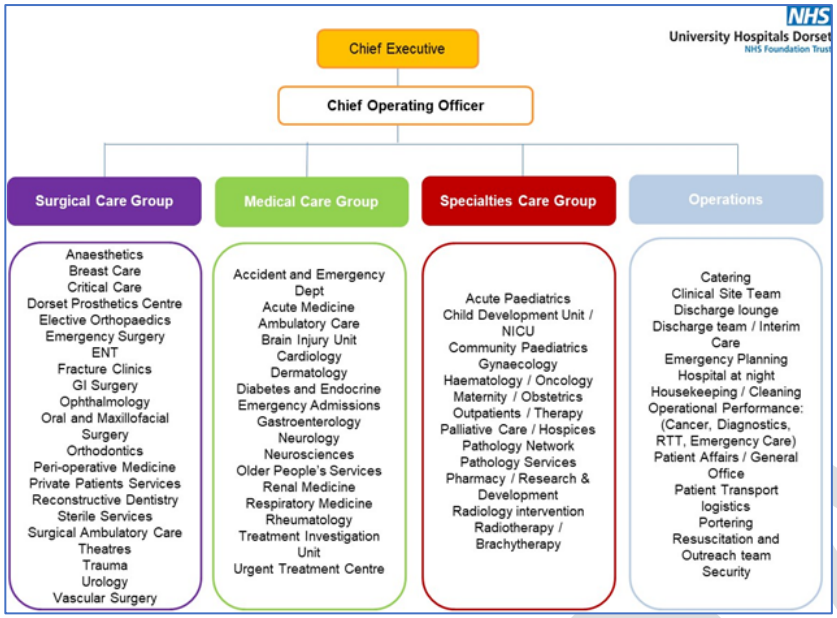
- Integrate current site based clinical teams, medical and nursing, into single UHD teams
- Continuing to work towards an ambitious strategy and transformation projects, in line with CSR
- Remain responsive to any future surges of COVID-19 to ensure rapid availability of clinical capacity and appropriate workforce
- Streamline front door Emergency Care services by further integration of minor injury and illness presentations with Primary Care Partners
- Deliver booked appointments in our Emergency Departments and Same Day Emergency Care (SEDC) services directly from NHS111
- Progress the acute East Dorset Cardiology pathway to ensure all patients requiring access to the laboratory suites at the RBH site are taken there directly
- Review the UHD stroke pathway and plan to move the full service to a single site ahead of 2026
- Implementation of the Trauma and Orthopaedic Ambulatory Care Unit within the Emergency Department at Poole Hospital to support reduced length of stay and timely review and decision making
- Sustain recovery of elective and diagnostic services across all specialties
- Involvement in the ‘Think Big Programme’ to establish the delivery of a high flow clinical assessment facility in a safe, clinical operating environment
- Partnership working with insourcing companies and the Independent Sector Providers to increase capacity and reduce long waits across the surgical services
- Continue to support and develop services in the wider healthcare system, including Dorset Healthcare, Dorset County Hospital and Salisbury District Hospital

2. Organisational Development and Workforce

2.1 Organisational Development and Merger

The completion of the merger transaction on the 1st October 2020 marked the successful end to a decade in which both PHT and RBCH have pursued working together. This started with the joint declaration by both boards to collaborate followed by the first application to merge, continued past the Clinical Services Review in 2014-2017 and finished with various changes in merger date between 2018 and 2020. Navigating the complex regulatory processes along the way, providing CQC "good" services and managing through the pandemic has demonstrated the commitment of putting patients first and maintaining safe, high quality services.
There has been a wide and diverse range of benefits seen it the first 6 months of merger. Some were planned as part of the merger planning process, some arising by virtue of the changes in both predecessor organisations coming together into University Hospitals Dorset (UHD) and some by way of how UHD responded to the Covid pandemic.
It is clear by the progress that has been made in the last six months that UHD is better placed to deliver safe, high quality, sustainable, patient centred services and recover from the pandemic as a single, merged Trust than as the previous two discrete Trusts. There is however much still to do. The pandemic has bought about delays in the bringing together of teams at service and function level and planned cultural changes are still very much underway. Recovering from the pandemic and treating the backlog of patients will be improved by the merger, however realising many of the benefits of merger should still be seen as in its early stages. With the reduction in Covid cases and increase in vaccinations we expect the delivery of merger plans to regain their previous momentum. Refreshed plans have been adapted to build on the lessons learned through the pandemic and the opportunity of bringing teams together to improve services can now be more fully taken forward.

The clinical structure was implemented from day 1 with the leadership triumvirates in place for all three care groups and Clinical Directors and Operational managers currently being recruited into Tier 3 roles. The care group structure is outlined below.



2.1 People Strategy

Our People Strategy sets out how we will unite our workforce behind our vision and make our new trust a great place to work. Our people have been under increasing pressure since the response to Covid-19 began and there will be further challenges ahead. It is therefore critical that we look after our people. Our People Strategy will drive the actions needed to keep our people safe, healthy and well, both physically and psychologically, and provide the necessary support and development needed to continue to deliver the highest possible standards of care in an environment of high demand, and at a time of significant change in the way patient services are organised and delivered across Dorset. Through this strategy, we will continue to build on the best from our existing organisations and ensure that the new trust has the workforce it needs to deliver its goals over this period.

Successful delivery of this strategy will support us to improve our people's experience and ensure the trust is a great place to work. We recognise the importance of engaging and involving our people, and despite the challenging time ahead for us and for the wider NHS, it is essential that we hold this at the heart of what we do.

We know there is a shortfall of trained people to meet the rising demands for healthcare and that we will need to be more flexible, creative and innovative in how we attract, retain and develop our people, to enable us to fulfil our core purpose and achieve our vision. Our People Strategy has five key action themes, which, through service integration, will enable appropriate support and care for our people while strengthening our organisational capabilities. Our work will be underpinned by the principles of the NHS Long Term Plan, the CQC Well Led domain and the NHS People Plan.

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

Key Actions for 2021/22:

Supporting the Health and Wellbeing of Staff and taking action on recruitment and retention

Our focus is on how we enable staff to be healthy in 'body and mind', to help them recover effectively and face the challenges of a post pandemic world.

We recognise that recovery will be different for everyone and there is no one-size fits all. This highly personalised experience will include the need to support rest and recuperation, mental, emotional, physical and financial wellbeing as well as changes to work / life practice, family / social life and loss and bereavement. We are assuming a two year timeframe for staff recovery, focusing on six key areas:

Compassionate and Inclusive Leadership

Our expressions of gratitude to staff, in recognition and acknowledgement of what we have been through, will be universal with no differentiation. We will place health and wellbeing at the heart of our line manager conversations and communicate clearly and consistently. Ensuring the strong voice of staff is essential to ensure their involvement and innovation. We recognise colleagues that most need help are the most likely to speak up. We will also face the inequalities agenda head-on.

Key actions:

- progress next phase of cultural development programme to embed organisational values with a focus on a) implementation of values-based appraisal b) reward and recognition and c) ensuring the voice of our staff is heard during COVID-19 recovery phase.
- review 2020 staff survey results at care group / departmental level and design improvement interventions, including:
    - reduction in % of Black, Asian and Minority Ethnic (BAME) staff experiencing harassment, bullying or abuse from staff and patients
    - increase in % BAME composition target to improve leadership diversity by 2025
- enhance staff network engagement and intersectionality to strengthen contribution to organisational decision-making processes
- explore our role and contribution as an Anchor Institution (Health Foundation)
- implement training resources / toolkit on civility and respect for all staff and ensure all UHD leadership and management programmes are refreshed to increase focus on inclusivity as a core theme

Teams are Everything

Staff will need supportive relationships with those they work closest to and strong social bonds within their home teams.

Key actions:

- continue to provide COVID-19 team debriefing sessions and peer review facilitation
- rollout of Affina Team Journey as part of COVID-19 recovery, service transformation and organisational change programme

Space and Resources to Recover

Staff will need time for reflection and available forums to develop a meaningful narrative and mitigate risk of moral injury. We will also focus on basic working conditions to ensure staff have more flexibility, visibility and control over their working patterns.

Key actions:

- introduce 'mini' schwartz rounds
- continue provision of *Safe Spaces* and improve provision of rest areas for staff alongside our planned building works, including alternative spaces e.g. 'pods' for individual relaxation and recuperation

Systemic Wellbeing Offer

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

Key actions:

- Implement our '*Building Healthy Working Lives'* 3-year plan to nurture a healthy and resilient culture and easily accessible interventions for all staff
- develop and implement a range of targeted education and support sessions for line-managers to encourage *Wellbeing Conversations* and monitoring of staff who may be more at risk of developing psychological difficulties and / or secondary stressors
- COVID risk assessments undertaken for all staff with line managers (subject to regular review) to aid mitigation of risk and deployment decision
- ensure ability for staff to return to work on a phased basis when recovering from the effects of COVID-19
- continue to support the work of our Freedom to Speak Up (FTSU) Guardian and ambassadors to identify staff areas of concern and help remove any barriers staff may face in speaking up

Recruitment and Retention

Retaining our current workforce remains a priority for us and we will endeavour to offer more flexible, varied roles. We will also make the most of the current high profile of the NHS to recruit across all roles and professions.

Key actions:

- increased and sustained recruitment and retention activity for key front line roles, including international nursing and health care support workers [HCSWs]
- develop attraction and retention incentives at local and system wide level
- optimise the recruitment and deployment to new and enhanced roles to supplement traditional roles
- enable more effective rostering so that people can plan their work time more productively around other

responsibilities

- promote flexibility in working practices where the services can support this
- use feedback from candidates and recruiting managers to understand how best to address market forces
- align and enhance temporary staffing services so performance is consistent for all role types across the site
- continue support to EU employees to understand the actions we can take to maintain this pipeline
- develop and launch UHD employee value proposition to support reputation as a 'good place to work' focusing on *Welcome Me* [recruitment / induction] – *Develop Me* [share opportunities] – *Help Me Do My Role* [manage performance] – *Engage and Motivate Me* [retention] – *Recognise Me* [appreciation and recognition] – *Wish Me Farewell* [handling leavers]
- ensure elective care pathway restoration includes a) talent management and succession planning and b) bespoke health and wellbeing offer for staff and patients

Transformation with System Collaboration

We will ensure all the creative thinking and innovative practice during the pandemic is built into our quality improvement (QI) work as clinical pathways come back online. This will help capture the best of what has happened rather than reverting back to any sub-optimal practice that was there before.

Key actions:

- continue visible and focused leadership for quality improvement and prioritise at board level
- align QI approach with leadership and talent management programme and team integration
- launch UHD QI Academy and refresh intranet site with interactive tools and resources
- develop a QI a social network for UHD improvers
- encourage *all teams at every level* to reflect and evaluate their service provision during and post crisis to a) amplify new practice and b) let go of practices that are no longer fit for purpose

Impact Measures:

- National Staff Survey Results
- Staff vacancy and turnover rates
- Sickness absence rates
- Appraisal compliance rates
- Trend in staff absences from work due to stress
- Measures of equality, diversity and inclusion [WRES, WDES, Gender Pay Gap]
- Number of staff / teams in active coaching contracts
- Delivery against ICS system objectives and 'closing the inequalities gap' within local community

3. Quality of Care and Safety

3.1 Quality and Safety

The trust's quality priorities are arranged within the domains of quality; safety, patient experience and clinical effectiveness (clinical outcomes). High quality care can only be achieved when all three of these domains are present equally and simultaneously. Additionally we recognise the fundamental role that our staff play in delivering high quality care and our people strategy therefore forms the fourth domain of our quality strategy. Individual priorities within each domain are derived from the national guidance and triangulation of internal data from a variety of sources including patient feedback, external stakeholders, regulators, governors and incident reports.

Each of the three pillars of quality; Patient Safety, Patient Experience, Clinical Outcomes/Clinical Effectiveness are monitored through the respective reporting groups in the trust governance framework (see below).

A. Approach philosophy
B. Pillars of Quality – focus of priorities
C. Work streams and processes
D. Strategic goals

Quality reporting through these structures supports to review, analysis and delivery of key metrics related to patient experience, safety and effectiveness of services up to the board of directors. Quality reporting is based on the Care Quality Commission (CQC) key lines of Enquiry (Safe, Caring, Responsive, Effective and Well Led). Board and Board subcommittee reporting support wider quality assurance processes such as peer review, clinical audit, and internal and external audit. Information in the Board and Quality Committee

reports routinely includes progress on quality, patient safety and patient experience metrics including:

- Risk register additions, updates, controls, action plans and assurances
- Serious incidents, incident reports, near misses and learning outcomes from investigations and reviews Trends – current and future risk, assurance and quality issues
- Internal comparisons and external benchmarks
- Directorate, specialty, ward and consultant level data where appropriate
- Quantitative and qualitative data
- Patient stories and patient feedback
- Statistical interpretation and analysis

.

Specific objectives for 2021/22:

The Quality priorities for 2021/22 have been derived from shared learning from SIs, Medical examiner reviews, Mortality reviews and feedback from Patient experience during 2020/21.

The 4 main priorities for 2021/22 are as follows:

- Fluid Management
- Difficult IV Access (DIVA)
- Deteriorating Patient
- Safety Checklists

3.2 Care Quality Commission (CQC)

RBCH and PHT were inspected separately in 2018 and 2020 respectively and a summary of the results are below:

	Safe	Effective	Caring	Responsive	Well-led	Overall
PHT	Requires improvement → ← Jan 2020	Good → ← Jan 2020	Outstanding ↑ Jan 2020	Good → ← Jan 2020	Good → ← Jan 2020	Good → ← Jan 2020
RBCH	Good ↑ Mar 2018	Good ↑ Mar 2018	Good → ← Mar 2018	Good ↑ Mar 2018	Outstanding ↑↑ Mar 2018	Good ↑ Mar 2018

CQC reviews will remain an important part of the quality approach at UHD and we will continue to use these to understand where further improvements to our services can be made.

3.3 Maternity Services

Ockenden Report - Immediate and Essential Actions

- Additional midwifery workforce
- Enhanced obstetrician availability
- Introduction/development of maternity MDT

The planning guidance sets out the availability of funding to support the Immediate and Essential Actions arising from the Ockenden Report. This will include a calculation of the Birth

Rate Plus metric for UHD and we anticipate that these will lead to a requirement for around a further 20 midwifes.

The second of these actions requires the further provision of consultant obstetrician time to support the provision of twice daily ward rounds; consultant leadership for fetal heart monitoring; and the introduction of Maternity MDTs.

The Trust will be bidding against these national monies early in 21/22 and continues to work in partnership with the Local Maternity Services to oversee the provision of maternity care for the local population.

3.4 Quality Improvement

The Quality Improvement (QI) strategy builds on the existing QI enthusiasm and knowledge of UHD staff and expertise within our QI team.

It aims to embed a culture of continuous improvement and learning across the organisation in which everyone is empowered to make changes to improve the quality of clinical and non-clinical services to enable improved patient care.

This strategy has been developed after consultation with UHD QI practitioners and enthusiasts and learning from the approaches of both previous organisations. We have also drawn on existing UHD strategies and a wide range of National strategies and reports.

Our QI strategy consists of three foundations for QI and five strategic aims that underpin our Trust value of improvement.

Our foundations of quality improvement define the three themes that will run through all our improvement work.

These cover how we will carry out QI:
- Patient involvement
- Digital first
- Sustainability

Our 5 strategic aims outline the five main strategic aims of our strategy and describe what we will do to develop our continuously improving and learning organisation.

- Leadership, governance and culture – to embed senior support and leadership for QI
- Vision and buy in – to raise awareness of the QI approach and support early delivery
- Improvement skills and infrastructure – to deliver training and development to staff to enable delivery of QI projects
- Aligning activity – to embed improvement approaches across all UHD activities
- Sustain and spread – to hold our QI gains and spread improvement

This strategy aims to deliver a systematic continuous approach improve clinical and non-clinical services and ultimately provide better outcomes for patients in terms of safety, efficiency and experience.

A series of success measures have been defined so we can demonstrate the achievement of the main aims of the strategy.

4. Operational Performance and Recovery

4.1 Organisational Performance and Challenges

In 2020/21 the focus of the Trust was redirected to responding to the COVID-19 pandemic. The planned response to each wave of the pandemic, including compliance with national infection control guidance and social distancing, has resulted in a reduction in elective and non-elective capacity and increased waits and numbers waiting for routine planned work.

A focus on re-establishing all cancer and urgent activity during the recovery periods (between peaks in Covid-19 positive activity) has also resulted in the Trust undertaking less activity in the re-established outpatient, procedure and theatre sessions for some specialities.

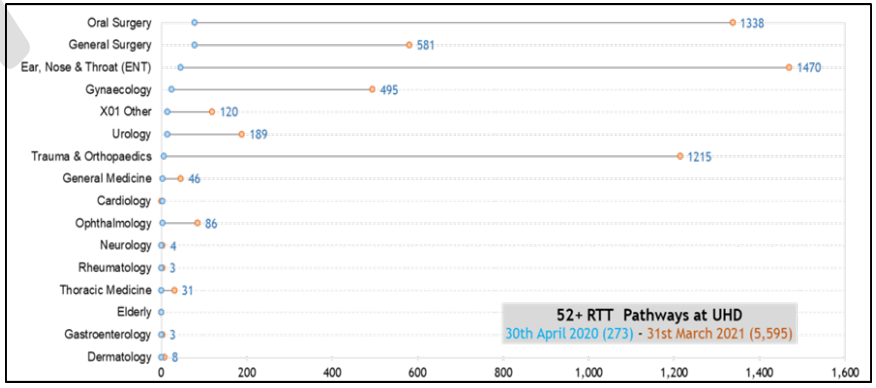
Consequently the Trust's position against national standards was mixed in 2020/21 with good performance against recovery of diagnostics (DM01) and progress being made against a number of urgent care indicators such as arrival time in the Emergency Department (ED) to initial assessment and arrival time in ED to treatment, but continued challenges against constitutional standards such as Referral to Treatment (RTT) and cancer waiting times, meantime in ED and ambulance handovers.

These challenges are multi-factorial but include increases in demand for cancer referrals, workforce capacity gaps, flow and inpatient capacity impacted by Covid and IPC measures, as well as patient's choosing to delay treatment due to the concerns related to Covid-19.

Referral to Treatment

In 2020/21, the RTT waiting list size has increased to over 47,000 and RTT performance fell to 58.2% against a target of 85%. Patients are now waiting extended periods of time for treatment and the number of patients waiting over 52 weeks has risen to 5,595 in March 2021. The proportion of patients waiting over 78 weeks has also increased with small number of patients waiting over 104 weeks.

The chart below highlights the growth in over 52 week waits with Oral Surgery, Ear Nose and Throat (ENT), General surgery and Orthopaedics standing out.



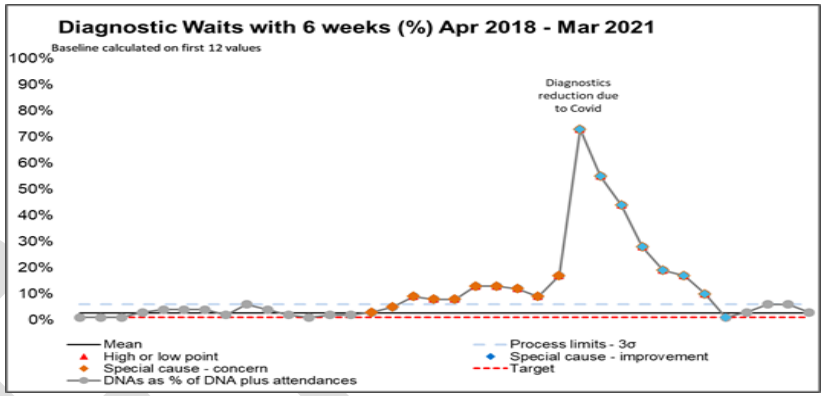
Cancer

Cancer referral numbers continue to exceed previous years putting additional pressure of several services at all stages of the pathway. Despite these pressures the Trust achieved the 28 day Faster Diagnosis and 31 day Cancer standards. The 62-day standard was not met. Diagnostic waits and late referrals have been contributing factors alongside surgical capacity.

Measure	Target	Quarter 1 2020/21	Q2 20/21	Q3 2020/21	Q4 20/21
Cancer Two Week Wait	93%	96.7%	97.3%	N/A	N/A
Cancer Plan 62 Day Standard (Tumour)	85%	79.3%	80.0%	78.6%	77.8%
62 Day Screening Standard (Tumour)	90%	73.3%	73.3%	94.1%	88.1%
31 Day First Treatment (Tumour)	96%	96.2%	94.4%	97.0%	96.7%
Subsequent Treatment - Surgery	94%	89.4%	86.7%	95.4%	90.5%
Subsequent Treatment - Radiotherapy	94%	98.8%	100.0%	98.7%	99.0%
Subsequent Treatment - Anti Cancer Drugs	98%	100.0%	100.0%	100.0%	99.7%
Faster Diagnosis	75%	76.3%	77.4%	80.7%	79.1%

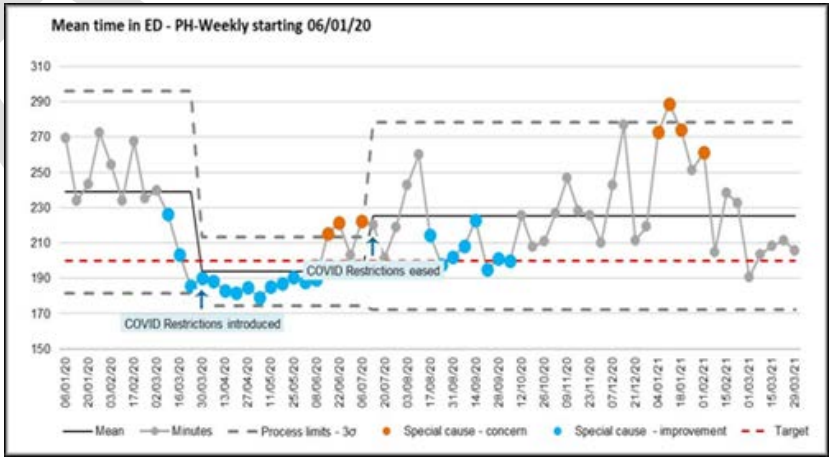
Diagnostics

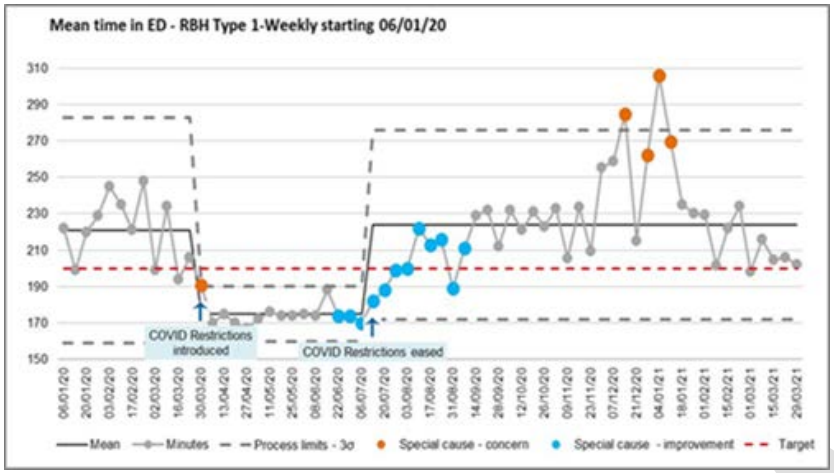
The graph below shows the strong recovery during 2020/21 against the national 6wk diagnostic standard (1%). Increased demand for diagnostics has been experienced as the Trust increases elective activity to support recovery and due to rising urgent referrals. The most challenged speciality continues to be endoscopy.



Urgent and Emergency Care

Both emergency departments made significant improvements in overall mean time in the last quarter of 2020/21.





4.2 Elective Performance and Recovery

Key challenges

Dorset is one of the most challenged areas in the country in 2020/21 for elective waiting times. In UHD, referral to treatment (RTT), end of March position is at its lowest monthly performance level in the last half of 2020/21 and the Trust is within the top third of Trusts in the South West with the greatest proportion of its waiting list waiting more than 52 weeks and where patient waits over 78 week are the greatest in the region. In contrast over 6 week waits in diagnostics is the lowest in the South West.

The COVID-19 pandemic has exacerbated the challenges UHD faces in managing the volume of patients requiring elective care. As systems, processes and teams come together in the newly merged Trust and as we continue planning elective recovery, it is essential that we understand the clinical risks associated with our patient treatment lists (PTL), review pathways and where necessary develop or formalise alternatives.

During the pandemic, services with historic challenges have been significantly impacted by reduced capacity and as a result, so have the lives of many patients waiting for treatment. The most challenged services include Oral surgery, Ear, Nose and Throat services, Orthopaedics and Ophthalmology in line with the national picture. Positively, we have seen increased collaboration across the Dorset system, rapid pathway changes implemented, reduced variation in waiting times across Bournemouth and Poole, and movement towards single waiting list in some areas.

We have an Outpatient (OP) Transformation Group leading a number of redesign and optimisation work streams, focused on demand management, follow up reduction and efficiency and productivity. To achieve:

- Care provided in the most appropriate care setting by the most appropriate clinician with quick and easy access to specialist opinion, advice and guidance when required.
- Care delivered in an efficient and streamlined way supported by timely and seamless clinician to clinician communication designed to deliver the best patient experience and outcomes possible within available resources.
- Effective use and or redeployment of Outpatient space.

In 2021/22 it's clear that recovery of pre-pandemic and pandemic related performance will not be delivered without us

transforming the design and delivery of services across UHD and the Dorset system. To realise the quadruple aims of transformation, to:

- Reduce unwarranted variation in access and outcomes
- Redesign clinical pathways to increase productivity
- Increase involvement of patients in decision making; and
- Accelerate progress on digitally enabled care

In 2021/22 we will:

- Undertake clinically led validation of our elective PTLs so that they are accurate, organised and prioritised in a way which seeks to engage and empower patients in decision making about their care. We will transfer the learning from this experience to develop further ways of reaching out to patients who are clinically vulnerable and promote self-management.
- Work as a system to avoid long waits for patients and better balance the capacity in the system to move towards recovery and then maintenance of acceptable waiting times. Including, the transfer of Consultant Led RTT, Theatre and Endoscopy activity from Dorset HealthCare (DHC) to University Hospitals Dorset (UHD).
- In specialties where patients are currently enduring long waits for treatment, we will co-ordinate any offers to long-waiting, for clinically-suitable patients to transfer their care to the independent sector. In addition, within Dorset we will endeavour to transfer patients between NHS hospitals, balancing Dorset's overall capacity with overall demand and move in the direction of single waiting lists.
- Across Oral and Maxillofacial, Orthopaedics, ENT and Ophthalmology services we will prioritise working as a system in Dorset to transform pathways of care and exploit technology to optimise care, including 'out-of-hospital' care.
- Implement an Outpatients (OP) Transformation programme that will include optimising the use of telephone and video consultations where clinically appropriate, increasing the use of Advice and Guidance and Patient Initiated Follow Up (PIFU) and reviewing OP estate usage.
- Embed clear accountability for elective recovery and implement key supporting business intelligence tools, increasingly at a system level, to support tracking of waiting lists, clinical review and prioritisation and dynamic planning of elective capacity. This will include reporting full quantitative data against the areas of Outpatient transformation above within the first half of 2021/22.
- Work within the Dorset system to determine the system's approach to developing high impact service models, initially through the progression of the 'Think Big' Project.
- Prioritise the clinically most urgent patients, including establishing the baseline of Evidence Based Interventions (EBI) undertaken and improvement plan.
- Maximise physical capacity by review learning from elsewhere and the high-impact changes including adapting the ward environment to enhance flow and physical

segregation, segregating elective care flow and service transformation initiatives to drive elective recovery.

- Access available support re innovative approaches to optimise workforce capacity locally, including system wide workforce planning, and build upon current passporting arrangements to allow flexible working of employed and bank staff between organisations.
- Deliver increased diagnostics capacity, including evaluating the development of Community Diagnostic Hubs (CDHs).
- Improving theatre scheduling, utilisation and efficiency using adapt and adopt methodology. Alongside this reviewing the effectiveness of pre-operative assessment capacity and processes.
- Move to a single Patient Administration System (PAS) for UHD and contribute to the planning for a common PAS for the Dorset System.
- Link elective recovery to monitoring the health and wellbeing of staff through the development of workforce scorecards at Care Group level which includes an appropriate set of measures, so that the rate of service restoration takes account of the need for individuals and teams to recover and the wider workforce capacity available.
- Through Dorset Intelligence and Insights Service (DiiS) take a system-wide approach to understanding and planning interventions to respond to pre-pandemic and pandemic related health inequalities using waiting list data to measure access, outcome and experience for BAME populations and those in the bottom 20% of IMD.

Assumptions

As a result of these actions, we are committed to deliver the following performance:

- Reducing diagnostic over 6-week waits to less than 1%
- Making progress on reducing 52 week waits to under 5% of the waiting list by March 2022 and elimination of 78+ week waits
- Prioritise reducing long waits and ensuring equitable access and waiting times across Dorset
- Full clinically led validation and prioritisation of existing active, planned and follow up PTLs
- Meeting the activity thresholds set out within 2021/22 planning guidance.
- At least 25% of Outpatient consultations will be delivered remotely via video or telephone consultation
- Patient-Initiated Follow-up (PIFU) will be implemented and scaled up across at least three outpatient specialities
- Advice and Guidance will be increased.

Risks and Issues

- People recovery- a key risk to elective recovery is the workforce capacity. We have a fatigued workforce,

which extends beyond frontline staff and our elective recovery plans require staff to deliver additional capacity.

- Theatre capacity - procedures are taking longer due to social distancing and the impact of IPC measures and we have insufficient internal capacity to meet the demand for routine surgery.
- Elective activity - the Dorset system is one of the most challenged systems in the country in terms of elective care. We are responding to pre- and Covid related backlogs.
- Patient compliance and public anxiety

Further details of elective care is includes within specialty plans on a page.

4.3 Cancer Recovery

Key Challenges

During the pandemic the Trust worked (as an integral part of the ICS) to ensure cancer treatment where clinically safe to do so was continued. If necessary, alternative treatments were discussed and agreed with patients. Also if the patient requested and it was safe to do so treatment was deferred. Throughout this period all patients were tracked and monitored to ensure their care was reviewed as required.

Work with the independent sector both within Dorset and latterly utilising the Wessex cancer hub meant critical surgery was maintained and where diagnostic interventions had to be deferred (or the patient requested deferral) this work has now being recommenced and actioned accordingly.

Whilst at the height of the pandemic there was a significant drop in referrals the Trust is now seeing a return to previous years' activity and in certain tumour sites the demand has increased.

The number of patients on an active PTL at UHD is now significantly greater than prior to the pandemic and UHD are working with colleagues in Primary care to manage this.

The trust is making significant strides in regaining performance standards and compared nationally is performing well against the key cancer deliverables.

Actions

In 2021/22 we will:

- Work with GPs and the local population to increase the number of people coming forward and being referred with suspected cancer, through: engaging with underrepresented groups to design and deliver messaging to improve symptom awareness and action; symptom awareness targeted advertising; a clinically led webinars to raise awareness of signs of lung cancer; lung cancer case finding and extension of case finding to other areas, and education for frontline professionals on symptom recognition.
- Actively support GP practices as they complete the Quality and Outcomes Framework (QOF) Quality Improvement module on early cancer diagnosis, via new Primary Care Network (PCN) cancer champions.

- Ensure the visibility of performance data at speciality and tumour site level to support reducing cancer waiting times, both at a Trust, ICS and Alliance level.
- Work with Wessex to further develop the RIS (Rapid investigation service) for patients in the Dorset area.
- Work with Macmillan and Wessex to improve holistic needs assessments for patients with suspected cancer.
- Improve the quality and quantity of treatment summaries for all patients at the end of treatment to enhance communication with Primary care, keeping the patient at the centre.
- Work with public health commissioning teams to restore all cancer screening programmes through enhancing current clinical delivery models in a socially distanced high throughput environment.
- Extend bowel cancer screening to include 50-60 year olds, with rollout to 56 year olds from April 2021.
- Make available to cancer champions best practice to improve uptake of screening for low-uptake groups.
- Build awareness of thrombocytosis as a risk factor for LEGO-C cancers, review existing pathways and identify areas for pathway improvement.
- Review data to identify practices with low usage of symptomatic FIT testing and promote FIT through cancer champions.
- Undertake an options appraisal for cancer early detection and safety netting tools for primary care. Including ERICA trial and direct incentive and commissioning options.
- Prioritise the clinically most urgent patients, e.g., for cancer and P1/P2 surgical treatments. Including continuing mutual aid arrangements within Dorset for management of 2ww referrals e.g., head and neck, dermatology, breast.
- Use a system-wide escalation protocol to support the identification and prioritisation of P1/P2 surgical cancer patients.
- Extend the centralised clinical prioritisation and hub model established during the pandemic for cancer surgery to patients on cancer diagnostic pathways including development of a system approach to clinical prioritisation in endoscopy, dermatology, breast and head and neck services.
- Increase the update of innovations including delivering the Cytosponge pilot, and colon capsule endoscopy, to support effective clinical prioritisation for diagnostics.
- Introduce new modalities to improve efficacy of pathways i.e. LA template biopsies.
- Working as part of Wessex cancer alliance review pathways to ensure best practice and minimise unnecessary delays.
- Develop an active cancer PTL for Dorset.
- Conclude an external review of Dorset optimal lung cancer pathway - MSD.
- Develop Dorset system pathways for endoscopy and breast and plan for head and neck.
- Extend personalised stratified follow up (PSFU) pathways as part of the National programme:
  - Breast, colorectal and prostate live - April 2021.
  - Thyroid and testicular live – Summer 2021.
  - Gynaecology and haematology live – Autumn/Winter 2021.
- Launch Dorset Care Record (DCR) MyDCR patient portal in December 2021.
- Implement a quit smoking app for 100 Dorset residents in collaboration with PCNs in areas of deprivation.

- Inform segmentation of the population through development an interactive text message based patient questionnaire for smokers measuring dependency and stage of change. Including motivational messaging and support options tailored to questionnaire responses.

Risks and issues

Key risks

- Continued increase in demand in certain tumour sites impacting on capacity, including breast/head and neck, colorectal, gynaecology and skin.
- Patients declining diagnostic interventions until they have received the vaccination, delaying either diagnosis and/or treatment.
- Capacity levels reduced due to on-going COVID restrictions
- Staffing skills and infrastructure to meet the increases in demand, especially in key diagnostic areas: radiology, pathology, radiotherapy,

As many pathways are reliant on more than one Provider, these risks are not just intra-Trust but inter-Trust

Issues

- IT infrastructure to support developments both in remote monitoring and protocol driven triage.
- Pressure on certain departments due to increase in suspected cancer referrals, especially highly specialised areas.
- Ability to review and change pathways whilst managing operational pressures.
- Adequate infrastructure to track patients.

Assumptions

As a result of these actions, we are committed to deliver the following performance:

- To return the number of people waiting for longer than 62 days to the level we saw in February 2020 (or to the national average in February 2020 where this is lower);
- Decrease 104 backstops to the level of Feb 2020
- Meet the increased level of referrals and treatment required to address the shortfall in number of first treatments by March 2022.
- Recover the backlog in breast cancer screening to meet national standards by end March 2022.
- Meet the new Faster Diagnosis Standard consistently from Q3. 2021/22.

4.4 Urgent and Emergency Care Recovery

Key Challenges

Responding to Covid has meant the implementation of a number of IPC related pathways and processes which have impacted both on patient flow as well as front door, inpatient and back door capacity. This includes lost bed utilisation to facilitate compliance with patient distancing. Bed modelling across UHD has demonstrated a gap in bed capacity which

requires mitigation. Furthermore, the impact of Covid on urgent and emergency patients is unknown and an increase in higher acuity presentations and/or backlog of patients who have avoided services can be anticipated. This, in addition to the demands created by 'staycations' and visitors to Dorset as well as knock on impact to the Trust of partner services also under strain with increasing demand. Achieving the new national Urgent & Emergency Care standards will be a challenge but as existing pilot sites, we strive to provide safe care and good clinical outcomes for our patients.

Actions

The following key areas will be progressed in line with the 2021/22 priorities and operational planning guidance.

Continue to progress the work already underway through the NHS 111 First and Same Day Emergency Care programmes

- Work with system partners and, subject to System prioritisation of investment, right size the CAS and launch full NHS 111 First comms
- Implement alternative booking / referral pathways to other community and mental health services including:
  - MIUs/UTC booking arrangements
  - Booking to Retreats and CFRs
  - Referrals to HI Service (OP Courage)
  - Labour line
  - Paediatric "SDEC"

<u>A&E attendances (excluding planned follow ups)</u>

- Continue to embed and expand ED booking towards a target of 70% of patients via 111 to have a booked appointment, led by System workstream meetings and weekly learning huddles
- Increase from 12 minors slots a day (84 per week) across all 3 acute trusts to match demand identified across 24/7
- Improve slot utilisation by reviewing 4-hour and 1-hour disposition booking opportunities.
- Enable NHS 111 on line direct bookings to ED via implementing Care Connect and Emergency Department Digital Integration (EDDI).
- Increase uptake of SDEC bookings and further develop SDEC pathways including from EDs
- Implement booking to Primary Care in hours

<u>NHS 111 referrals to SDEC and development of SDEC services</u>

- Appointment slots currently open in following specialties: -
  - Acute Medicine – Poole
  - Frailty – Bournemouth
  - Acute Medicine – Bournemouth
- Secondary Care Physicians and Primary Care clinical pathway meetings
- Development of service videos to support 111/CAS staff training by specialty teams at Poole and Bournemouth
- Establishment of full service specifications on DoS.

- Monitoring of SDEC dispositions against availability of slots.
- UHD SDEC Steering Group established chaired by Deputy Chief Operating Officer (COO) with speciality SDEC workstreams
- SDEC workstreams to progress improvement priorities and consider options to expand/optimise service capacity
- Performance metrics under development which will include 111/CAS activity.
- Open slots in Cardiology by mid-May
- Surgery and Surgical SDEC to open access to 111 – trial Spring/Summer
- Review referral process and pathways (e.g. SPoA through one clinician taking all referrals and booking specialty SDEC slots)
- Optimise use of Consultant Connect

Urgent & Emergency Care standards and improvement actions

- Full roll out of new Urgent & Emergency Care standards (noting previously pilot sites) supported by new dashboards and operational escalation processes:
    - *Response times for ambulances*
    - *Reducing avoidable trips (conveyance rates) to emergency departments by 999 ambulances*
    - *Proportion of contacts via NHS 111 that receive clinical input*

  A&E
    - *Percentage of ambulance handovers (from ambulance to A&E) within 15 minutes*
    - *Time to initial assessment — percentage within 15 minutes*
    - *Average (mean) time in department — for non-admitted patients*

  Hospital
    - *Average (mean) time in department — for admitted patients*
    - *Clinically ready to proceed (time from when decision is made to admit or discharge, and patient is admitted or discharged)*

  Whole system
    - *Patients spending more than 12 hours in A&E*
    - *Critical time standards — aimed at ensuring the highest priority patients get care within a set timeframe such as an hour*
- Fortnightly meeting with CCG and SWAST to monitor and sustain improvements achieved in Q4 20/21 in Ambulance Handover performance.
- Continued review and development of escalation protocols to respond to increasing pressures
- Review of pathways and processes in EDs, including new models supported by completion of ED estate works (incl Pit Stop and early senior decision making)
- Integrated UTC/Minors models
- Medical and nursing establishments supported by business cases

Risks and Issues

- Unknown post Covid wave demand and future Covid/non Covid demand

- Holiday period / staycation / visitor demand
- Workforce – wellbeing, sickness, vacancies, recruitment
- Ability to divert patients to Minor Injuries Units (MIUs)/Urgent Treatment Centres (UTC) or other appropriate services
- Timely availability of booked appointments
- Ability/capacity to clinically validate all booked appointments
- Timeliness, effectiveness and continual nature of local public communication
- Increase in minors' attendances over the Summer
- Underutilisation of appointment slots
- Inappropriate referrals
- Complexity of referral/booking processes/symptoms
- Funding/ability to implement capacity mitigation schemes (e.g. enhanced SDEC) and bed escalation capacity.
- Ability of partners to respond to demand pressures and avoid additional impact on UHD

Assumptions

- Improvement initiatives and/or funding support for schemes/development/bed capacity will facilitate deliverables, safe care and progress against key standards
- Pressures on and support from partners avoids demand and delay in acute services
- Key ambitions against indicated national UEC standards will be achieved if actions delivered and risks mitigated

4.5 Patient Flow & Bed Capacity

Underpinning the Trust's surge and capacity planning is our bed modelling. With the backdrop of lost bed utilisation due to IPC risk assessment as well as reconfiguration of areas to meet Covid demands (e.g. Blue ITU) the model demonstrates the need for 'escalation' beds, above core, throughout the year. See section 4.6. A key assumption in our modelling, as well as out bed gap mitigation plans, is the role of the Home First and Criteria to Reside programmes. There are two key components of the drive to ensure that patients are not admitted unnecessarily and are discharged when they no longer require the hospitals' services. These are Home First and Criteria to Reside (C2R).

Home First

The following table shows some of the highlights of the Home First work

Pathway	Proportion of patients	Features / "What Does Good Look Like"
0 – Discharge Home	50%	Voluntary sector provision. Provides rapid short term 'settling in support' to facilitate timely discharge. Services act as a 'facilitator' to access other smaller place based voluntary/third sector services as required
1 – Discharge	45%	Five Integrated cluster teams with responsibility for receiving referrals,

Home with Support		determining pathway, allocating care, provide rehab / reablement, case management and assessment for ongoing need. Standardised processes across teams. Integrated/ single IT systems to support processes and data collection.
2 – Discharge to Interim Beds	4%	Range of commissioned beds to meet needs. Single bed management function (flow) and leadership. Step up for known patients or via Acute ambulatory services.
3 – Discharge – Complex and End of Life	1%	Robust hospital and centralised processes for case managing people out of hospital on P3 (and P1 complex and EOL). Timely discharge on P3 to patient's final destination. Timely assessment for ongoing funding.

Further improvements for the Home First Model and discharge offer during 21/22:

- To agree the ambition / trajectory for improvement e.g. 25% reduction in LLOS (as previously monitored through NHSE/I)
- Baseline for "admissions not avoided" in ED and Assessment Units where community services have not been able to respond to avoid admission to an inpatient ward
- Design a Pathway 1 & 2 Community Service Offer to increase discharges via Home First & Decision to Admit (D2A) from ED & Assessment Units across the acutes to avoid a long length of stay in hospital
- Commencement of weekly "complex / stranded patient meeting (14 & 21 day LOS)" with representation from Dorset ICS partners to expedite discharge arrangements for patients referred to community services via Home First / D2A.
- Establish a Dorset ICS escalation process for patients who do not meet Criteria to Reside, where a community offer for discharge has not been established e.g. within 72 hours of receipt of referral within the SPA / Cluster Team.
- Establishing an external strategic partner to support the Dorset system and draw on learning from elsewhere.

Criteria to Reside (C2R)

The new Discharge to Assess guidance was issued during the COVID-19 pandemic and the Dorset System is being supported by NHSEI to facilitate timely discharge underpinned by a "Home First" model of care. The ethos behind this guiding principle is that patients receive acute hospital care

when needed, only for the period required; underpinning quality of care and patient outcomes.

This Discharge to Assess guidance includes Criteria to Reside (C2R), which aims to move assessment out of hospital and into people's homes – patients only remain in hospital if they meet a defined set of "clinical criteria to reside". It is designed to provide an evidence base for identifying the on-going care needs of patients during and beyond the acute phase of care.

Key Benefits

- It's good for patients – helps to ensure right care, best place at the right time. Reduces the clinical risk of hospital acquired infection and deconditioning by ensuring an optimised length of stay, supporting best patient outcomes.
- It reduces pressure on staff, wards and the front door; allowing our sickest patients to be admitted more quickly.
- It will inform our partners when and how to help and support; enabling effective demand planning.
- The information and data will provide assurance to regulators.

Actions

- Development of the implementation plan for a 4–6 month period which considers all aspects of C2R including engagement and awareness.
- Embed Criteria to Reside into the Trust's assurance framework and work with senior nurse leads to include within quality metrics as well as part of the Care Group's performance.
- Using a QI approach to roll out to 4–6 wards by way of a demonstration of the benefit to patients and staff alike; and an opportunity to showcase to other areas to help engage others and rollout UHD-wide.
- Have in place an improvement trajectory that is able to demonstrate progress or highlight where further work is needed.

Commencing in late 20/21, good progress has been made through the launch of the C2R internal programme. Our UHD-wide Health of the Ward digital system and C2R dashboard are now supporting:

- focus on areas for improvement
- visibility of patients who have No Reason to Reside or require further input to optimise care and recovery
- improved accuracy of reporting internally and externally.

Risks and Issues

- Demand (non elective and/or elective) exceeds bed modelling scenario assumptions
- 'Staycations' and visitors to Dorset result in surge demand at peak periods
- Reductions in patients in hospital with No Reason to Reside seen through 20/21 are not sustained

- Home First and Discharge to Assess capacity and pathways are unable to deliver further reductions in Length of Stay to offset the acute bed capacity gap
- Ability and capacity to support engagement and delivery across all clinical and ward teams in the Criteria to Reside framework
- Further Covid waves, outstripping planning assumptions.

4.6 COVID Planning

The coronavirus pandemic has presented an unprecedented challenge for the National Health Service in response to record demands for care, whilst protecting the health of patients and staff. Nationally, understanding and learning how community rates and nosocomial (healthcare acquired) infections may have contributed to coronavirus outbreaks within secondary care organisations is essential, enabling us to ensure the continued protection of patients, staff and the wider community population. Therefore, all our plans are developed in the context of ensuring Infection Prevention and Control (IPC) is at the heart of what we do.

Incident Management

We now have a well-established incident management (operational, tactical, strategic) response model which can be escalated as required. In line with current NHS incident levels, our current arrangements remain responsive to the ongoing requirements of incident management, internal and external escalation, receipt of national guidance etc.

As a minimum, a 3x weekly senior clinical and management group supports oversight, planning and response, linking closely to daily operational structures as well as to our Executive group and system level resilience forums

As a minimum, a 3x weekly senior clinical and management group supports oversight, planning and response, linking closely to daily operational structures as well as to our Executive group and system level resilience forums.

Preparations for any future potential surge requirements for COVID patients

Capacity

Our current operational capacity plan is being updated to take account of the current and estimated future prevalence of COVID in the local community and to address expected winter pressures.

Bed Modelling

The advent of COVID19 and the resultant IPC and social distancing measures has reduced our bed capacity significantly. Our estimates of the impact of this on bed numbers is 81 across UHD. In addition, reconfiguration of areas and pathways (e.g. Blue ITU) has also reduced core bed availability. Our bed capacity modelling includes both non-COVID and COVID scenarios. Planning for COVID activity will remain iterative as more is known about community incidence and vaccination impact.

Internal bed model based assumptions:

- 88% max occupancy (to allow for swabbing, distancing and other related pathway challenges)
- 0% growth on 19/20 non elective activity
- Elective activity assumptions that meet the national recovery trajectory requirements
- Base model assumes COVID activity increase is offset by non COVID activity reduction
- Continued benefit from a reduction in patients with No Reason to Reside, as seen during Covid.

The principal scenario being modelled is for up to 5% COVID – additional c50 beds across UHD (or equivalent capacity required) - and we are working on if/what further mitigations and/or system support to offset this are possible. It is anticipated that this may be more manageable in the summer of 2021, depending on elective activity, the use of escalation beds and levels of surge demand from visitors/'staycations'. Capacity becomes substantially more challenging from the autumn onwards.

The above scenario demonstrates a gap and so we are working on LoS/admission avoidance plans to mitigate this and considering funding for full "winter" level escalation capacity throughout the year as part of our financial planning assumptions.

Further mitigations, in addition to the escalation capacity, to offset the remaining gaps encompass admission avoidance and reduced length of stay and include:

- Review of speciality pathways and cross site bed capacity demands for opportunities to optimise bed capacity across UHD
- Improvement to the (Non-ST Segment Elevation Myocardial Infarction (NSTEMI) pathway

- Expansion of the current Rapid Access Consultant Evaluation (RACE)/Same Day Emergency Clinic (SDEC) in OPS to 7 days per week
- Alternative care models which support admission avoidance, Same Day Emergency Care to avoid unnecessary overnight stays and/or reduced Length of Stay across UHD
- Local anaesthetic treatments to be used in ophthalmology to reduce overnight stays
- Work internally and with Dorset System partners to optimise the Criteria to Reside framework and Home First programme.
- Review and refinement of our UHD-wide escalation (OPEL) plans and associated risk assessments

From the modelling and having developed an understanding of what beds we could use, we have now reviewed the nursing skill mix required for this escalation. This will support the decision making process for the phased opening of additional beds.

Critical Care

Previous experience indicates that circa 10% of COVID admissions require critical care. So our modelling of 5% of inpatient beds (c50) with COVID, would suggest a COVID occupancy of 5 Intensive Care Unit (ICU) beds.

Currently both hospitals are maintaining COVID ICU areas for COVID escalation but we are reviewing whether a single site ICU is possible in early escalation phase or in later de-escalation phase.

Our current critical care plans envisage 3 blue beds on each acute site and this can be escalated further if required, but noting that this critical care escalation would potentially risk elective care recovery.

RBH (phase 1 up to 6 beds; phase 2 up to 10 beds total, phase 3 up to 15 beds total) – noting requires additional staffing as separate area plus in addition to non COVID in green ICU. Phase 2 and phase 3 would remove these beds as being available for COVID/non COVID General & Acute beds.

RBCH -Trigger Level	Level 3 Equivalent Beds	Poole - Trigger Level	Level 3 Equivalent Beds
Level 1a Our normal bed base and staffing template. All patients housed within our normal ICU footprint. uate number of side rooms for patients requiring isolation for infective processes/AGPs.	8	**Trigger Level 1** Our normal bed base and staffing template. All patients housed within our normal ICU footprint. Adequate number of side rooms for patients requiring isolation for infective processes/AGPs.	8
Level 1b Level 1b rooms in GREEN ICU full requiring an additional ICU nurse. Contact Poole Critical Care to explore possible transfers .	8		
Level 2 OVID SUSPECTED/POSITIVE PATIENT REQUIRING ADMISSION TO ICU triggers opening of BLUE ICU, or... Need for additional side rooms necessitates opening of BLUE ICU.	12	**Trigger Level 2** COVID SUSPECTED/POSITIVE PATIENT REQUIRING ADMISSION TO ICU triggers opening of BLUE ICU.	11
Level 3a All 4 side rooms on BLUE ICU filled.	12	**Trigger Level 3** More than 11 level 3 equivalent patients	16
Level 3b GREEN ICU fully occupied. de rooms on BLUE ICU filled and 2 beds in main bay of BLUE ICU occupied.	20		
RE THE POSSIBILITY OF MUTUAL AID FROM NEIGHBOURING TRUSTS IN ADVANCE OF NEED TO ESCALATE TO LEVEL 3c **Level 3c** BLUE ICU expands into CCU step down bays. One Consultant becomes resident.	29		
Level 4a ion into theatres 1-4 with up to 3 patients per theatre/anaesthetic room. Backfill consultant cover with consultant anaesthetists.	41	**Trigger Level 4** 16-24 LEVEL 3 EQUIVALENTS – REQUIRES BOTH ENDS OF B2 WARD OPEN AS CRITICAL CARE BEDS	24
Level 4b ion into theatres 5-8 with up to 3 patients per theatre/anaesthetic room. consultant cover with consultant anaesthetists/SpRs with ICU experience.	53		
Level 5 sion in to Recovery as able depending on staff and equipment availability	Incident Mgmtment		

COVID Pathways and Infection Prevention and Control (IPC)

In line with the national IPC guidance, we aim to maintain separate COVID pathways, minimising as far as possible transfer through front door (ED / Amber Admission Unit) areas. This includes a model of dedicated COVID ward/s and we are reviewing whether this could be single site and/or mixed speciality in escalating Phase 1 or requires both sites. We are also reviewing whether this could be established as a direct admission area, but this would require dedicated staffing and medical teams in addition to our existing admission areas. Alongside the above we are also reviewing medical and nursing roles to support blue and green pathways and further develop the staffing escalation policy.

COVID Testing

Rapid testing:

We have a range of rapid testing equipment on site in dedicated areas. These include Samba II, GeneXpert and Roche Liat. There are a number of steps that are being considered to aid capacity:

- Although there are no further SAMBA machines available at present, we have the capacity to accommodate them when they do become available
- There are plans to reduce the incubation time which will improve flow and increase capacity - there is no date for the upgrade yet
- Stock levels of reagents enables periodic testing flex up as required. There are more reagents available nationally if required.

Non-rapid Testing:

We also have a range of non-rapid testing on site. Developments include:

- Potentially switching some testing to testing for variants of concern.
- The Perkin Elmer system is currently running c50 tests per day, but with IT connectivity / interfacing this will allow stepped increases in capacity leading to 500 tests per day.

Vaccination

In late 2020 / early 2021, the Trust delivered a vaccination programme for UHD staff and the wider health and social care workforce. In total we vaccinated around 35,000 staff using out-patient accommodation and co-opting a wide range of clinical and non-clinical staff to deliver this. We concluded this programme in mid-April 2021 and await further guidance regarding any future COVID vaccination for staff, such as a booster programme.

Post COVID Syndrome Services

The majority of these services are being conducted in the community / primary care, but we do expect to see an impact on hospital services such as respiratory.

Infection Prevention and Control (IPC) - COVID Actions

COVID-19 Specific

- Complete post infection review reports for all COVID-19 outbreaks developing a thematic learning plan for the Trust
- Complete Trust wide report for cases, contacts and outbreaks including staff.
- Set up and establish a COVID-19 dedicated pathway and ward on both sites with clear guidance for admissions
- Support the potential development of a Respiratory High Care Unit
- Develop COVID-19 policy removing the need for action cards
- Risk assess requirements for weekend cover for IPC across UHD to ensure that a plan is in place to deliver the Trusts requirements for IPC in the presence of any increased peaks or outbreaks of COVID-19. Current staffing model is not templated for this.

Other IPC Actions in 2021/22

- **Surveillance -** Fully integrate ICNET (Electronic surveillance tool) into reporting and managing of patients with alert organisms. This will include integration with the details recorded by Microbiologists within the WINPATH IT system to ensure sharing of information between teams. Importing data from Trust records for patient location to enable outbreak detection and reporting in real time. Incorporating a surgical feed to enable monitoring of surgical site infections.
- **New builds/ modifications of existing structure -** Continue to work with organisation to ensure that all new builds and modifications are planned and delivered in a safe way for patients. This will cover not only the design concept but also ensuring a risk

assessment takes place to review impact on the clinical environment.

- **Staffing -** Merge the two IPC Teams into 1 to ensure resilience and support available for the Trust establishing key roles for all members of the team.
- Complete programme of listening events and debrief for team members to ensure all members are fully supported.
- Integrate IPC Team and the Microbiology Departments across both sites and ensure that the role of the IPC Doctor is set out clearly for the role.
- **Training -** Deliver training and education programme for IPC Champions across UHD to enable them to support the IPC Team during periods of extreme pressure.
- **Policy -** Risk assess all IPC UHD policies alongside Dorset ICS IPC policies to create a plan to review, update and merge policies based upon risk.

5. Transformation, Capital Development and Sustainability

5.1 Clinical Services Review

One of the key drivers for the integrated approach within Dorset was the development of a Dorset-wide Clinical Services Review (CSR). The CSR entails a considerable reconfiguration of health services in the east of the county, particularly across the Royal Bournemouth Hospital (RBH) and Poole Hospital. Specifically, Poole Hospital has been designated as the Major Planned Hospital and RBH as the Major Emergency Hospital for Dorset. National clinical evidence shows that more lives are saved when people are treated in specialist centres with senior specialist staff available seven days a week. We expect to see some of the early changes in services such as the centralisation of acute stroke services and further integration of cardiology, midwifery and pathology, ahead of the major changes planned for 2024/2026, as the new estate is completed.

5.2 Capital Development

The University Hospitals Dorset (UHD) estates strategy up to 2026 is well established, with key service reconfigurations in 2024 and 2026 resulting from the major build programmes.

In 2021/2022 significant enabling works includes the creation of the road at the Royal Bournemouth Hospital (RBH), new West entrance, IT hub room and retail pharmacy. However many other changes are also underway to prepare for the future, including office moves.

Poole Hospital will see the completion of works, including the changes in the Emergency Department and installation of major new equipment such as Linear Accelerators for Radiotherapy. Progress will also be made in establishing estates quality compliance systems and reducing backlog work.

The Capital Expenditure Departmental Limit (CEDL) allocated to Dorset and UHD is insufficient to cover both backlog and maintenance, plus the major service reconfigurations required to deliver the Integrated Care System (ICS) strategy set out in the Clinical Service Review (CSR). As a result the Dorset Pathology Hub will start later in the year and complete by the end of 2022/2023.

For 2021/2022 the estates capital programme focus is on:

i) Completion of works already in progress, many related to Covid improvements and enabling works for reconfiguration.

ii) Essential and backlog reduction maintenance

iii) Planning and preparation of major schemes such as the Maternity, Children's and Emergency Centre (MCEC), and Poole Hospital theatres.

5.3 Sustainability- Green UHD Plan

This sustainability strategy builds on the historic work that has been carried out by the two trusts that formed UHD and aligns it with the requirements set out in the NHS national plan, delivering a "Net Zero" national health service.

The green plan sets ambitious targets across a wide range of action areas that will affect every area of the organisation. We have already made significant progress in many areas to become more sustainable but we need to do more. By having this green plan at the heart of what we do, we can drive long-term success and real change.

The Sustainability Strategy, or Green UHD Plan as it will be referred to, is built around four levels, these are

- Our vision to provide excellent healthcare
- Our green objectives, healthy lives, healthy community and a healthy environment
- A set of cornerstone targets relating to carbon, clean air and the use of resources all supported by our staff

• Actions, targets and monitoring of ten key areas

To realise our green plan there are ten areas of activity that will cover all the aspects of services that UHD has.
• Asset management and utilities
• Use of resources
• Monitoring or carbon and greenhouse gases
• Capital development
• Adaption to climate change
• Our green spaces and biodiversity
• Sustainable models of care
• Travel and logistics
• Our staff and how they can help with the change
• All of the above supported by a firm corporate approach

This plan will put the trust on the route to being a net zero organization by 2040 in line with the wider NHS plan. The plan contains a range of measures across the action areas that will be revised regularly as we move along the reduction trajectory.

5.4 Digital Programmes

UHD will continue in 21/22 with its Digital Transformation Strategy which aims to make patient care safer and more efficient improve staff working lives by achieving paperless patient journeys using linked clinical computer systems

We will respond to the needs of UHD and the Dorset ICS, as set out in the national planning framework, which is recovering from the pandemic and will focus on transformation of the elective pathway.
The main programmes are as follows:

- **Electronic Prescribing and Medicines Administration** - the computerisation of the processes of prescribing and recording of the administration of medicine.
- **DCR (Dorset Care Record)** - an electronic repository providing a consolidated view of information from health and social care systems across Dorset
- **ICE Order Communication System (OCS Project) -** Radiology and Pathology are now fully live and the focus for 21/22 is deploying these services for Cardiology and Endoscopy
- **Electronic Nursing Assessment & electronic Observations -** eNA and eOBs are used to capture relevant nursing observations and assessments electronically, this platform will be enhanced to include a programme for managing the Medical Take and managing patient's Fluid Balance
- **Electronic Forms (e-forms) -** continue to progress paperless care in line with our vision and, where necessary, prioritise e-form development that supports Covid Recovery/Elective Transformation.
- **Outpatient Transformation -** a range of digital solutions will be supported to transform this service for patients and clinicians

- **Emergency Department IT System Review -** provide a complete review of the current ED system with options put forward for short term 1 year and 5 year strategy.
- **Dorset Wide Maternity -** to implement a Dorset wide single maternity system to achieve two key recommendations from the national Better Births Initiative
- **Team Based Notification System** - clinically relevant notifications will be accessible on a variety of user friendly applications including the common clinical EPR portal on fixed and mobile devices for pathology and radiology results
- **Infrastructure Programme** - underlying IT infrastructure of UHD will be enhanced by a variety of network and cloud developments
- **Single Signon** a solution called Single Sign On - simplifies the login and logout process for users.
- **Single Domain** – the new UHD domain will be deployed to make signing on to the network simpler whichever UHD site the staff member attends
- **IT security** – a programme of work with strengthen the mitigations of the risk of cyber security incidents.
- **Information Governance –** support to Information Asset Owners will be strengthened and the Information Asset Register will be fully deployed to enable a compliant Data Security and Protection Toolkit.

5.5 Bournemouth University (BU) Partnership Strategy

Bournemouth University

NHS University Hospitals Dorset NHS Foundation Trust

Both RBCH and PH have worked closely with Bournemouth University for a number of years, before agreeing to a more formal partnership as University Hospitals Dorset upon merger in October 2020. The Memorandum of Understanding agreed by the UHD Board and BU Senate paved the way for a new way of working, aiming to realise the benefits of collaboration across all areas of UHD and BU faculties.

The Strategy sets out actions in the 6 main areas of focus for the BU-UHD partnership programme for the next 3 years. These are:

- strategic alignment – better coordination of strategic objectives
- stimulus for research and innovation – facilitate collaboration and increase research activities
- education and training of future workforce – develop training opportunities and meeting future workforce training needs
- recruit and retain talent – making BU and UHD great places to work
- meeting future challenges – working together to better solve future challenges

- wider private and public partnerships – working closely with other partners

The strategy promotes a “joint by default approach” between the organisations, complementing the existing work and strategies of each individual organisation, enhancing the work that is already done together and developing on both organisations strengths.

The strategy is underpinned by a jointly agreed work programme, governed by a partnership steering group and has an agreed set of success measures.

The accompanying communications strategy underpins the work to raise the profile of the partnership and communicate the benefits of the programme across BU-UHD and beyond.

6. Governance, ICS Development and Communications

6.1 Governance and Assurance

University Hospitals Dorset Hospitals NHS Foundation Trust aims to provide excellent person-centred emergency and planned care to the people we serve. The Board recognises risk is inherent in the provision of healthcare and its services, and therefore a defined approach is necessary to identify and contextualise risk, ensuring that the Trust understands the risks it is prepared to accept in pursuing the Trust's aims and objectives.

The overall aim of the Trust is to achieve a culture where risk management and safety is everyone's business, that there is open and honest recording of risks and a culture that encourages organisation wide learning and risks are continuously identified, assessed and minimised. A culture of ownership and responsibility for risk management is fostered and supported throughout the organisation.

The Trust Risk Management Strategy sets out the Board's strategic approach to risk-taking by defining its boundaries and risk tolerance thresholds. The strategy supports the delivery of;

- Devolved decision making and accountability for the management of risk throughout the organisation; from the point of delivery to the Board.
- Promoting a culture of assurance, monitoring, and improvement, ensuring risks to the delivery of Trust strategic objectives are well understood.
- Supporting patients, carers, and other stakeholders through the management of risks to patient safety, patient experience, and service delivery.
- Refining processes and systems to ensure engagement in risk management is efficient and effective, enabling good decision making through robust reporting to relevant decision making groups and scrutiny groups.
- Supporting the Trust Board, commissioners, and other key stakeholders in receiving and providing assurance that the Trust understands its risk profile and is working to mitigate key risks in appropriate and timely ways.

The Trust Board of directors recognise that Risk Management is an integral part of the Trust's quality, governance, and performance management processes. The Board, with support from its committees will ensure a robust system of risk management is effectively maintained, and champion a culture whereby risk management is embedded across the Trust through policy, strategy, and plans (business planning, policy documentation, strategies, etc. should all explicitly reference risks they are seeking to manage)

The strategy covers all aspects of risk including clinical risk, staff related risk, environmental risk, corporate risk and financial risk and is underpinned by policy and toolkits guiding staff on the day to day delivery of effective risk management processes.

The Trust manages risks by:

- Undertaking an annual assessment of the organisation's objectives and identifying the principal risks to achieving those objectives (Board Assurance Framework (BAF) risks). The BAF is a key mechanism to reinforce the strategic focus of the board and better manage risk. It is used to help the organisation capture, report and monitor key risks to the strategic objectives, implement corrective action and report to Board on progress. It is designed to provide assurance that the organisation is delivering on its objectives and draw attention to areas of concern. The BAF also helps the organisation to assess the controls it has in place to mitigate the risks and review the assurances to check the controls are effective.

- Regular monitoring of the effectiveness of the Board Assurance Framework by the Trust's Board and the Audit Committee.

- Consideration of independent sources of assurance to verify the accuracy and completeness of the risks identified and the controls in place to mitigate them e.g. internal and external audit, commissioned independent reviews, Care Quality Commission (CQC) reports and other external/peer review inspections.

- Regular monitoring and review of the risk register and risk appetite ensuring the risks are managed effectively and at the appropriate level within the organisation and escalated where appropriate. The Trust uses a risk register to record, prioritise and monitor risks across the organisation. Risks that are scored in excess of the Trust appetite are presented to the Executive Directors and Committees in accordance with the relevant Governance Cycles. Both the BAF and the Risk Register are managed through the Trust's electronic governance system; DATIX

- Integrating risk management into business planning, quality improvement and cost improvement planning processes, ensuring that objectives that are set across the organisation with plans to manage risk in accordance with quality impact assessment and risk assessment procedures.

As well as the Board itself, all Board committees have defined responsibilities to oversee relevant risks

This is further supported by risks being reviewed by defined groups through the organisation including:

- Trust Quality Governance Group
- Care Group and Directorate Risk and Governance Groups

The Quality Committee is a committee of the board of directors and is chaired by a non-executive director. The committee receives detailed quality, safety and performance reports including Serious Incident reports so that it can ensure that patient safety and quality of services meet registrations

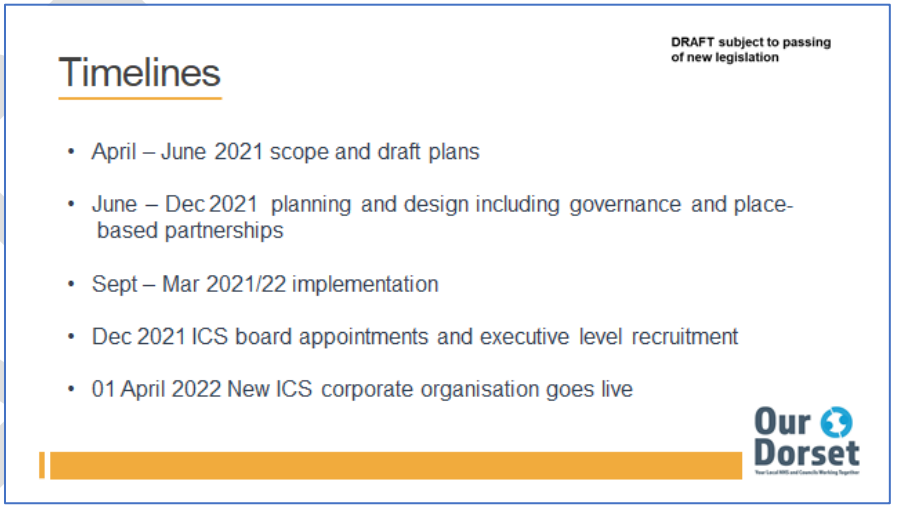
and compliance requirements. The Committee reviews the new and current risks rated 12-25 on a monthly basis prior to the risk register report being presented to Board. New risks are presented to the committee by an in depth report by the executive sponsor or risk owner/handler.

6.2 Integrated Care System (ICS) Development

This 2021/22 plan for University Hospital Dorset (UHD) is written in the context of an NHS which is moving away from a system based on a series of individual organisations to an environment where the system is the dominant structure and where integration of the services across organisations is of paramount importance. The Dorset health and social care system was an early national pilot of the Integrated Care System (ICS) and thus the plan for UHD is not only important in its own right, it is also very important in terms of its contribution to the wider Dorset system plan and its implementation. All of the organisations operating within the Dorset ICS recognise that their effectiveness is dependent on the connections with other organisations across the health and care system, which in turn significantly impacts on the outcomes and experience of our patients. UHD has always had a strong commitment to partnership working, with its vision being “To positively transform our health and care services as part of the Dorset Integrated Care System”.

The Dorset CCG area became a pilot for an ICS in 2018 and in 21/22 will move from this status, subject to legislation, to a substantive ICS, with the statutory functions entailed in this.

This will include the appointment of a Board for the ICS. The timetable for this is anticipated as follows:



6.3 Comms and Engagement

The University Hospitals Dorset communications strategy and plan supports the 2021/22 priorities and operational plan. We will do this by focusing on the main priorities of the plan, including:

Health and wellbeing

We will ensure that all staff have easy access to information to signpost them to all that the Trust has on offer to support their health and wellbeing. Working closely with colleagues in

Occupational Health and Organisational Development, we will highlight how we reward and celebrate our staff and also what support we offer for staff who are struggling for whatever reason. We need to give staff the opportunity to recover from the last year and will continue to support all the work being undertaken to do this through our communications.

Recruitment and retention

We will promote the benefits of working across our Trust in the many varied roles available. This will be based on the benefits of our new university hospital trust status, our career development possibilities and our location. We will also work closely with the Human Resources team on promoting opportunities for staff development to ensure that colleagues do not have to look elsewhere to have the staff progression they desire.

Vaccination programme

The communications team has worked hand-in-hand with the successful rollout of the vaccination across UHD and would expect to be involved in any future campaigns for the COVID - 19 vaccination and any flu campaigns.

Restoration of elective and cancer care services

We have worked closely with the media over the last year to update the public on our services during the COVID-19 pandemic and plan to continue this work as we now move to the recovery phase. We also need to focus on what we have learnt through the pandemic to highlight the benefits of digital healthcare where appropriate and work with colleagues on promoting new models of care which break away from the traditional acute setting of care.

Preventing inappropriate attendance at ED

Working with the Dorset CCG and with the local media and across our social media channels, we have produced several campaigns focussing on where the best place to go for care is. We will continue to do this to ensure that our ED can provide the best possible care for those who need it the most in a timely fashion. We will work with our partners to showcase the alternatives as well as reminding people to ensure they don't ignore symptoms but get them seen to.

Working collaboratively

The UHD communications team works very closely with partners across the Our Dorset Integrated Care System (ICS). The pandemic brought us closer together and we will continue this. Our work together will be focussed on joint resilience and also on addressing the health inequalities of our region.

The hospitals have always good relations with the local GP community and COVID gave us the opportunity to develop this further. The Primary Care Networks (PCNs) are taking an increasing role in the development of primary care and from the commencement of COVID in March 2020, we have had weekly / fortnightly calls between our medical directors and the clinical directors of the PCNs. This is a development we wish to continue; to build upon; and to extend the awareness

of this across UHD as an opportunity for us to improve clinical services across the primary/secondary care interface.

All this work will be underpinned by our communications plan which has been developed to be multi-channel. We need to ensure that all our communication reaches the correct audiences at the right time and by the right channel. This means we need to explore all forms of communications, from digital, to social media, to traditional posters and signposts on location. We have recently rolled out a staff app which helps frontline staff who traditionally haven't had access to our communications through desktops. We have built up very strong media relations both locally and nationally and will continue to focus on these.

7. Finance and Activity

In response to the COVID-19 pandemic; national interim financial arrangements were implemented to support organisations respond effectively, with additional funding made available. Consistent with these arrangements, the Trusts income was fixed through nationally calculated block contract payments, with additional funding provided for specific COVID-19 costs.

Due to the evolving nature of the pandemic, the planning guidance, and detailed financial allocations for 2021/22 were not published until the end of March 2021. This confirmed that the year will comprise two halves: H1, being the period from 1 April to 30 September; and H2, being the period from 1 October to 31 March.

The published guidance and allocations cover the H1 period only, with additional guidance and allocations for H2 expected in July.

Revenue

In advance of the planning guidance and financial allocations, the Trust undertook a comprehensive financial planning process with full clinical and operational engagement. This included a number of stages, including:

- re-confirming the recurrent opening budget
- uplifting for inflation and national cost pressures
- considering business cases for patient safety developments
- inclusion of an appropriate efficiency target
- considering business cases for the Trusts continued COVID-19 response
    - considering business cases for activity/ recovery

This comprehensive process to develop detailed directorate level expenditure budgets was supported by an ICS-wide prioritisation process.

Following receipt of the final guidance and allocations, the Trusts interim budget was reviewed and refined, including amendments to income assumptions consistent with the final national allocations and ICS allocation agreements. The H1 budget can be summarised as follows:

H1 (1 April to 30 September)	£'000
Substantive staff	(203,133)
Bank staff	(7,116)
Agency staff	(3,928)
Total pay expenditure	(214,177)
Drugs	(32,912)
Clinical supplies	(27,519)
Other non-pay	(43,914)
Total non-pay expenditure	(104,345)
Total income	322,763
Net finance costs	(4,242)
Total surplus/ (deficit)	**0**

Consistent with the final H1 planning guidance and financial allocations, in addition to the nationally calculated block contracts; this budget includes £30m of national 'top-up' funding and £12m of specific COVID-19 funding.

However, this budget excludes the impact of the Elective Recovery Fund which has been confirmed within the final H1 guidance. This scheme will provide further funding for the recovery of elective activity, with payment received for additional activity above agreed thresholds.

Several key risks are present within this H1 budget, including:

- Non-NHS income has not yet returned to pre-COVID levels, representing a continued financial risk should this not increase in line with the budget assumptions.
- savings schemes may not be identified to fully achieve the budgeted savings target of £1.5m.
- the Elective Recovery Scheme operates at an ICS level resulting in a risk that costs are incurred and income is not received, either due to a failure to qualify for the scheme or because the aggregate ICS activity is below the required threshold overall.
- no financial contingency has been included within the budget, meaning that there is no scope for additional costs above budgeted levels.

Similarly, a small number of financial opportunities exist to partially off-set these risks:

- COVID-19 costs should start to reduce, with costs therefore coming below the budgeted level.
- the Elective Recovery Scheme, if maximised, could result in a saving against base budgets which include an element of recovery given the pre-existing capacity challenges.

Whilst, subject to the risks highlighted above, the Trust is expecting to deliver a financial break-even position within H1; the expectation is that H2 will see the Trust return to a very challenging financial position. This is reflective of the pre-COVID recurrent underlying deficit which has been exacerbated by the impact of the pandemic.

Current projections indicate that this could result in a deficit of up to £32m during the H2 period, subject to final guidance and ICS-wide allocation agreements.

Capital

The Trust has a comprehensive medium-term capital programme, developed as part of the acute reconfiguration business case and fully aligned to the outcome of the Dorset Clinical Services Review. This programme has been updated to reflect the final capital outturn from 2020/21.

However, following receipt of the ICS capital allocation it became apparent that the respective organisational capital programmes were significantly above this allocation. This resulted in a requirement to re-prioritise schemes, either removing these entirely or rescheduling them into future years.

The Trust fully engaged with this process and reduced the 2021/22 capital programme considerably. The final, full year, capital programme can be summarised as follows:

2021/22	**£'000**
Estates	23,906
Informatics	2,584
Medical Equipment	8,092
Strategic Capital	43,646
Total Capital Programme	**78,228**

The scale of reprioritisation required to deliver a compliant ICS capital programme results in a range of risks for the Trust, including:

- a significant number of priority schemes have been removed from the programme due to affordability within the ICS allocation. There is a risk that these will become urgent and unavoidable, requiring in-year expenditure to address.
- £5.4m of strategic priority schemes have been included, with the assumption that national funding will be received from the New Hospitals Programme national allocation. If this funding is not received, these schemes will need to be deferred or prioritised over other in-year schemes. Any deferral or slippage will have a significant impact upon the acute reconfiguration programme including the critical path for inter-site service transfers.
- no financial contingency has been included within the budget, meaning that there is no scope for additional costs above budgeted levels.
- there is a risk to operational productivity due to slow running aged equipment or the failure of medical equipment in-year.

Mitigations continue to be sought for these risks, including identifying further charitable donations, seeking additional national capital funding and utilising slippage that may occur within other Integrated Care Systems across the South West.

In addition to the Board itself, financial risks are overseen by the Audit, Transformation and Sustainability committees.

Cash

The trust commenced the year with a cash balance of £98m. This significant cash balance has been built up over many years and is fully committed, supporting the medium-term capital programme and specifically the unfunded elements of the acute reconfiguration programme.

The Trust is expecting to end the H1 period with cash reserves of £81m, and will develop the H2 cash plan following finalisation of the H2 budget.

2021/22 Financial Priorities

The Trust's focus during 2021/22 is to deliver within the agreed revenue and capital budgets, pursuing identified and additional mitigations to off-set in-year risks and improve upon the budgeted performance.

In addition, the Trust will work with partners to develop a comprehensive medium term financial plan and associated financial strategy. This is required to address the material recurrent underlying revenue deficit within the Dorset ICS, together with the capital affordability in future years driven by the level of capital slippage/ deferral from the current year.

This financial strategy will include the development of a multi-year financial improvement programme within the Trust, including the achievement of the identified merger savings that have been delayed as a result of the pandemic.

Appendix A – Trust Objectives

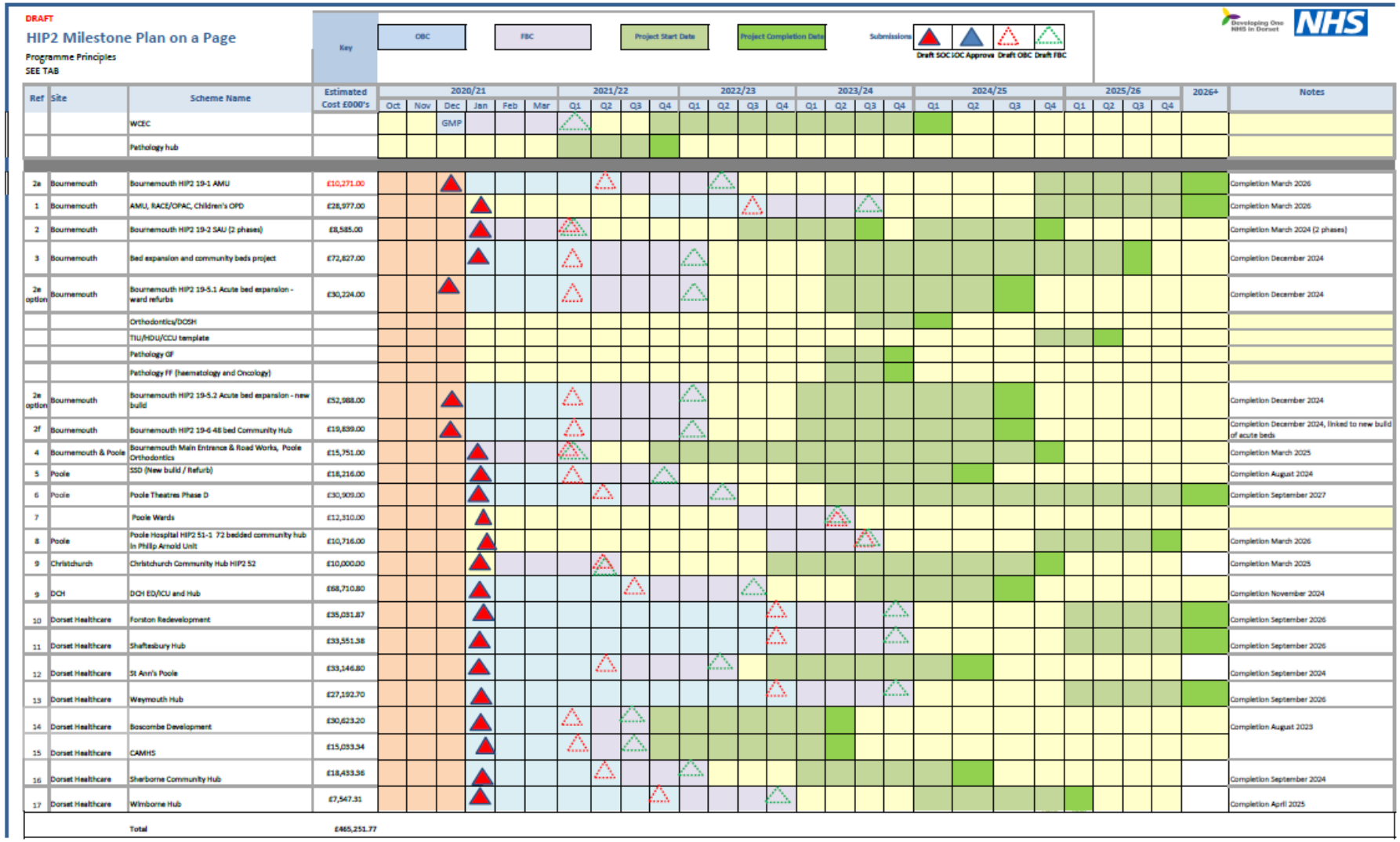
Strategic Objective 1: To be a great place to work, by creating a positive and open culture, and supporting and developing staff across the Trust, so that they are able to realise their potential and give of their best.			**Exec Lead**
1	1.1	To engage with staff at all levels to ensure we maintain focus and realise the Health, Wellbeing and Covid-recovery needs and priorities of all our people, investing in appropriate provision of holistic interventions and resources.	KA
	1.2	To develop a framework that enables leaders to hold meaningful appraisal conversations with staff that will reinforce our shared values and behaviours, provide a mechanism to identify talent and raise performance and engagement across the Trust.	KA
	1.3	To engage with staff so that they feel valued and listened to and would recommend UHD as an employer of choice, demonstrating success through the national staff survey and other local measures and promoting positive outcomes to aid staff retention and net promotion.	KA
	1.4	To deliver the trust's People Strategy by developing effective and responsive People services, policies and practices for each stage of the employee cycle. This will include workforce planning, recruitment and retention, training and education, employee relations, temporary workforce and workforce systems.	KA
	1.5	To champion Equality, Diversity and Inclusion across UHD through positive action and promote initiatives which continue to improve results against workforce equality standards (e.g. WRES and WDES). Focus on inclusive leadership, equal opportunities in career development, endorsement of staff networks and improved collection and use of relevant data.	KA
Strategic Objective 2: To ensure that all resources are used efficiently to establish financially and environmentally sustainable services and deliver key operational standards and targets.			**Exec Lead**
2	2.1	Agree and deliver a sustainable budget, including Cost Improvement Programme (CIP) and merger savings programme	PP

	2.2	To deliver a Covid restoration programme that returns waiting times and waiting patient numbers towards the national standards, for elective, cancer, diagnostics and emergency care.	MM
	2.3	To continue to deliver efficiency and productivity opportunities using Getting it Right First Time (GIRFT) and Model Hospital benchmarking data, in the context of the Covid-19 response. This includes resetting services in ways to reduce unwarranted variation in our clinical and non-clinical services both across sites and between services.	AOD
	2.4	To agree and publish the multi-year Green Plan, to measure, and reduce our carbon footprint, improve air quality and make more sustainable use of resources as part of a multi-year sustainability strategy. This is to be developed by the Trust and agreed by the Board by July 2021 and progress reported to the Board by March 2022.	RR
Strategic Objective 3: To continually improve the quality of care so that services are safe, compassionate timely, and responsive, achieving consistently good outcomes and an excellent patient experience			**Exec Lead**
3	3.1	To deliver 4 priority clinical Quality Improvement (QI) programmes to improve: • Fluid management for inpatients • Escalation of deteriorating patients • Urgent IV access • Safety checklists for procedures • As well as supporting clinical and non-clinical QI work across the Trust.	AOD/PS
	3.2	To redesign and transform our outpatient pathways, with a Digital First offer, improving access to care, reducing travel times, and supporting patients through and changes.	MM
	3.3	To implement the elective care priority programmes for Dorset, so as to improve quality and sustainability of these services: • Ophthalmology • Orthopaedics, as part of the Dorset wide MSK plans	MM

		• Oral, Max Fax and ENT) • Theatres	
	3.4	Improve Urgent and Emergency Care (UEC) flow and quality of care as measured by the new national UEC Emergency Department waiting time standard and same day emergency care outputs.	MM
	3.5	To reduce towards zero the number of patients in hospital beds who don't have a reason to reside, by working with partners and improving our own processes to support safe and timely discharge from hospital.	MM
Strategic Objective 4: To be a well governed and well managed organisation that works effectively in partnership with others, is strongly connected to the local population and is valued by local people.			**Exec Lead**
4	4.1	Strengthen and improve communications/engagement with staff, governors, patients, local people and key stakeholders through a communication and engagement plan, delivered over the year and reviewed by February 2022. A key focus is leading for Equality, Diversity and Inclusion strategy and our work as an ICS partner on reducing health inequalities.	DF
	4.2	Support delivery of a continuously improving organisation and culture of improvement by developing a QI strategy and an innovation strategy. Implement the strategies across UHD and the Dorset ICS to improve outcomes and deliver efficiencies.	RR
	4.3	To provide direct HR and OD interventions and first class business partnering support to leaders and teams facing organisational change across UHD as a result of merger or Clinical Services Review.	MM/KA
	4.4	Develop the Bournemouth University partnership, including the partnership strategy to be approved by Trust Board by July 2021 and implementing throughout 2021/22 and future years	RR
Strategic Objective 5: 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.			**Exec Lead**
5	5.1	Develop a robust plan for reconfiguration to create the emergency and planned hospitals. This includes	RR

		site decants and clinical services moves starting in 2021, and teams being prepared and understanding their trajectory so they are ready with new models of care, and to occupy new estate when it is delivered.	
	5.2	Establishing robust arrangements for taking forwards Health Infrastructure Plan with Dorset partners and NHSI/E, such that Dorset programme business cases start to be submitted in 2021/2 including the new entrance, ward refurbishments and that options appraisals on other cases are completed.	RR
	5.3	Under the national requirements for establishing a new Dorset ICS, work with system partners to develop a provider collaborative across Dorset and help to shape the Dorset Integrated Care System as it transitions onto a statutory basis from April 2022.	DF
	5.4	Implement the UHD Digital Transformation Strategy: Play an active part in the key Dorset transformation plans programmes, including Digital Dorset, by implementing core clinical and non-clinical applications and support the clinical leaders of these programs transform clinical processes to achieve the maximum benefit from these investments. Ensure that the underlying infrastructure and BAU support services are fit for purpose and the technical layers are subject to a rolling stock replacement programme. Migrate all devices to Windows10, stabilise the underlying infrastructure and mitigate against all IT security threats and achieve a compliant Data Protection and Security Toolkit submission.	PG

Appendix B – Summary of CSR Capital Programme



DRAFT

HIP2 Milestone Plan on a Page

Programme Principles

SEE TAB

Key: OBC | FBC | Project Start Date | Project Completion Date | Submissions: Draft SOC, IOC Approva, Draft OBC, Draft FBC

Developing One NHS in Dorset

Ref	Site	Scheme Name	Estimated Cost £000's	2020/21 Oct	Nov	Dec	Jan	Feb	Mar	2021/22 Q1	Q2	Q3	Q4	2022/23 Q1	Q2	Q3	Q4	2023/24 Q1	Q2	Q3	Q4	2024/25 Q1	Q2	Q3	Q4	2025/26 Q1	Q2	Q3	Q4	2026+	Notes
		WCEC				GMP																								
		Pathology hub																												
2a	Bournemouth	Bournemouth HIP2 19-1 AMU	£10,271.00																											Completion March 2026
1	Bournemouth	AMU, RACE/OPAC, Children's OPD	£28,977.00																											Completion March 2026
2	Bournemouth	Bournemouth HIP2 19-2 SAU (2 phases)	£8,585.00																											Completion March 2024 (2 phases)
3	Bournemouth	Bed expansion and community beds project	£72,827.00																											Completion December 2024
2e option	Bournemouth	Bournemouth HIP2 19-5.1 Acute bed expansion - ward refurbs	£30,224.00																											Completion December 2024
		Orthodontics/DOSH																												
		TIU/HDU/CCU template																												
		Pathology GF																												
		Pathology FF (haematology and Oncology)																												
2e option	Bournemouth	Bournemouth HIP2 19-5.2 Acute bed expansion - new build	£52,988.00																											Completion December 2024
2f	Bournemouth	Bournemouth HIP2 19-6 48 bed Community Hub	£19,839.00																											Completion December 2024, linked to new build of acute beds
4	Bournemouth & Poole	Bournemouth Main Entrance & Road Works, Poole Orthodontics	£15,751.00																											Completion March 2025
5	Poole	SSD (New build / Refurb)	£18,216.00																											Completion August 2024
6	Poole	Poole Theatres Phase D	£30,909.00																											Completion September 2027
7		Poole Wards	£12,310.00																											
8	Poole	Poole Hospital HIP2 51-1 72 bedded community hub in Philip Arnold Unit	£10,716.00																											Completion March 2026
9	Christchurch	Christchurch Community Hub HIP2 52	£10,000.00																											Completion March 2025
9	DCH	DCH ED/ICU and Hub	£68,710.80																											Completion November 2024
10	Dorset Healthcare	Forston Redevelopment	£35,031.87																											Completion September 2026
11	Dorset Healthcare	Shaftesbury Hub	£33,551.38																											Completion September 2026
12	Dorset Healthcare	St Ann's Poole	£33,146.80																											Completion September 2024
13	Dorset Healthcare	Weymouth Hub	£27,192.70																											Completion September 2026
14	Dorset Healthcare	Boscombe Development	£30,623.20																											Completion August 2023
15	Dorset Healthcare	CAMHS	£15,033.34																											
16	Dorset Healthcare	Sherborne Community Hub	£18,433.36																											Completion September 2024
17	Dorset Healthcare	Wimborne Hub	£7,547.31																											Completion April 2025
		Total	£465,251.77																											

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS – PART 1

Meeting Date: 28 July 2021

Agenda item: 9.1

Subject:	CQC Action plan

Prepared by:	Joanne Sims, Associate Director Quality, Governance and Risk Tracey Cooper, Acting Directorate Manager and Quality Governance Lead Debbie Gritt, Quality Governance Team
Presented by:	Paula Shobbrook, Chief Nursing Officer

Purpose of paper:	This report advises the Board of Directors of outcome of the CQC Well led review undertaken on the 20 April 21 and the action plan in place to address the CQC must and should recommendations.
Background:	On 20 April 2021 the CQC visited Poole hospital and undertook an announced focused inspection of elements within 'well-led' for UHD. The inspection team consisted of two CQC inspectors and one specialist governance advisor. The inspection focused on the following themes: • Incidents of and learning from the recent never events • Patients, specifically cancer patients, lost to follow-up • Information governance and patient-data security • Recruitment of locum/agency staff and assurance processes The CQC published the final report on 4 June 2021 which highlighted 3 areas for improvement across UHD. In accordance with CQC timescales an action plan was submitted to the CQC on the 21 July 21.
Key points for members:	To discuss the agreed action plan
Options and decisions required:	The Board is asked to discuss the action plan
Recommendations:	The Board is asked to discuss the action plan
Next steps:	

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

Quality Committee	28 June 21

Care Quality Commission (CQC) Focus Review - 20 April 2021

University Hospitals Dorset NHS Foundation Trust

1 Introduction

On 20 April 2021 the CQC visited Poole hospital and undertook an announced focused inspection of elements within 'well-led' for UHD. The inspection team consisted of two CQC inspectors and one specialist governance advisor.
The inspection focused on the following governance themes including reference to specific incidents highlighted by the CQC:

- Incidents of and learning from the recent never events
- Patients, specifically cancer patients, lost to follow-up
- Information governance and patient-data security
- Recruitment of locum/agency staff and assurance processes

The trust was informed that a rating would not be given as the scope was too narrow but a report would be published following the factual accuracy process.

2 Inspection

The inspection consisted of an introduction session, a suite of four focus groups and a slot for initial feedback. Each focus group session covered an area of concern raised by the CQC.

Each focus group session was attended by a number of relevant staff and was supported by the Chief Medical Officer and Chief Nursing Officer.

Following the inspection, UHD was invited to provide relevant evidence within 10 working days to support the information shared on the day.

3 Report

Following a factual accuracy process, the CQC published the final report on 4 June 2021 which highlighted 3 areas for improvement across UHD:

- **Action the trust MUST take to improve**
  Ensure governance systems are effective in determining patients' pathways of care and treatment and these are being completed safely while new systems are developed and made available. In a small number of cases of patients being treated for cancer at Poole Hospital, the system used did not prevent treatment pathways being missed, delayed or terminated in error. We recognised the trust had taken steps to address these gaps, but until the system is tested and these fully investigated, the risk to patient care and treatment still remains. Regulation 17 (1) (2) (b)

Action the trust SHOULD take to improve

- Consider whether the culture around information governance accountabilities and issues of trust are sufficiently recognised and understood to prevent a breach of information access rights. Consider also whether culture is a continuing problem area, as already recognised, in the prevalence of some never events despite some concerns already being acted upon but appearing not entirely resolved.
- Review how events which become statistical outliers for the organisation, as was the case with the 13 never events over the 11 month period, are collectively highlighted to the board over time for effective assurance. Although these were reported as required to the board through the integrated performance report, the high prevalence was not clearly identified for any further discussion or analysis.

Each of three actions has an executive sponsor to lead improvements. The Quality Governance Team will coordinate the updating of the action plan at regular intervals.

4 Action Plan

ACTION PLAN - CQC WELL LED FOCUS REVIEW - 20 APRIL 2021

Created: June 2021 Click here to access glossary
Updated:

	Regulation breach 17 (1) (2) b - Good Governance	
	17 (1) - Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part	
	17 (2) b - Without limiting(1), such systems or processes must enable the registered person, in particular, to (b) assess, monitor and mitigate risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated	
		Exec Lead(s)
1 Must	Ensure governance systems are effective in determining patients' pathways of care and treatment and these are being completed safely while new systems are developed and made available. In a small number of cases patients being treated for cancer at Poole Hospital, the system used did not prevent treatment pathways being missed, delayed or terminated in error. We recognised the trust had taken steps to address these gaps, but until the system is tested and these fully investigated, the risk to patient care and treatment still remains	Chief Operating Officer
2 Should	Consider whether the culture around information governance accountabilities and issues of trust are sufficiently recognised and understood to prevent a breach of information access rights. Consider also whether culture is a continuing problem area, as already recognised, in the prevalence of some never events despite some concerns already being acted upon but appearing not ensure resolved	Chief Informatics and IT Officer l (IG governance accountabilities) Chief Nursing Officer and Director of OD (culture of never events)
3 Should	Review how events which become statistical outliers for the organisations, as was the case with the 13 never events over the 11 month period, are collectively highlighted to the board over time for effective assurance. Although these were reported as required to the board through the integrated performance report, the high prevalence was not clearly identified for any further discussion or analysis	Chief Medical Officer

Ref	Topic	Actions		Progess & Mitigation	Target Date	Lead	Evidence anticipated		
1M	Governance systems - patient pathways	1M.1	Undertake a stocktake of current SOPs to identify urgent areas of improvement for SOPs that relate to patient cancer pathways in particualr management of Cancer MDTs.	Stocktake design underway, will report progress to Operational Performance Group	30/06/2021	Deputy Chief Operating Officer / Associate Director of Operational Performance, Assurance & Delivery / Associate Director for Cancer Services	Elective Care Recovery and Improvement Plan		
		1M.2	Revise and standardise UHD administrative SOPs to include outpatients, diagnostic and admissions booking processes with a focus on the SOPs to manage ASIs, New and Follow up outpatient referrals.	SOP review commenced and will be signed off by Operational Performance Assurance and Delivery Programme Group.	30/08/2021	Head of Patient Access / Deputy Group Director of Operations - Medicine	Elective Care Recovery and Improvement Plan		
		1M.3	Standardise PTL and waiting list management across UHD in line with national rules	PTL meetings established at specialty level and governed through Operational Performance Assurance and Delivery Programme Group	30/06/2021	Head of Patient Access	Elective Care Recovery and Improvement Plan	Long wait PTLs reducing, IPR to Finance and Performance Committee	
		1M.4	Retrain all staff in new SOPs and guidance & implement across UHD	Training plan being developed ready for implementation once SOPs signed off.	30/09/2021	Head of Patient Access / Deputy Group Director of Operations - Specialties	Elective Care Recovery and Improvement Plan		
		1M.5	Clinically led validation of waiting lists	Validation and prioritisation of all wait lists commenced in April, every patient will be contacted by text or letter to access a portal and complete a few questions to help prioritse their care if still required. 4 specialties currently underway with > 50% response rate to date.	30/09/2021	Head of Patient Access	Elective Care Recovery and Improvement Plan	Monthly report and data reports to Operational Performance Group	
		1M.6	Associate Director for OPAD - Cancer to embed weekly breach meeting for each tumour site with respective specialty teams.	Tumour site breach meetings in place, retraining provided across UHD to join tumour sites across RBCH and PH sites.	31/07/2021	Associate Director for Cancer Services	Elective Care Recovery and Improvement Plan		

2S	Information governance accountabilities & culture	2S.1	Review of staff survey to identify responses to safety culture questions	Report at the Quality Committee and Care Group governance meetings	31/08/2021	Director of Organisational Development, Care Group Directors of Nursing	QC papers		
		2S.2	Review themes which are identified through Freedom to Speak Up guardians and Trust incidents inorder to triangulate findings and assess the impact of safety culture through the organisation	Quality Governance Team and F2SU team to consider themes or 'hot spots'.	30/09/2021	F2SU Guardian	Reporting from F2SU guardian to the Board of Directors.		
		2S.3	Embed a framework for incident reporting across UHD, which highlights the positive reporting cutlure and shared learning	Re-Launch of "Share to Care" LERN Forms for UHD. with Learning Events reporting and shared learning	30/09/2021	Associate Director Quality Goverance and Risk	Increased reporting for all 4 types of LERN form across all sites.		
		2S.4	The Board to consider the findings from the CQC to shape the cultural review and OD programme for the Trust	Board seminar on Safety Culture	25/08/2021	Chief Medical Officer, Chief Nursing Officer			
		2S.5	Internal Audit to undertake a review of SI reporting, dissemination of learning and staff engagement.	Scoping meeting held with CMO. Associate Meeting Director, Associate Director Quality Governance and Risk , Head of Internal Audit - June 21. Plan for Internal Audit in Q2/Q3	31/10/2021	Chief Medical Officer	Internal Audit report to QC and Audit Committee		
		2S.6	Continued rollout of Single Sign-On ("SSO") solution trust-wide	Project is currently underway, and is targeting 100% of clinical applications and users to be enrolled by March 2022	31/03/2022	Chief Informatics & IT Officer	Project documentation		
		2S.7	Continued development of new IAR solution which will enable closer monitoring to ensure appropriate checks on userbases are carried out	Rolled out 4 May 2021, 50% of IAOs/IAAs received refresher training on responsibilities in the first two weeks, remainder being followed up	31/03/2022	Chief Informatics & IT Officer	Training records	monitoring of IAO compliance	
3S	Never event reporting - board level	3S.1	Chief Medical Officer's serious incident report to have a standing section of never events to track numbers and themes	To provide robust visibility to Board members	30/06/2021	Chief Medical Officer	Minutes of meeting	Copy of report	

CQC Action Plan well led Inspection April 2:

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PART 1 – COVER SHEET
Meeting Date: 28 July 2021

Agenda item: 9.2

Subject:	Quality Strategy 2021/22

Prepared by:	Joanne Sims, Associate Director Quality Governance and Risk Tracey Cooper, Directorate Manager and Quality Assurance Lead
Presented by:	Paula Shobbrook, Chief Nursing Officer

Purpose of paper:	UHD Quality Strategy for 2021/22
Background:	This report sets out the quality priorities and Quality Strategy for UHD for 2021/22. The UHD Quality Strategy details the aims, objectives, time-scales, responsibilities and monitoring process of the Trust strategic goals for patient safety, patient outcome and patient experience. Quality priorities have been identified through themes from incidents and from recent CQC action plans.
Key points for members:	Progress will be monitored in year and reported to the Quality Committee and assurance will be provided to external partners such as Health Scrutiny panel /CCG as appropriate.
Options and decisions required:	For approval
Recommendations:	The Board is asked to approve the strategy
Next steps:	

Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register		
Strategic Objective:	All	
BAF/Corporate Risk Register: (if applicable)	1598, 1599, 1605, 1473,	
CQC Reference:	Well Led	
Committees/Meetings at which the paper has been submitted:		**Date**

University Hospitals Dorset
NHS Foundation Trust

Quality Strategy
2021 - 2022

Approval Committee	Version	Issue Date	Review Date	Document Author
Quality Committee	2	June 2021	April 2022	Associate Director Quality Governance & Risk

Version Control

Version	Date	Author	Section	Principal Amendment Changes
2	June 2021	JS	6, 12	Revised objectives and quality priorities for 2021/22

Contents

Figures

Appendices

Foreword

Debbie Fleming
Chief Executive

I am delighted to present our Quality Strategy for the years 2021 - 2022 which reaffirms and strengthens our commitment to deliver high quality care in University Hospitals Dorset NHS Foundation Trust

This Strategy supports the achievement of our strategic objectives and specifically sets out the mechanisms that will provide robust quality governance arrangements whilst we continue to develop our services and work towards our goal of delivering outstanding care to our patients and their families.

The delivery of high quality care is dependent on the trust continuing to build its capacity and capability for learning and applying methods of Risk Management, Quality Assurance and Quality Improvement (QI). As a trust we understand that adopting a systematic approach to drive improvements in patient safety, patient experience and quality can enable us to build on our good early foundations as University Hospitals Dorset. .

Our Strategy, as always, continues to support the core values of compassion, openness, respect, accountability, and safety and it is so important that these values remain at the heart of everything we do.

Introduction

A quality strategy details the aims, objectives, time-scales, responsibilities and monitoring processes of how to achieve the Trust strategic goals for patient safety, patient outcome and patient experience.

The overall aim of the Quality Strategy is to ensure that there is a robust quality framework in place which will assure the Board of Directors that the organisation has the ability to provide safe, high quality care, is compliant with the CQC regulations, and continues to strive for further quality improvements.

High quality care is at the centre of everything we do and maintaining and improving the quality of patient care remains the top priority for the trust. This vision is underpinned by the Trust's values and is delivered through five key strategic objectives:

We recognise that our most valuable asset is our staff and the Quality Strategy dovetails into other important strategic documents such as the trust Annual plan, Risk Management Strategy and People Strategy. Together these documents set out our commitment to improve the quality of learning, education and training. Central to this is developing the collective leadership for quality improvement and a culture that enables individuals and teams to flourish.

'Improvements in the quality of care do not occur by chance. They come from the intentional actions of staff equipped with the skills needed to bring about changes in care, directly and constantly supported by leaders at all levels'

The Kings Fund [1]

This strategy takes into account the key changes taking place across the NHS as part of Covid recovery and the development of (Integrated Care Systems. It incorporates the plans set out in the new National Patient Safety strategy and the increasing use of digital and IT technology to enhance patient safety and patient care.

The strategy for 2021/22 also recognises the pressure that the NHS and NHS staff have been under over the past 12 months and therefore seeks to identify realistic targets and timescales for aspirations and developments.

Background

In 2008, a national review of quality by Lord Darzi, led to the widespread implementation of his recommendations to achieve 'High Quality Care for All' (2008). The report set out an ambition for quality to be at the heart of everything we do and determined that in the NHS quality includes the following dimensions:

- Patient safety.
- Patient experience.
- Patient Outcomes.

The Darzi report was followed by the Government's commitment to quality through legislation (the Health and Social Care Act, 2008). To ensure organisations operate within this legislation, the Care Quality Commission (CQC) was established as the official regulator of the NH. Measures of quality are also explicitly set down in the recent governmental white paper entitled 'Equity and Excellence for All' (Department of Health (DoH) 2010) and its associated document 'The NHS Outcomes Framework' (DoH 2010). The Francis Reports 2010 and 2013 also cite the importance of clear vision and transparent operating partnered with a duty of candour to ensure quality is embedded and appropriately risk assessed in any process within the Trust.

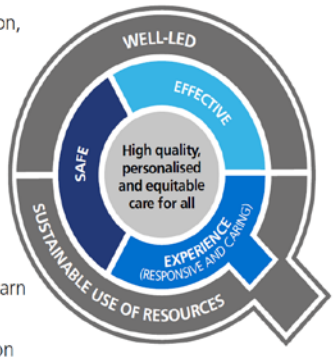
The Trust Quality Strategy supports all of the above guidance and recommendations. The strategy also meets the new National Patient Safety Strategy objectives (published February 2021) and the National Quality Board "Shared Commitment to Quality" published in April 2021.

A shared single view of quality

High-quality, personalised and equitable care for all, now and into the future

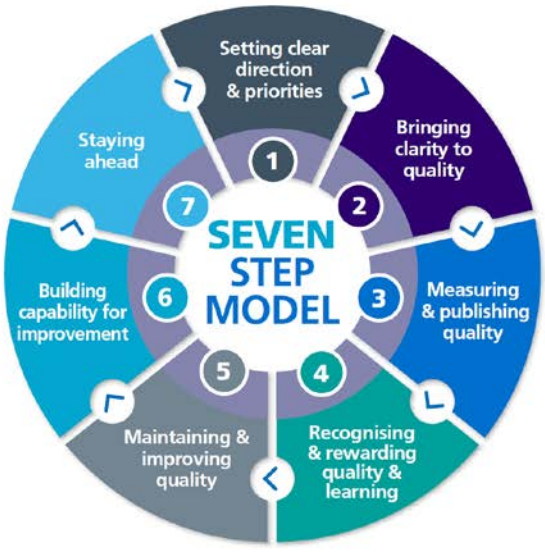
What does this mean in practice? That people working in systems deliver care that is:

- **Safe** - delivered in a way that minimises things going wrong and maximises things going right; continuously reduces risk, empowers, supports and enables people to make safe choices and protects people from harm, neglect, abuse and breaches of their human rights; and ensures improvements are made when problems occur.
- **Effective** - informed by consistent and up to date high quality training, guidelines and evidence; designed to improve the health and wellbeing of a population and address inequalities through prevention and by addressing the wider determinants of health; delivered in a way that enables continuous quality improvements based on research, evidence, benchmarking and clinical audit.
- **Positive experience**
  - **Responsive and personalised** - shaped by what matters to people, their preferences and strengths; empowers people to make informed decisions and design their own care; coordinated; inclusive and equitable.
  - **Caring** - delivered with compassion, dignity and mutual respect.
- **Well-led** - driven by collective and compassionate leadership, which champions a shared vision, values and learning; delivered by accountable organisations and systems with proportionate governance; driven by continual promotion of a just and inclusive culture, allowing organisations to learn rather than blame.
- **Sustainably-resourced** - focused on delivering optimum outcomes within financial envelopes, reduces impact on public health and the environment.
- **Quality care is also equitable** - everybody should have access to high-quality care and outcomes, and those working in systems must be committed to understanding and reducing variation and inequalities.



Reference: National Quality Board "Shared Commitment to Quality" published in April 2021

Delivering quality care in systems: **the seven steps**



1	**Setting clear direction and priorities** To deliver a new service model for the 21st century, which delivers better services in response to local needs, invests in keeping people healthy and out of hospital, and is based on clear priorities, including a commitment to reducing health inequalities.
2	**Bringing clarity to quality** setting clear standards for what high quality care and outcomes look like, based on what matters to people and communities.
3	**Measuring and publishing quality** Measuring what matters to people using services, monitoring quality and safety consistently, sharing information in a timely and transparent way, using data effectively to inform improvement and decision-making.
4	**Recognising and rewarding quality and learning** Recognising, celebrating and sharing outstanding health and care, learning from others and helping others learn, recognising when things have not gone well.
5	**Maintaining and improving quality** Working together to maintain quality, reduce risk and drive improvement.
6	**Building capability for improvement** Providing multi-professional leadership for quality; building learning and improvement cultures; supporting staff and people using services to engage in coproduction; supporting staff development and wellbeing.
7	**Staying ahead** By adopting innovation, embedding research and monitoring care and outcomes to provide progressive, high-quality heath and care policy.

Reference: National Quality Board "Shared Commitment to Quality" published in April 2021

Roles and Responsibilities for Quality Governance

Whilst frontline individuals and clinical teams are responsible for delivering high quality care, it is the responsibility of the Board of Directors to create a culture within the organisation that enables clinicians and clinical teams to work at their best.

The overall responsibility for delivery of the quality agenda rests with the Chief Executive. This responsibility is delegated to the Chief Nursing Officer, in conjunction with the Chief Medical Officer, who has executive responsibility for ensuring that risk management, patient safety, quality and patient experience is delivered throughout the organisation and remains a Trust priority and an integral part of the Trust policies and procedures.

Figure 1. Leadership of Quality

All Executive, Non-Executive Directors and Senior Leaders in the trust engage with front line staff, patients and carers through a variety of forums to enable them to contextualise the information they receive and become familiar with the care environment and clinical practice including:

- Filmed patient stories and Care Conversations.
- Executive Walkabouts.
- Focus groups

- Staff briefing sessions
- Open days and engagement events.

Measurement of our performance

Quality Governance describes the structures and processes in place to provide adequate leadership and scrutiny of quality to ensure high quality care is delivered and risks are understood and managed at all levels of the organisation. Our comprehensive reporting frameworks for the Board and its subcommittees promote transparent and open reporting and are underpinned by directorate structures that provide identification and early resolution of problems.

We measure our quality performance using a broad range of indicators (Figure 2). These indicators are triangulated through Trust, Care Group and Directorate governance meetings and Ward to Board reporting.

Figure 2. Sources of data for measurement of quality

Patient and family feedback including patient surveys, focus groups, complaints, complements	**Quality outcome measures including Getting it Right First Time (GIRFT)**	**Measures of the reliability of critical safety processes**
National and local audit	**NICE Compliance**	**Capacity to respond to and learn from safety, quality and risk information**
Data on staff satisfaction, culture, values and behaviours	**Learning from deaths including structured case note reviews (emortality), learning from inquests, Claims and Medical Examiner reviews**	**Ward Accreditation and Quality reporting**
Compliance with fundamental standards of care and CQC key lines of enquiry	**Incident reports and reporting culture. Evidence of learning and improvement**	**Learning from Claims**

Scrutiny of our services

Reporting our performance

Mechanisms are in place to provide two way transfer of information from the front line staff up to the board and back again. The trust has an established governance structure (Appendix A).

Quality reporting through these structures supports to review, analysis and delivery of key metrics related to patient experience, safety and effectiveness of services up to the board of directors.

All Performance and Quality reporting in the new organisation will be based on the CQC key lines of Enquiry (Safe, Caring, Responsive, Effective and Well Led). Board and Board subcommittee reporting will support wider quality assurance processes such as peer review, annual self-assessment and internal and external audit.

Information in the Board Integrated Performance Report and Quality Committee reports will routinely include:

- Locally defined priorities and performance against them
- National requirements and performance against them
- Exception reporting and risk based narrative commentary
- Trends – current and future risk, assurance and quality issues
- Internal comparisons and external benchmarks
- Directorate, specialty, ward level data where appropriate
- Quantitative and qualitative data
- Patient stories
- Statistical interpretation and analysis

Specific metrics will include:

Monitoring Committee/Group	CQC Key line of Enquiry	Quality Metrics
Board of Directors Integrated Performance Report (IPR)	Safe	Serious Incidents Never Events Pressure Ulcers Falls Incident Reporting (NRLS) Medication Incidents Hospital acquired Infections
	Caring	Complaints FFT Section 42s (Safeguarding)

Monitoring Committee/Group	CQC Key line of Enquiry	Quality Metrics
	Effective	Mortality
	Responsive	eNurse Assessment compliance (falls, Tissue Viability, Nutrition) Patient Moves
	Well Led	Risks 12+ Red Flags Patient safety alerts
Quality Committee	Safe	Patient safety Incidents – Serious Incidents (internal and external), Never Events, Staff Accidents Medication Incidents Radiation Incident (CQC) Hospital Acquired Infections,
	Caring	Complaints Patient Feedback Safeguarding (Adults and Children)
	Effective	Mortality HSMR, SHMI, learning from deaths, Medical examiner results) NICE compliance National Clinical audits
	Responsive	eNA Red flags
	Well led	Mandatory training Risk register Board Assurance Framework Learning from Inquests and Claims CQC Staff survey results – safety culture
Quality Governance Group		As above and: LERNS Restraint Incidents Inquests Claims
Directorate Risk and Governance Groups		As above – Key metrics to be included as standard agenda items (as set out in the Trust Risk Management Strategy).
Ward Meetings	Safe	Patient safety Incidents Staff Accidents Medication Incidents Hospital Acquired Infections, Saving

Monitoring Committee/Group	CQC Key line of Enquiry	Quality Metrics
		Lives KPIs, Hand hygiene
	Caring	Privacy and dignity, single sex accommodation
	Effective	eNA, eObs,
	Responsive	Complaints, Patient moves, outliers, delayed transfers,
	Well led	Risks 12+, Essential Core skills, Staffing and skill mix,

External

Externally, the Trust is reviewed by a range of external organisations and stakeholders. These include:

- CQC – review of compliance against the CQC regulatory framework and Key Lines of Enquiry (KLOE) via announced and unannounced reviews and inspections.
- NHSI – review of compliance against NHS Improvements Well-led Framework
- Clinical Commissioning Groups – review of compliance against National and local CQUIN targets and contractual quality provisions, outcomes and assurance, routine and ad hoc inspections
- Local Healthwatch – review and publically comment on the Trust Annual Quality Report
- Council of Governors – routine monitoring of patient safety, patient experience and patient outcome measures, risks and performance
- Local Health Overview and Scrutiny Committees -review and public comment on the Trust Annual Quality Report
- External Auditors (Internal and External Audit) - review and public comment on the Trust Annual Quality Report, completion of annual Internal Audit plan.
- Dorset Quality Surveillance Group as part of the Integrated Care System.

Sharing progress with patients and the public occurs through the Trust Member Newsletter, meetings and open days. The Annual Quality Account reports on the quality of trust services including progress with our quality priorities.

Our quality priorities

The relationship between our values, strategic objectives and quality priorities are expressed within the Quality Wheel [5] (Appendix B)

The trust's quality priorities are arranged within the domains of quality; safety, patient experience and clinical effectiveness (clinical outcomes). Additionally we recognise the fundamental role that our staff play in delivering high quality care and our people strategy therefore forms the fourth domain.

Individual priorities within each domain are derived from the national guidance and triangulation of internal data from a variety of sources including patient feedback, external stakeholders, regulators, governors and incident reports.

We take an inclusive approach in the way we deliver quality improvement, recognising that a variety of techniques can lead to improvement.

Patient experience objectives

The involvement of patients and their families in care is central to developing a positive patient experience. Fundamentally, we aspire to care for all patients as individuals and devise care plans which are personal to their needs. When developing services we aspire for patients and the public to have a voice in that planning process and when possible lead it.

Our main quality strategy objective for 2021/22 is to work with colleagues across the system to implement the requirements of the NHS Patient Safety Partners Framework (due to be published Summer 21) including:

- The appointment of Patient Safety Partners (PSPs) and development of the role as partners in safety across the system. Local systems should aim to include two PSPs on their safety related clinical governance committees (or equivalent) by April 2022 and elsewhere as appropriate.
  The Dorset Patient Safety Strategy Steering group has asked that a task and finish group is set up. The objectives will be to review the requirements of the finalised framework, the impact on Trusts and to consider a recruitment strategy across the ICS for patient safety partners and ensure there is an effective peer support network from the outset.

- Supporting staff to empower patients to be partners in their own healthcare safety

- Maintaining high standards of patient information

- Involving patients and their families or carers in the response to a patient safety incident including any investigation

Patient safety

The Trust is committed to continue to engage with any new national patient safety campaigns and any safety collaborative established by the Academic Health Science Networks, CCG or NHS Improvement.

Our main priorities for patient safety for 2021/22 are to implement the key requirements of the National Patient Strategy (published February 21) including:

- Appoint a Patient Safety Specialist for the Trust and participate in the Dorset ICS Patient Safety Strategy Steering Group.

- Participate in the work across the ICS (led by the CCG) to develop and adopt agreed principles and policies to support a Just Culture.

- Achieve 100% compliance with National Patient Safety Alerts by their action complete deadlines

- Demonstrate improvements in the results of the NHS staff survey (safety culture questions)

- Improve the quality of incident reporting across the Trust and (LERN incidents, issues, excellent events and ideas) across all staff groups.

- Support transition from the National Reporting and Learning System and STEIS to the new national Patient Safety Incident Management System (PSIMS) as required and subject to local software compatibility.

- Work with colleagues across the system to plan to implement the new Patient Safety Incident Response Framework as and when published (Spring 22)

- Support implementation of the new national Patient Safety Syllabus (outline launched May 21) as and when training materials become available.

- Support Covid-19 recovery planning focusing on the identification, investigation and learning from patient safety incidents that may be associated with extended waiting times for treatment.

Additional Local Priorities for 2021/22:

- **Surgical checklists.** A Trust QI Project has been identified to progress this work during 2021/22. The aim of the project will be to standardise surgical checklist processes across UHD.

- **Identification and escalation of the deteriorating patient.** A Trust QI Project group has been established to progress this work during 2021/22.

- **Fluid Management**. A Trust QI Project group has been established to progress this work during 2021/22.

- **Difficult Intravascular Access (DIVA)**. A Trust QI group has been set up to devise a new UHD process, standardise devices and agree a policy for management of patients with difficult intravascular access.

Clinical Effectiveness

At University Hospitals Dorset NHS Foundation Trust, to reduce variation and ensure the best possible clinical outcomes, we strive to ensure our patients are provided the most effective evidence-based care. The Trust participates in a robust clinical audit and clinical outcomes programme and over the forthcoming years our quality priorities are to:

- **Develop a UHD Consent policy**
  The Deputy Chief Medical Officer is leading a Task and finish group to produce a UHD Consent Policy and toolkit.

- **Embed governance structures**
  A Governance toolkit has been issued to Directorates Care Group and Specialities. The Quality Governance team are supporting Directorate leads to implement. An audit will be undertaken at the end of Q2 2021/22 with results reported to the Quality Governance Group and Quality Committee.

- **Embed Morbidity and Mortality (M&M) framework**
  A standard M&M toolkit has been issued to Directorates Care Group and Specialities. The Quality Governance team will support Directorate Mortality leads to implement and embed during 2021/22. An audit will be undertaken at the end of Q2 2021/22 with results reported to the Quality Governance Group and Quality Committee.

- **Standardise use of electronic nurse assessment (eNA) across UHD**

  The Head of Clinical Practice will lead on a review of current eNA metrics to standardise across UHD. Following this work, eNA metrics will be included in Ward to Board Dashboards in phase 2.

- **Standardise Ward to board reporting**

  The Quality Governance team will work with Information Department to produce phase 1 UHD Ward to Board reporting on key quality and patient safety metrics for Q1 21/22.

- **Nursing documentation**

  The Head of Clinical Practice has been appointed as Chief Nursing Information Officer. The role will focus on the development of IT to support nursing and clinical practice, building on the work of our midwifery and allied health professional colleagues. The initial focus of this role will be to digitise existing paper-based patient documentation and care planning, allowing us to bring together our current nursing digital applications – reducing the need to record information in multiple places while improving patient safety. This project will be monitored by the Strategic Nursing, Midwifery and AHP/HCS forum, chaired by the Chief Nursing Officer.

- **Peer review**

  A task and finish group has been established to develop a new methodology across UHD for Peer review in line with the CQC Key Lines of Enquiry. The project will be monitored by the Strategic Nursing, Midwifery and AHP/HCS forum, chaired by the Chief Nursing Officer

  Learning from Claims

  Use litigation packs provided by GIRFT to maximise learning opportunities. Triangulate litigation data with Trust information on complaints, inquests, learning from death reviews and SI investigations to consider interventions to improve patient care.

Keeping on track and strategy delivery

Each of the three pillars of quality; Patient Safety, Patient Experience, Clinical Outcomes/Clinical Effectiveness are monitored through the respective reporting groups in the trust governance framework (Appendix A). Through these groups specific measurable objectives will be set and monitored. This strategy overall will be reviewed annually by the Trust wide the Quality Committee.

The Chief Nursing Officer and Chief Medical Officer will monitor the process for governing quality locally to ensure it is being complied with in respect of this strategy. This will be

reported at the Care Group and Directorate governance meetings.

Aspects of quality and governance implementation will be subject to monitoring through the annual internal audit review and Annual Quality Account.

References

- The Kings Fund (2016) Improving Quality in the English NHS: A strategy for action.
- Department of Health (2008) High Quality Care for All. NHS next stage review final report.
- Department of Health (2014) Five Year Forward View.
- NHS Improvement (2016) Implementing the Five Year Forward View.
- NHS Long Term Plan (2019) #longtermplan www.longtermplan.nhs.uk
- The NHS Patient Safety Strategy – safer culture, safer systems, safer patients. July 2019
- NHS Patient Safety Strategy:2021 update. Published February 2021
- National Quality Board – A shared commitment to quality for those working in health and care systems. April 21
    - National Quality Board (2011) Quality Governance in the NHS – a guide for provider boards.
    - National Advisory Group on the safety of patients in England (2013) A promise to learn- a commitment to act: Improving the safety of patients in England. (The Berwick Report).

Equality Impact Assessment

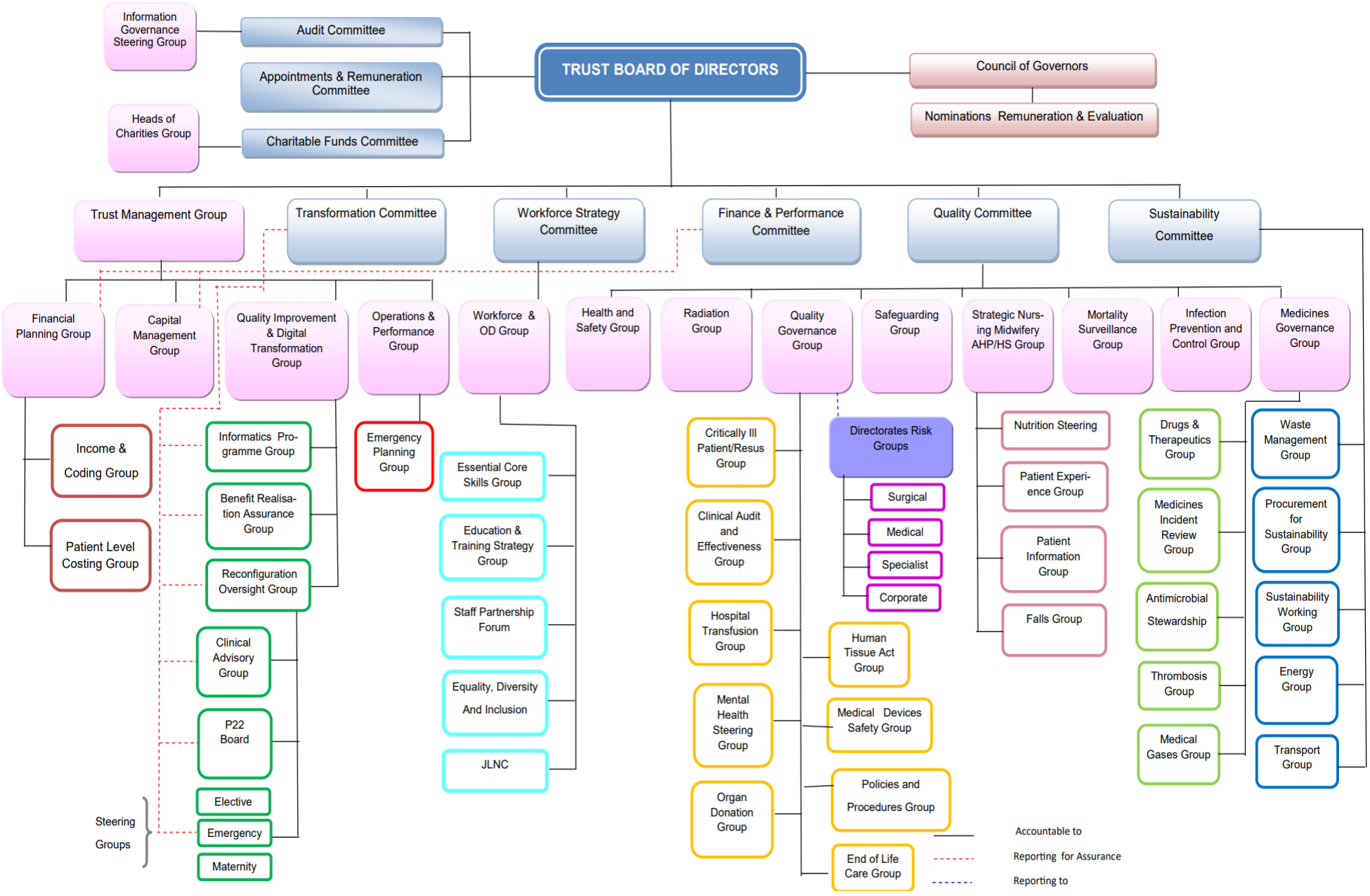
1. Title of document	**Quality Strategy 2021/22**
2. Date of EIA	June 21
3. Date for review	June 22
4. Directorate/Specialty	Quality and Risk

5. Does the document/service affect one group less or more favorably than another on the basis of:

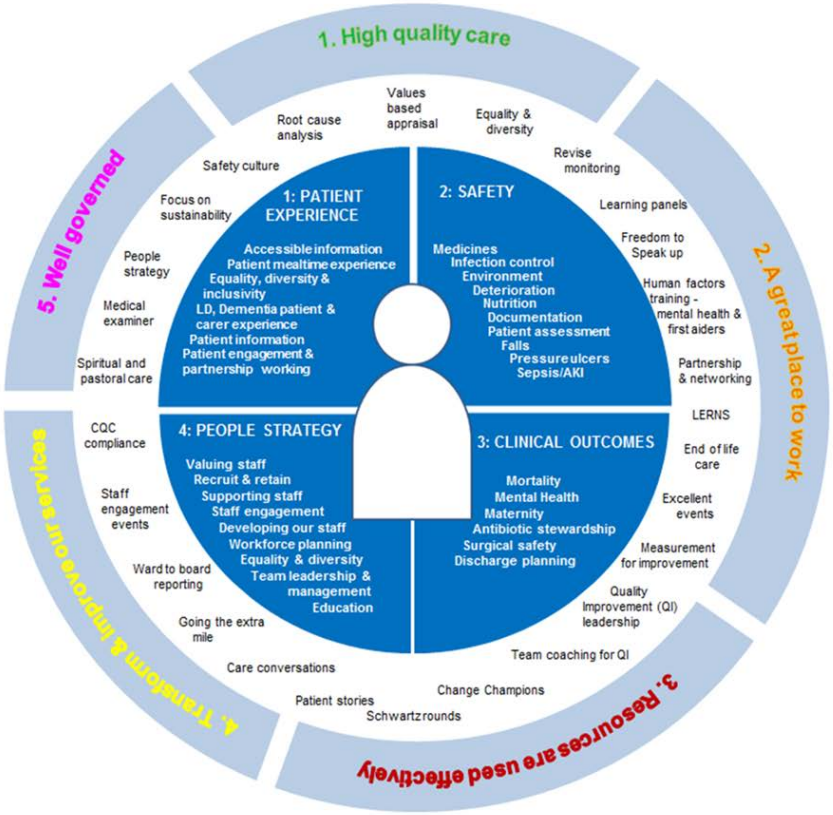
	Yes/No	Rationale
• Age – where this is referred to, it refers to a person belonging to a particular age or range of ages.	N	
• Disability – a person has a disability if they have a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal daily activities.	N	
• Gender reassignment – the process of transitioning from one gender to another.		
• Marriage and civil partnership – marriage can include a union between a man and a woman and a marriage between a same-sex couple.	N	
• Pregnancy and maternity – pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavorably because she is breastfeeding.	N	
• Race – refers to the protected characteristic of Race. It refers to a group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.	N	
• Religion and belief – religion has the meaning usually given to it but belief includes religious and philosophical beliefs including lack of belief (such as Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.	N	
• Sex – a man or a woman.	N	
• Sexual orientation – whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.	N	
7. If you have identified potential discrimination, are the exceptions valid, legal and/or justified?	N	
8. If the answers to any of the above questions is 'yes' then:	**Yes**	**Rationale**
Demonstrate that such a disadvantage or advantage can be justified or is valid.		
Adjust the policy to remove disadvantage identified or better promote equality.		

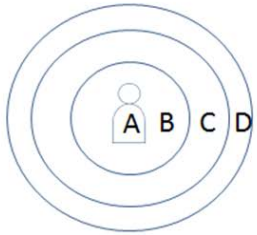
Appendix A

University Hospitals Dorset NHS Foundation Trust



Appendix B – Quality Wheel





A. Approach philosophy
B. Pillars of Quality – focus of priorities
C. Workstreams and processes
D. Strategic goals

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 28 July 2021

Agenda item: 9.3

Subject:	Information Governance Annual Report

Prepared by:	Camilla Axtell, Information Governance Manager
Presented by:	Peter Gill, Chief Informatics Officer

Purpose of paper:	For discussion
Background:	Quarterly update from IG Steering Group, which is a sub-group of the Audit Committee
Key points for Board members:	- New Information Asset Register to strengthen assurance. - Poor FOI compliance levels (target set by ICO is 90% compliance). - Training compliance short of 95% target required to pass DSP Toolkit. - Issues around accurate and comparable incident reporting.
Options and decisions required:	For discussion
Recommendations:	The Board is asked to discuss the annual report.
Next steps:	n/a

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:	

Committees/Meetings at which the paper has been submitted:	**Date**
IG Steering Group, Audit Committee	July 2021

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST
BOARD OF DIRECTORS

Meeting Date: July 2021

INFORMATION GOVERNANCE (IG) ANNUAL REPORT

1. Overview

The aim of imbedding good Information Governance practice throughout the Trust is to provide assurance to patients and to the Board that information is managed in a legally compliant fashion. This remains a priority for the Trust during 2020/21.

The single IG department was formed in September 2020. Work is continuing to understand and appraise the responsibilities of both previous IG functions, taking a "best of breed" approach in terms of aligning policy and procedure.

The events of 2020 – specifically the Covid-19 pandemic and creation of University Hospitals Dorset – have conspired to make this an extremely busy and challenging year for the Information Governance department, as work is undertaken to support healthcare services to be compliant and safe by keeping information confidential and secure.

It is hoped that the ever-increasing national focus on Information Governance will prove to be positive for the Trust in terms of continuing to push this improvement agenda forwards.

2. Data Security and Protection Toolkit

The Data Security and Protection Toolkit (DSP Toolkit) is a self-assessment audit completed by every NHS Trust and submitted to NHS Digital annually. The purpose of the DSP Toolkit is to assure an organisation's IG practices through the provision of evidence around 10 Data Security Standards, each of which has numerous mandatory individual requirements, known as "assertions". This is the most significant single piece of work regularly undertaken by the Information Governance department. As well as submission to NHS Digital, compliance also forms an aspect of the contract with commissioners.

The DSP Toolkit sets the standard for cyber and data security for healthcare organisations, placing a significant focus on assuring against legislation as well as modern threats such as cyber-attacks. The majority of the assurance required falls under the remit of IG and IT Security teams. A number of elements also require input from the wider organisation – further information is provided in section 3.

The DSP Toolkit sets out the standards that organisations are required to meet with an expectation that this will be an ongoing journey towards compliance. The tenets of good Information Governance can be built around the audit; however, the audit does not cover the full breadth of the IG agenda and therefore additional assurance work is necessary.

As a result of the Covid-19 pandemic, NHS Digital postponed the date at which a submission must be made to 30th June. As at this date, the Trust submitted a non-

compliant DSP Toolkit; evidence was provided to satisfy 93 out of 110 mandatory assertions, but the nature of the audit is that all mandatory assertions must be met in order to achieve a status of “Standards Met”. As such the Trust’s submission currently shows as “Standards Not Met”.

An action plan has been formulated to address the remaining 17 assertions before the end of the calendar year. The extent of this action plan means that it will not currently be accepted by NHS Digital, who will only permit an action plan comprised of 15 assertions or fewer. Once enough actions have been completed, the plan will be resubmitted to NHS Digital with a view to the Trust’s status being updated to “Standards Not Met (Plan Agreed)”.

A summary of compliance against the Data Security Standards is provided at Appendix A. The Trust’s action plan is provided at Appendix B.

3. Information Asset Assurance

Substantial importance is placed on the effective management of the vast amount of digital information held across the Trust. This is a key part of compliance with the DSP Toolkit, but this is also a matter of best practice.

A significant portion of the DSP Toolkit audit is underpinned by work associated with information risk assurance. This involves the identification of the Trust’s key information systems (known as information assets), the designation of a senior person who is responsible for each system (known as an Information Asset Owner/IAO), and ensuring that each of these systems has in place such measures as appropriate contract clauses, adequate access controls, regular risk assessments and suitable business continuity plans, and to ensure that any information which is transferred into or out of the Trust through this system is risk assessed and appropriately protected. IAOs are supported in these tasks by Information Asset Administrators/IAAs. This work is essential to ensure the continuous provision of effective care and to ensure that any risks to the integrity and availability of critical information are mitigated as far as is possible.

The IAOs co-operation is critical to achieving compliance with he DSP Toolkit, as they take responsibility for providing the required assurance within each separate area of the Trust, meaning that the level of assurance provided within the DSP Toolkit submission covers the whole organisation rather than selected areas. These members of staff are directed by the Information Governance Manager under the jurisdiction of the Chief Informatics Officer, and compliance amongst IAOs is routinely monitored through IG Steering Group.

In early May 2021 the Trust rolled out its new in-house built Information Asset Register, with role-specific training offered to all IAOs and IAAs. This system will enable IAOs to manage their own assets and guide them in providing the information required. This will be a key tool for the Trust going forwards. Reports are being created as the data is populated; the below table shows the number of Information Assets currently recorded by Care Group.

	Number of Information Assets	Number of IAOs	Number of IAAs
CG A – Surgical	25	13	18
CG B - Medical	83	29	49
CG C - Specialties	99	46	72
Other / Corporate	126	48	82
Unknown / TBC	15	11	11
Total	**348**	**147**	**232**

The work that has been undertaken during the last few years to ensure that the tasks required to be completed by IAOs are started and seen through to completion or maintained year on year has been reinvigorated through the introduction of the new IAR and delivery of refresher training to IAOs and IAAs. The Trust must continue to maintain the traction that is has gathered on this work in order to firmly imbed the concepts as "business as usual" – this must be seen as an ongoing assurance project in order to be successful.

4. Freedom of Information

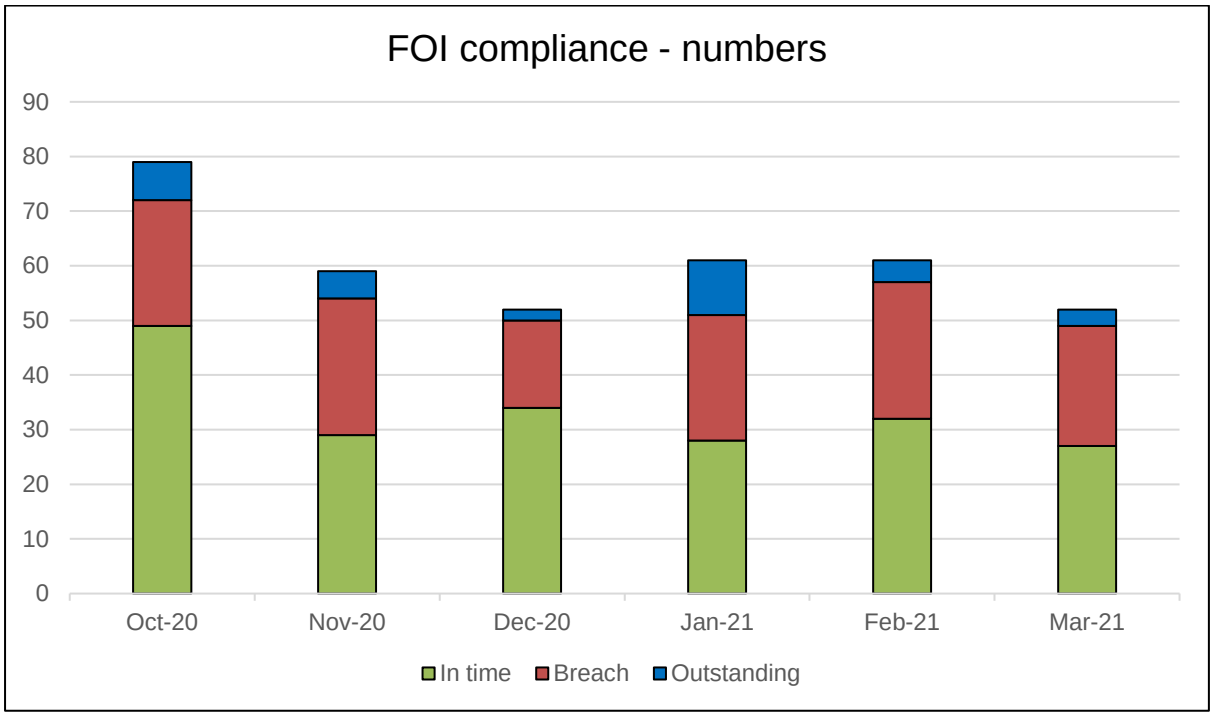
In spite of the well-documented pressures that the NHS has been under in the last 18 months, the number of FOI requests received has not diminished.

Compliance with the statutory time limit imposed by the FOIA remains markedly removed from the 90% compliance target imposed by the Information Commissioner's Office; a steady maintenance of compliance levels can be observed in the chart below. The number of breaches seen generally remains indicative of the large number of requests received, and the increased complexity of these requests which can require a significant amount of work to locate the information requested. Additionally, this can also be attributed to the difficulty of obtaining full and timely responses from staff who are managing competing priorities, and the Trust's position that critical reporting that is key to patient care and managing the financial affairs of the Trust should take priority over handling FOI requests. Further complexity has been introduced with personnel changes throughout the Trust, increasing the challenge of locating information.

The ICO will monitor selected organisations to review their performance in adhering to the Freedom of Information Act, targeting those authorities which repeatedly fail to respond to at least 90% of FOI requests received within the appropriate timescales. Monitoring may be a precursor to further action if an authority is unable to demonstrate an improvement. Further action could include the Trust having to sign an undertaking to improve its practices, an enforcement notice, reports to Parliament, or prosecution.

The issue of poor FOI compliance will continue to be monitored throughout 2021/22 through the Information Governance Steering Group and Audit Committee; as the pandemic response winds down and departments begin to settle post-merger it is hoped that this compliance will improve.

	Total received	% In time	% Breach	% Outstanding
October ‘20	79	62%	29%	9%
November ‘20	59	49%	42%	8%
December ‘20	52	65%	31%	4%
January ‘21	61	46%	38%	16%
February ‘21	61	52%	41%	7%
March ‘21	52	52%	42%	6%



5. IG Training

Information Governance training compliance has inevitably been reduced in the last year. Whilst compliance remains relatively good, the DSP Toolkit explicitly states the target required; this is reflected in the question:

> *Have at least 95% of all staff, completed their annual Data Security awareness training in the period 1 April to 31 March?*

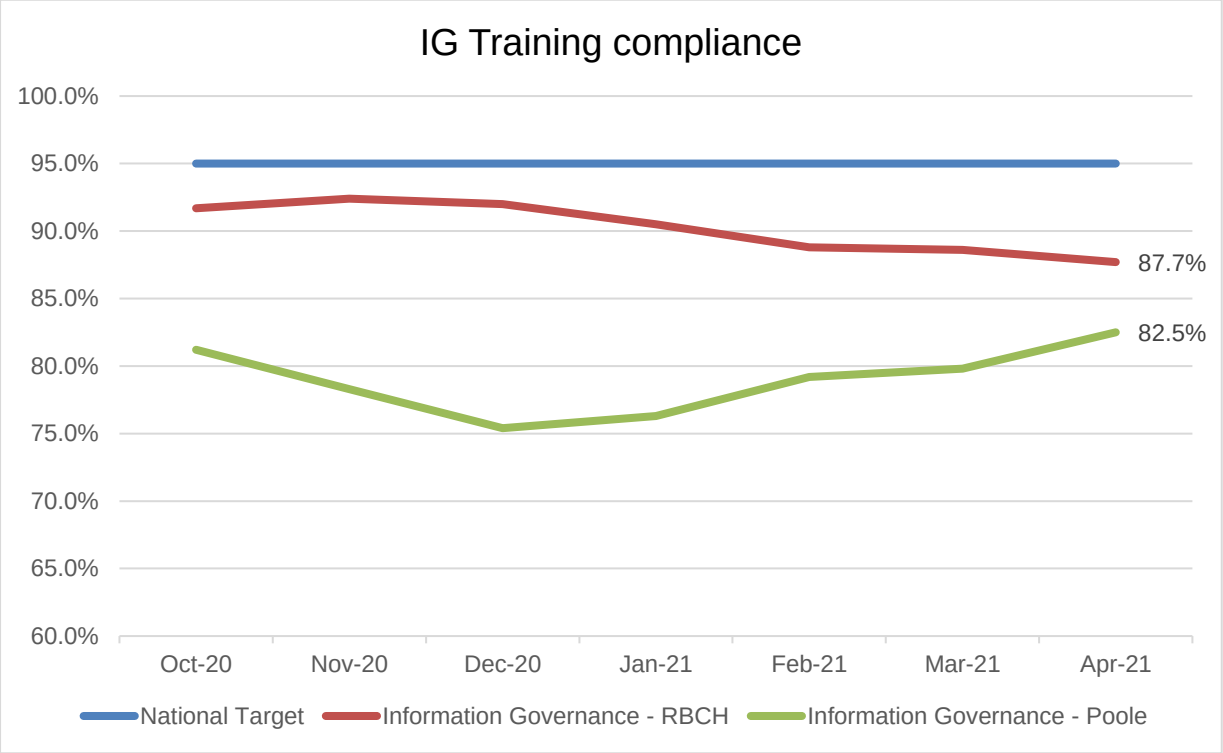
During 2020/21 it was confirmed that this target could be met at any point in the 12-month window, however the Trust was not able to reach this.

An automated e-mail reminder is issued weekly to staff who are not compliant with their IG training, with additional emails being sent in the month prior to compliance lapsing. However, the concerted campaign of chasing those who remain non-compliant has been stood down this year in acknowledgement of the additional pressures on staff. Training compliance is one of the elements included on the Trust’s DSP Toolkit action plan, and the IG team will therefore look to recommence the process of encouraging compliance.

One of the major challenges in attaining compliance is the fact that IG training is singularly an annual competency for all staff; all other topics require renewing every two

or three years. Therefore, completion of IG training requires staff to go out of their way to obtain this competency in the “off years”.

At present, IG Training is completed using the “Data Security Awareness Training Level 1” e-learning programme from eLearning for Healthcare. This is delivered locally to staff through the BEAT VLE, with a small number of face-to-face training sessions also being delivered in some areas. In the future, the Trust will look at bringing the creation of the e-learning content back in house in order to exercise greater control over this.



6. Incidents

It has become apparent since merger that the two legacy Trusts were reporting IG incidents differently. The manner in which these were recorded for Poole Hospital required manual review with non-IG incidents being excluded from the totals, whereas for The Royal Bournemouth and Christchurch Hospitals incidents were noted specifically as IG incidents upon reporting.

Since April 2021, the Trust has been using the legacy Poole Hospital means of reporting incidents; this more comprehensive approach means that a larger number of incidents are captured which may have an IG element to them, but which may not be considered exclusively IG incidents.

Once reviewed, these incidents are divided into one of three categories – Confidentiality, Integrity or Availability. Known as the “CIA Triad”, these are the three high-level types of breaches as defined in by European guidance on personal data breach notification. The table below indicates the breakdown of incidents by these categories.

Under the UK General Data Protection Regulation and Data Protection Act 2018, the Trust has statutory obligations to report the most serious breaches within 78 hours and to inform data subjects affected by these breaches. This legislation introduces

significantly increased financial penalties for a wider range of breaches of the legislation. Successful completion of and compliance with the DSP Toolkit enables the Trust to comply with some of the requirements of the updated legislation; however it remains essential to ensure that work streams which are key to maintaining compliance with data protection legislation, such as data flow mapping and the completion of data protection impact assessments, are supported to be considered as a "business as usual" processes.

Incidents	Total	Confidentiality	Integrity	Availability
October '20	35	26	1	8
November '20	28	17	2	9
December '20	33	24	1	8
January '21	16	12	1	3
February '21	24	16	3	5
March '21	31	16	9	6

Conclusion

Progress is being made to embed changes to legislation and assurance mechanisms required across the new organisation; however there is still a lot of work to do.

It must be recognised that the assurance work undertaken through the DSP Toolkit is ongoing and requires continual update and maintenance to ensure that compliance with the relevant legislation and national standards can be sustained. While the initial drive to begin to imbed this initiative is perhaps the most difficult, it is essential that this momentum is sustained to avoid a retrograde slump, negating any achievements realised. Support is required from the organisation as a whole to ensure that this work is given the necessary priority on an ongoing basis.

During 2021/22, the priority will be to improve upon the current level of compliance with FOI and information risk assurance work, as well as the successful completion of the DSP Toolkit action plan by the end of 2021.

Camilla Axtell
Information Governance Manager and Data Protection Officer
12th July 2021

Appendix A – Data Security and Protection Toolkit scores

Order	Evidence code	Assertion	Predicted Status
1		**Data Security Standard 1** All staff ensure that personal confidential data is handled, stored and transmitted securely, whether in electronic or paper form. Personal confidential data is only shared for lawful and appropriate purposes. Staff understand how to strike the balance between sharing and protecting information, and expertise is on hand to help them make sensible judgments. Staff are trained in the relevant pieces of legislation and periodically reminded of the consequences to patients, their employer and to themselves of mishandling personal confidential data.	
		Mandatory assertions satisfied – 7 / 8	Incomplete
2		**Data Security Standard 2** All staff understand their responsibilities under the National Data Guardian's Data Security Standards, including their obligation to handle information responsibly and their personal accountability for deliberate or avoidable breaches. All staff understand what constitutes deliberate, negligent or complacent behaviour and the implications for their employment. They are made aware that their usage of IT systems is logged and attributable to them personally. Insecure behaviours are reported without fear of recrimination and procedures which prompt insecure workarounds are reported, with action taken.	
		Mandatory assertions satisfied – 1 / 1	Complete
3		**Data Security Standard 3** All staff complete appropriate annual data security training and pass a mandatory test, provided linked to the revised Information Governance Toolkit. All staff complete an annual security module, linked to 'CareCERT Assurance'. The course is followed by a test, which can be re-taken unlimited times but which must ultimately be passed. Staff are supported by their organisation in understanding data security and in passing the test. The training includes a number of realistic and relevant case studies.	

	Mandatory assertions satisfied – 3 / 4	Incomplete
4	**Data Security Standard 4** Personal confidential data is only accessible to staff who need it for their current role and access is removed as soon as it is no longer required. All access to personal confidential data on IT systems can be attributed to individuals. The principle of 'least privilege' is applied, so that users do not have access to data they have no business need to see. Staff do not accumulate system accesses over time. User privileges are proactively managed so that there is, as far as is practicable, a forensic trail back to a specific user or user group. Where necessary, organisations will look to non-technical means of recording IT usage (e.g. sign in sheets, CCTV, correlation with other systems, shift rosters etc).	
	Mandatory assertions satisfied – 3 / 5	Incomplete
5	**Data Security Standard 5** Processes are reviewed at least annually to identify and improve processes which have caused breaches or near misses, or which force staff to use workarounds which compromise data security. Past security breaches and near misses are recorded and used to inform periodic workshops to identify and manage problem processes. User representation is crucial. This should be a candid look at where high risk behaviours are most commonly seen, followed by actions to address these issues while not making life more painful for users (as pain will often be the root cause of an insecure workaround). If security feels like a hassle, it's not being done properly.	
	Mandatory assertions satisfied – 1 / 1	Complete
6	**Data Security Standard 6** Cyber-attacks against services are identified and resisted and CareCERT security advice is responded to. Action is taken immediately following a data breach or a near miss, with a report made to senior management within 12 hours of detection. All staff are trained in how to report an incident, and appreciation is expressed when incidents are reported. Sitting on an incident, rather than reporting it promptly, faces harsh sanctions. [The Board] understands that it is ultimately accountable for the impact of security incidents, and bear the responsibility for making staff aware of their responsibilities to report upwards. Basic safeguards are in place to prevent users from unsafe internet use. Anti-virus, anti-spam filters and basic firewall protections are deployed to protect users from basic internet-borne threats.	

	Mandatory assertions satisfied – 2 / 3	Incomplete
7	**Data Security Standard 7** A continuity plan is in place to respond to threats to data security, including significant data breaches or near misses, and it is tested once a year as a minimum, with a report to senior management. A business continuity exercise is run every year as a minimum, with guidance and templates available from [CareCERT Assurance]. Those in key roles will receive dedicated training so as to make judicious use of the available materials, ensuring that planning is modelled around the needs of their own business. There should be a clear focus on enabling senior management to make good decisions, and this requires genuine understanding of the topic, as well as the good use of plain English.	
	Mandatory assertions satisfied – 1 / 3	Incomplete
8	**Data Security Standard 8** No unsupported operating systems, software or internet browsers are used within the IT estate. Guidance and support is available from CareCERT Assurance to ensure risk owners understand how to prioritise their vulnerabilities. There is a clear recognition that not all unsupported systems can be upgraded and that financial and other constraints should drive intelligent discussion around priorities. Value for money is of utmost importance, as is the need to understand the risks posed by those systems which cannot be upgraded. It's about demonstrating that analysis has been done and informed decisions were made.	
	Mandatory assertions satisfied – 1 / 4	Incomplete
9	**Data Security Standard 9** A strategy is in place for protecting IT systems from cyber threats which is based on a proven cyber security framework such as Cyber Essentials. This is reviewed at least annually. [CareCERT Assurance] assists risk owners in understanding which national frameworks do what, and which components are intended to achieve which outcomes. There is a clear understanding that organisations can tackle the NDG Standards in whichever order they choose, and that the emphasis is on progress from their own starting points.	
	Mandatory assertions satisfied – 3 / 6	Incomplete

10	**Data Security Standard 10** IT suppliers are held accountable via contracts for protecting the personal confidential data they process and meeting the National Data Guardian's Data Security Standards. IT suppliers understand their obligations as data processors under the GDPR, and the necessity to educate and inform customers, working with them to combine security and usability in systems. IT suppliers typically service large numbers of similar organisations and as such represent a large proportion of the overall 'attack surface'. Consequently, their duty to robust risk management is vital and should be built into contracts as a matter of course. It is incumbent on suppliers of all IT systems to ensure their software runs on supported operating systems and is compatible with supported internet browsers and plug-ins.	
	Mandatory assertions satisfied – 1 / 2	Incomplete

BOARD OF DIRECTORS PAPER PART 1 – COVER SHEET

Meeting Date: 28 July 2021

Agenda item: 9.4

Subject:	Board and Committee Schedule 2022

Prepared by:	Zoe Jones, Corporate Governance Manager
Presented by:	David Moss, Chairman

Purpose of paper:	To note the meeting dates for 2022
Background:	The attached schedule shows the planned dates for the Board and its Committees for 2022.
Key points for Board members:	• The attached schedule shows the dates for the Board and its Committees for 2022; • Please note that the venues may be updated.
Options and decisions required:	To note the meeting schedule
Recommendations:	The Board is asked to note the meeting dates for 2022
Next steps:	Once noted the meeting schedule will be submitted to the Council of Governors meeting for noting. The dates will be added to Members' diaries

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

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

University Hospitals Dorset NHS Foundation Trust

Board of Directors' & Committee Meetings Schedule 2022

University Hospitals Dorset
NHS Foundation Trust

	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUGUST	SEPT	OCT	NOV	DEC
BOARD OF DIRECTORS PART 1	26/01/22 13:15pm	-	30/03/22 13:15pm	-	25/05/22 13:15pm	-	27/07/22 13:15pm	-	28/09/22 13:15pm	-	30/11/22 13:15pm	-
BOARD OF DIRECTORS PART 2	26/01/22 15:30pm	23/02/22 11:00am	30/03/22 15:30pm	27/04/22 11:00am	25/05/22 15:30pm	29/06/22 11:00am	27/07/22 15:30pm	24/08/22 11:00am	28/09/22 15:30pm	26/10/22 11:00am	30/11/22 15:30pm	-
BOARD DEVELOPMENT	26/01/22 10:30am	23/02/22 13:15pm	30/03/22 10:30am	-	25/05/22 10:30am	29/06/22 13:15pm	-	24/08/22 13:15pm	28/09/22 10:30am	-	30/11/21 10:30am	-
BOD/COG DEVELOPMENT	-	-	-	06/04/22 Times TBA	-	-	06/07/22 Times TBA	-	-	12/10/22 Times TBA	-	-
AUDIT	20/01/22 9am	-	17/03/22 9am	-	19/05/22 9am	-	21/07/22 9am	-	-	20/10/22 9am	-	-
FINANCE AND PERFORMANCE	24/01/22 10am	21/02/22 10am	28/03/22 10am	25/04/22 10am	23/05/22 10am	27/06/22 10am	25/07/22 10am	22/08/22 10am	26/09/22 10am	24/10/22 10am	28/11/22 10am	29/12/22 10am
WORKFORCE STRATEGY	-	16.02.22 11am	-	20.04.22 11am	-	15.06.22 11am	-	17.08.22 11am	-	19.10.22 11am	-	15.12.22 11am
QUALITY	24/01/22 2pm	21/02/22 2pm	28/03/22 2pm	25/04/22 2pm	23/05/22 2pm	27/06/22 2pm	25/07/22 2pm	22/08/22 2pm	26/09/22 2pm	24/10/22 2pm	28/11/22 2pm	19/12/22 2pm
TRANSFORMATION	-	17/02/22 2pm	-	-	29/05/22 2pm	-	-	18/08/22 2pm	-	-	17/11/22 2pm	-
SUSTAINABILITY	-	-	09/03/22 10.30am	-	-	08/06/22 10.30am	-	-	07/09/22 10.30am	-	-	14/12/22 10.30am
CHARITABLE FUNDS	-	14/02/22 9am	-	-	09/05/22 9am	-	-	08/08/22 9am	-	-	14/11/22 9am	-
JOINT AUDIT/FPC	-	-	-	-	25/05/22	-	-	-	-	-	-	-
PRIVATE PATIENTS	-	-	09/03/22 2pm	-	-	-	13/07/22 2pm	-	-	-	09/11/22 2pm	-

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS – PART 1 – COVER SHEET

Meeting Date: 28 July 2021

Agenda item: 9.5

Subject:	Board Committee Annual Reports (October 2020 – March 2021)
Prepared by:	Jennifer Nabwogi, Interim Assistant Company Secretary
Presented by:	David Moss, Chair of the Board of Directors
Purpose of paper:	To set out how the following committees satisfied their terms of reference during 2020/21 and to provide the Board with evidence relevant to their responsibilities: 1. Workforce Strategy Committee 2. Audit Committee 3. Quality Committee 4. Finance and Performance Committee 5. Transformation Committee 6. Sustainability Committee
Background:	The NHS Foundation Trust Code of Governance advises that the Board of Directors should undertake a formal and rigorous evaluation of its Committees. The terms of reference require the Committees above to provide an annual report of their work showing how they discharged their responsibilities. The attached annual reports have been reviewed and endorsed by the respective Committees.
Key points for members:	A review of the Committees' compliance with their terms of reference was carried out by scrutinising the agendas and minutes of all the Committee meetings that took place between October 2020 and March 2021. The findings confirm that the Committees complied with their terms of reference during 2020/21 as set out in the enclosed reports.
Options and decisions required:	The Board is asked to note the annual reports.
Recommendations:	**Members are asked to:** Note the Committee annual reports as a true reflection of how the Committees complied with their terms of reference in 2020/21.

Next steps:	The Committees will continue to execute their duties as set out in their terms of reference in order to enable the Trust to achieve its vision and annual objectives.
Links to University Hospitals Dorset NHS Foundation Trust Strategic objectives, Board Assurance Framework, Corporate Risk Register	
Strategic Objective:	To be a well governed and well managed organisation that works effectively in partnership with others, is strongly connected to the local population and is valued by local people.
BAF/Corporate Risk Register: (if applicable)	
CQC Reference:	Well Led

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

UNIVERSITY HOSPITAL DORSET NHS FOUNDATION TRUST

WORKFORCE STRATEGY COMMITTEE ANNUAL REPORT (OCTOBER 2020 – MARCH 2021)

1 PURPOSE OF THE REPORT

1.1 The Workforce Strategy Committee (the "Committee") has prepared this report for the Board of Directors. It sets out how the Committee satisfied its terms of reference during 2020/21 and seeks to provide the Board with evidence relevant to its responsibilities which include (i) ensuring that workforce strategies are appropriate and (ii) gaining assurance by monitoring the management needed to deliver a workforce with the capacity and capability to provide high quality safe patient care.

2 OVERVIEW

2.1 The existence of the Committee is the central means by which the Board ensures that there are adequate and appropriate workforce structures, processes and controls in place throughout the Trust.

2.2 The Committee independently scrutinises and monitors the Board Assurance Framework as it relates to the principle strategic objective of the Trust being a great place to work. In particular, the Committee's work focuses on;

- Workforce strategies to ensure they are appropriate, are being effectively implemented, reviewed and monitored;
- Organisational development, Leadership and Talent management;
- Pay and Reward;
- Recruitment and Retention;
- Staff engagement and the implementation of the Equality Delivery System;
- Education, Training, Apprenticeship and Development.

2.3 The Committee receives a number of annual and bi-annual reports appropriate to its purpose. Paragraph 6.2 details the reports received in 2020/21.

2.4 A governance cycle detailing which papers are to be expected at each Workforce Strategy Committee is reviewed annually but is updated as necessary throughout the year. The Committee's governance cycle was reviewed and approved in October 2020 and has been updated as necessary throughout the year. The governance cycle is attached at **Appendix 1.**

2.5 During the course of the year, one of the Trust's Governors, from the Council of Governors attended one meeting as an observer.

3 MEMBERSHIP

3.1 The Committee membership in respect of the financial year 2020/21 comprised:

- Cliff Shearman (Prof), Non-Executive Director and Committee Chair
- Caroline Tapster, Non-Executive Director
- Christine Hallett (Prof), Non-Executive Director
- Stephen Mount, Non-Executive Director
- Karen Allman, Chief People Officer
- Paula Shobbrook (Prof), Chief Nursing Officer and Deputy Chief Executive Officer
- Alyson O'Donnell (Prof), Chief Medical Officer
- Mark Mould, Chief Operating Officer

4 COMPLIANCE WITH TERMS OF REFERENCE

4.1 In accordance with its terms of reference, the Committee is composed of four non-executive directors (one of whom chairs the committee), the Medical Director, Chief Nursing Officer, Chief Operating Officer and Chief People Officer.

4.2 All meetings for 2020/21 were quorate.

4.3 A substantive review of the Committee's terms of reference was undertaken in August 2020 to ensure compliance with the planned revised governance structure. A review of the committee's compliance with its own terms of reference has been undertaken by scrutiny of agendas and minutes of the three Committee meetings that took place between October 2020 and March 2021.

4.4 This review indicates that reports were received, scrutinised and discussed in accordance with the Committee's terms of reference. The Committee discussed and scrutinised the following reports during the year:

- Risk Register: review of risks relating to workforce;
- Care Group Update – key issues for escalation;
- Guardian of Safe Working Hours Q2;
- Chief People Officer's Report;
- Mapping UHD People and OD Plans to National NHS People Plan;
- Chief Medical Officer's Report;
- Chief Nursing Officer's Report;
- Education and Training Quarterly Report;
- Equality Diversity and Inclusion Strategy;
- Equality Diversity and Inclusion Group Terms of Reference;
- Essential Core Skills (ECS) policy; and
- Freedom to Speak up Quarterly Report for period Quarter 3.

5 MEETINGS

5.1 Three formal meetings were held during the year.

- Wednesday, 21 October 2020
- Wednesday, 16 December 2020
- Wednesday, 17 February 2021

5.2 Meeting attendance is detailed in **Appendix 2**.

6 DUTIES AND FINDING

6.1 The terms of reference require the Committee to have oversight over the performance and delivery of the following key areas:

6.1.1 Workforce Development, Planning and Performance:

In October 2020 the committee received a workforce report which included the outcome of successful bids submitted to NHSI that would assist with international recruitment of nurses. The report also provided an update on Brexit, vacancy rates, staff turnover, sickness levels, performance appraisal rates and policy alignment, among other items. At the December 2020 meeting, the committee received a detailed Chief People Officer's report with details of progress on the workforce consultation process, workforce systems as well as workforce flu campaigns. Again at the December 2020 meeting, the committee received a presentation showing Trust people plans mapped to the NHS People Plan. At the February 2021 meeting, the committee received an update on the Red Flag policy which outlined the approach being taken within the Trust for the governance of, and operational processes to support safe nurse staffing levels.

6.1.2 Risk Management:

The Committee reviewed the register of risks relating to workforce at each of the three meetings that took place in 2020/21. The Committee also received a Care Group update at each meeting. The update highlighted key issues for escalation, including risks.

6.1.3 Staff Engagement:

In October 2020, the Committee received a report on the outcome of a listening exercise across the Trust which was for the purpose of finding out what values were important to staff, to review those findings and make informed recommendations for the Trust's new values. At the February 2021 meeting, the Committee received the Chief People Officer's Report which included an outline of a series of staff engagement events.

6.1.4 Education, Training, Apprenticeship and Development:

At the December 2020 meeting, the Committee received a Chief Nursing Officer's Report with details of progress on recruitment. At the same meeting, the Committee received the Education and Training Quarterly Report that provided an overview of some of the initiatives, issues, developments and direction of travel within the department. At the February 2021 meeting, the Committee discussed the Essential Core Skills (ECS) policy which had been updated in light of both the merger and the implementation of the BEAT Virtual Learning Environment system.

6.1.5 Workforce Strategies and Performance:

At the October 2020 meeting, the Committee discussed the bi-Annual Safe Staffing Review which highlighted the challenges to reporting on safe staffing during the pandemic. At the December 2020 meeting, the Committee received a Chief Medical Officer's Report with details of job plans and at the February 2021 meeting the Committee received a Chief Medical Officer's Report with a focus on compliance with performance appraisals and mandatory training requirements.

6.1.6 Oversee and monitor the implementation of the Equality, Diversity and Inclusion strategy:

In October 2020 the Committee reviewed the 2020 Workforce Race Equality Standard (WRES) and the 2020 Workforce Disability Equality Standard (WDES) action plans. At the February 2021 meeting, the Committee discussed the Equality Diversity and Inclusion Strategy that outlined a three year programme for equality, diversity and inclusion.

6.1.7 Strategy Planning:

In October 2020 the Committee reviewed and approved the Workforce Strategy Committee Governance Cycle.

6.2 **Bi- Annual and Annual Reports and Declarations**

6.2.1 The Committee received and discussed the following annual and bi-annual reports:

- Equality and Diversity Workforce Monitoring Report (incl Workforce Race Equality Standard (WRES));
- Workforce Report;
- Bi-annual Safe Staffing Review.

7 CONCLUSION

7.1 The Committee has complied with its terms of reference during 2020/21, during which it has:

i) Held quorate meetings;

ii) Reviewed risks relating to workforce and organisational development;
iii) Reviewed and discussed a number of reports covering workforce strategy and performance;
iv) Reviewed and scrutinised issues impacting on equality, diversity and inclusion; education and training and staff engagement;
v) Reviewed and scrutinised annual and bi-annual reports, as outlined in paragraph 6.2.

Prof Cliff Shearman
Non-executive Director and Chair of the Workforce Strategy Committee
June 2021

Appendix 1

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

WORKFORCE STRATEGY COMMITTEE

GOVERNANCE CYCLE (OCTOBER 2020)

REGULAR REPORTS

People Plan: report on progress to include Recruitment & Retention; Workforce Planning & Forecasting; People Engagement; Diversity, inclusion and race equality; Education and Training; Health and Wellbeing; People Policies, Processes and Systems; and Leadership and Management	CPO
Chief Medical Officer's Report	CMO
Chief Nursing Officer's Report	CNO
Care Group Updates	Care Group Dir. Ops
Staff Network: Staff Experience	Network Chairs
Board Assurance Framework – Quarterly review of strategic risks relating to Workforce and Organisational Development	CPO

QUARTERLY REPORTS		
Freedom to Speak Up	February; April; August; December;	FTSUG
Guardian of Safe Hours Report	Q4 – June; Q1 – August; Q2 – December Q3 – Feb	CMO
Monitoring and Implementation of the Equality, Diversity and Inclusion Strategy, including reports on staff networks	April/June/August December	Director of OD
Education and Training: including apprenticeships and essential core skills	February; June; October; December	Head of Education

BI-ANNUAL REPORTS

Safe Staffing Review	December/June	CNO
NHS Staff Survey Update	April/October	Director of OD

ANNUAL REPORTS

Workforce Strategy Committee Terms of Reference	October	Chair
Workforce Strategy Committee Governance Cycle	October	Chair
Workforce Strategy Committee Annual Report	June	Co Sec
Annual Freedom to Speak Up Report	April	FTSUG
Workforce Race Equality Standard (WRES)	October	Director of OD
Workforce Disability Equality Standard	October	Director of OD
Annual Equality and Diversity Workforce Monitoring Report	May	Director of OD
National NHS Staff Survey (Family and Friends Test)	When published	Director of OD

GMC Trainees Survey	When published	CMO
Revalidation: Annual Organisational Audit	June	CMO
Gender Pay Gap	February	CPO/ Director of OD

Appendix 2

WORKFORCE STRATEGY COMMITTEE MEETING ATTENDANCE

REGISTER 2020/21

NAME OF COMMITTEE:	**WORKFORCE STRATEGY COMMITTEE**		
REPORTS TO :	**BOARD OF DIRECTORS**		
Membership (as per Terms of Reference)	**MEETING DATES**		
	21 October 2020	**16 December 2020**	**17 February 2021**
PROF CLIFF SHEARMAN (chair) Non-executive Director	✓	✓	✓
CAROLINE TAPSTER Non-Executive Director	✓	✓	✓
CHRISTINE HALLETT (Prof) Non-Executive Director	✓	✓	✓
STEPHEN MOUNT Non-Executive Director	x	✓	✓
KAREN ALLMAN Chief People Officer	✓	✓	✓
PAULA SHOBBROOK Chief Nursing Officer and Deputy Chief Executive Officer	✓	✓	x
ALYSON O'DONNELL (Prof) Chief Medical Officer	✓	x	✓
MARK MOULD Chief Operating Officer	✓	x	x
In attendance:			
SANDY WILSON Trust Governor	n/a	n/a	✓
Was the meeting quorate? Y/N	Y	Y	Y

UNIVERSITY HOSPITAL DORSET NHS FOUNDATION TRUST

FINANCE AND PERFORMANCE COMMITTEE REPORT 2020/21

1 PURPOSE OF THE REPORT

1.1 The Finance and Performance Committee (the "Committee") has prepared this report for the Board of Directors. It sets out how the Committee satisfied its terms of reference during the period October 2020 – March 2021 and seeks to provide the Board with evidence relevant to meeting its responsibilities for assuring that the use of the Trust's financial resources is robust and for setting the policy for cash investments, detailed business cases, overseeing the progress of agreed capital investments and reviewing financial planning and the budgeting processes.

2 OVERVIEW

2.1 The existence of the Committee is the central means by which the Board ensures that there are adequate and appropriate financial planning controls in place throughout the Trust. The Committee monitors financial performance against budget on a monthly basis and examines requests for capital expenditure. It provides expertise and advice on the long term financial strategic plans, level of capital investment and financial risk.

2.2 The Committee independently scrutinises and monitors the Board Assurance Framework as it relates to the principle strategic objective of ensuring that all resources are used efficiently to establish financially and environmentally sustainable services and deliver key operational standards and targets, and the principle strategic objective of transforming and improving Trust services in line with the Dorset ICS Long Term Plan by separating emergency and planned care, and integrating Trust services with those in the community.

2.3 In accordance with its terms, the Committee receives a number of annual reports appropriate to its purpose which include:

- National Costs Submission Assurance;
- Costing Transformation Programme;
- Budget Setting Process and Timetable;
- Draft Operational Plans;
- Draft Annual Accounts;
- Draft Annual Report and Annual Accounts;
- Draft Annual Revenue Budget;
- Draft Annual Capital Programme;
- Going Concern

2.4 A governance cycle detailing which papers are to be expected at each Finance and Performance Committee meeting is reviewed annually but is updated as necessary

throughout the year. The Committee's governance cycle was reviewed and approved in November 2020. The governance cycle is attached as **Appendix 1.**

3 MEMBERSHIP

3.1 Membership of the Finance and Performance Committee comprises four non-executive directors, the Chief Finance Officer, the Chief Strategy and Transformation Officer, the Chief Executive Officer and the Chief Operating Officer. All appointments to the Committee are made by the Board of Directors.

3.2 The Committee membership during the six month period comprised:

- Stephen Mount, Non-Executive Director and Committee Chair;
- Pankaj Dave, Non-Executive Director;
- John Lelliott, Non-Executive Director;
- Debbie Fleming, Chief Executive Officer;
- Pete Papworth, Chief Finance Officer;
- Mark Mould, Chief Operating Officer;
- Richard Renaut, Chief Strategy and Transformation Officer.

4 MEETINGS

4.1 Six formal meetings were held during the six month period:

- 26 October 2020
- 23 November 2020
- 21 December 2020
- 25 January 2021
- 22 February 2021
- 29 March 2021

4.2 Meeting attendance is detailed in Appendix 2.

5 COMPLIANCE WITH TERMS OF REFERENCE

5.1 In accordance with its terms, during the year, the Committee was composed of four non-executive directors, the Chief Finance Officer, the Chief Strategy and Transformation Officer, the Chief Operating Officer and the Chief Executive Officer. At the time of reporting, the Committee terms of reference have been updated to remove the Chief Executive Officer as a member of the Committee. The Chief Executive Officer may attend meetings on an adhoc basis or as required.

5.2 All meetings in the six month period were quorate.

5.3 The Committee's terms of reference require the Committee to receive detailed financial reports so that it can ensure there are adequate and appropriate financial planning controls in place.

5.4 The terms of reference are reviewed annually and the last formal review took place in July 2020. The terms have been updated throughout the year as necessary. A review of the Committee's compliance with its own terms of reference has been carried out in June 2021 by scrutinising the agendas and minutes of the six committee meetings that took place between October 2020 and March 2021.

6 DUTIES AND FINDINGS

6.1 This review indicates that reports were received, scrutinised and discussed in accordance with the Committee's constitution as set out in its terms of reference.

6.2 **Board Assurance Framework (BAF)**

The Committee received and scrutinised the Board Assurance Framework exception report of strategic risks relating to Finance, Investment, Performance and Strategy at all its meetings.

6.3 **Financial Performance, budgets and capital investment**

Throughout the period, the committee received the following reports relating to financial performance, budgets and capital investment:

- Update on Financial Plan for Months 7-12;
- Month 6 Financial Performance;
- University Hospitals Dorset NHS Foundation Trust Performance Report (IPR); September 2020 and recovery plans;
- 2021/2022 Budget Setting Process and Timetable;
- Consultancy Spend and Commitments;
- Six Year Capital Plan;
- Financial Performance Report – Month 07;
- University Hospitals Dorset NHS Foundation Trust Integrated Performance; Report (IPR) October 2020;
- Elective Care Patient Access Report;
- Productivity and Efficiency Report;
- Operational Performance Report & Phase 3 Recovery;
- IUCS Update;
- 2020/21 Financial Performance Month 8;
- Productivity and Efficiency Report – Month 8;
- CT Scanner – Poole;
- 2020/21 Financial Performance – Month 9;
- Productivity and Efficiency Report – Month 9;
- Operational Performance Report & Phase 3 Recovery;
- Capital Programme;
- Operational Planning Update;
- ICS update;

- 2020/21 Financial Performance – Month 10;
- Productivity and Efficiency Report – Month 9 including Deep Dive Report; corporate savings – Merger benefits.

6.4 **Contracts and Business Cases**

During the course of the period, the Committee received and discussed contracts and business cases pertaining to:

- CT and MRI business cases;
- Wessex Fields Business case;
- Supply of Trauma Consumables and Instrumentation contract;
- Supply of Trauma Products contract;
- Orthopaedic Consumables contract;
- Pathology MES Extension contract;
- Contract Decision Timetable;
- Stour Building Business case;
- Clinical Waste Services business case;
- Siemens Pathology MES Extension business case;
- Managed Laboratory Services MES extension business case;
- Linear Accelerator Machine (Linac) business case;
- Approved Framework Contractors List for Repairs and Maintenance;
- Surface Guided Radiotherapy business case;
- Health Infrastructure Plan (HIP2) Strategic Outline Case - UHD Projects;
- CT Scanner – Poole purchase;
- MRI Scanner – RBH purchase;
- MRI Scanner – Poole purchase;
- Mammography Equipment purchase;
- Yeoman's way business case;
- Yeoman's Way Business Case Update;
- Supply of Pathology Services for One Dorset contract;
- HIP2 Capital Project business case;
- Acute Reconfiguration business case;
- Transactional Financial Services contract;
- Poole Theatres Instrumentation uplift to support CSSD closure and merge to Alderney business case;
- Medicines Supply Chain Partnership business case;
- Temporary Staffing business case.

6.5 **NHS Improvement**

Submissions to NHSE/I were scrutinised by the Committee prior to their respective submission dates. The Committee received reports on Consultancy Costs throughout the period and scrutinised agency costs, both medical and nursing. The Committee received updates as part of the Monthly Financial Performance reports on the Trust's performance against the agency cap and the imposed ceiling.

6.6 **Debtors**

Throughout the financial year the Committee considered the Trust debtors' position, including monies owed by both third parties and those owed within the Dorset system.

6.7 **Minutes**

In accordance with the terms of reference, throughout the period, minutes of each meeting of the Committee were formally recorded and submitted to the next meeting for approval. The Committee received minutes or summary reports from the following groups:

- Financial Planning Group;
- Capital Management Group;
- Income and Coding Group;
- Patient Level Income & Costing Group;
- Transformation Committee.

7 CONCLUSION

7.1 The committee complied with its terms of reference for the period October 2020 – March 2021. The level of financial and operational challenge facing the Trust rose during the year due to the pandemic, merger of the Trust, merger of two ledgers and merger of two finance teams. The Trust has worked very effectively throughout the period with the wider Dorset integrated care system to deliver its agreed control total and other statutory commitments. Such an achievement in the face of significant challenges owes much to the professionalism, commitment and leadership of the finance and wider executive team who have worked closely with the Committee, and consulted with it on an appropriate and timely basis both within and outside of the scheduled meeting dates.

Stephen Mount
Chair of Finance and Performance Committee
June 2020

APPENDIX 1

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

FINANCE AND PERFORMANCE COMMITTEE

GOVERNANCE CYCLE

NOVEMBER 2020

REGULAR REPORTS

Finance and Performance Committee Minutes	Chairman
Financial Performance Report	CFO

Productivity & Efficiency Update	CFO
Contract Decision Timetable	CFO
Operational Performance Report	COO

EXCEPTION REPORTS

Financial Planning Group	CFO
Capital Management Group	CFO
Income and Coding Group	CFO
Patient Level Income & Costing Group	CFO
Board Assurance Framework: Exception Reporting of Strategic Risks relating to Finance and Performance	CFO/COO
Audit Reports (as appropriate)	CFO
Investment and Business Cases	CFO
Debtors Reports (as appropriate)	CFO
Financial Systems Development Updates	CFO
Charitable Funds Committee Reports	CFO

QUARTERLY REPORTS

Review Board Assurance Framework changes relating to Finance and Performance (Q1 - July; Q2 - Nov; Q3 – Jan; Q4 May)	CFO
Consultancy Commitments (July, Oct, Jan, April)	CFO
Deep Dive on Performance by theme or service (Q1 – July; Q2 – Nov; Q3 – Jan; Q4 – May)	COO/GDO's
Update from Transformation Committee (TC) (Aug; Nov; Feb; May)	CSO/Chair of TC
Update from Sustainability Committee (SC) (Sept; Dec; March; June)	CSO/Chair of SC
Update from the Dorset Integrated Care System (ICS) (Aug; Nov; Feb; May)	Dorset CCG DoF
Reporting Accountant: Financial Reporting Procedures Action Plan (Jan; April; July; Oct)	CFO

½ YEARLY / ANNUAL REPORTS

	Lead	**½ Yearly**	**Annual Reports**
REVIEW REPORTS			
National Costs Submission Assurance	CFO	-	September
Costing Transformation Programme (Board Declaration)	CFO	----	April
Budget Setting Process and Timetable	CFO	----	October
Draft Operational Plans	CFO	----	Jan/Feb

Draft Annual Accounts	CFO	-----	April
Annual Report and Annual Accounts*	CFO	----	May
Draft Annual Revenue Budget	CFO	----	March
Draft Annual Capital Programme and half year update	CFO	Sept	March
Going Concern	CFO	-----	March
Key Areas of Judgement and Estimation within the Annual Accounts	CFO		March
Finance & Performance Committee Governance Cycle	Chairman	-----	March
Finance & Performance Committee Terms of Reference	Chairman	----	September
Finance & Performance Committee Annual Report	Chairman	-----	June

* denotes Special Audit Committee and Finance and Performance Committee meeting

APPENDIX 2

FINANCE AND PERFORMANCE COMMITTEE
ATTENDANCE REGISTER 2020/21

NAME OF COMMITTEE	**FINANCE & PERFORMANCE COMMITTEE**
REPORTS TO:	**BOARD OF DIRECTORS**
Membership (as per Terms	**MEETING DATES**

of Reference).	**26 October 2020**	**23 November 2020**	**21 December 2020**	**25 January 2021**	**22 February 2021**	**29 March 2021**
STEPHEN MOUNT (chair) Non-Executive Director	✓	✓	✓	✓	✓	✓
DEBBIE FLEMING Chief executive	✓	✓	✓	x	✓	✓
JOHN LELLIOT Non-executive director	✓	✓	✓	✓	✓	✓
PANKAJ DAVE Non-executive director	✓	✓	✓	✓	✓	✓
PETE PAPWORTH Chief Finance Officer	x	✓	x	✓	✓	✓
MARK MOULD Chief Operating Officer	x	✓	✓	✓	✓	✓
RICHARD RENAUT Chief Strategy & Transformation Officer	✓	✓	✓	✓	✓	✓
In attendance:						
Trust Governor	n/a	n/a	n/a	n/a	✓	✓
Deputy Chief Finance Officer	✓	✓	✓	✓	✓	✓
Was the meeting quorate? Y/N	Y	Y	Y	Y	Y	Y

UNIVERSITY HOSPITAL DORSET NHS FOUNDATION TRUST

QUALITY COMMITTEE ANNUAL REPORT 2020/21

1 PURPOSE OF THE REPORT

1.1 The Quality Committee (the "Committee") has prepared this report for the Board of Directors. It sets out how the Committee satisfied its terms of reference between 1 October 2020 and 31 March 2021. The Committee seeks to provide the Board with evidence that it met its responsibilities for assuring that high standards of care are provided by the Trust and, in particular, that adequate and appropriate clinical governance structures, processes and controls are in place throughout the Trust.

2 OVERVIEW

2.1 The existence of the Committee is the central means by which the Board ensures that there are adequate and appropriate clinical governance structures, processes and controls in place throughout the Trust.

2.2 The Committee independently scrutinises and monitors the Board Assurance Framework as it relates to the principle strategic objective of continually improving quality. In particular, the Committee's work focuses on; quality, patient experience, patient safety, clinical outcomes, risk management, health and safety, safeguarding (Children and Vulnerable Adults), infection prevention and control, medicines management, learning from deaths and end of life care.

2.3 The Committee receives a number of annual reports appropriate to its purpose. See paragraph 5.8 for further detail.

2.4 A governance cycle detailing which papers are to be expected at each Quality Committee is reviewed annually but is updated as necessary throughout the year. The Committee's governance cycle was formally reviewed and approved in October 2020. The updated governance cycle is attached as **Appendix 1.**

3 MEMBERSHIP

3.1 Membership of the Quality Committee comprises four Non-Executive Directors, one of whom is a member of the Audit Committee, the Chief Nursing Officer, the Chief Medical Officer, the Chief Operating Officer and the Chief People Officer. The Committee membership in 2020/21 included:

- Caroline Tapster, Non-Executive Director and Committee Chair
- Philip Green, Non-Executive Director
- Prof Christine Hallett, Non-Executive Director
- Prof Cliff Shearman, Non-Executive Director
- Prof Alyson O'Donnell, Chief Medical Officer
- Prof Paula Shobbrook, Chief Nursing Officer
- Mark Mould, Chief Operating Officer

- Debbie Fleming, Chief Executive Officer
- Karen Allman, Chief People Officer

4 COMPLIANCE WITH TERMS OF REFERENCE

4.1 In accordance with its terms, the Committee is composed of four Non-Executive directors, the Chief Executive Officer, the Medical Director, Director of Nursing and Chief Operating Officer. Philip Green is the Chair of the Trust's Audit Committee; this allows the Committee to meet the requirement to have a member of the Audit Committee. At the time of reporting, the Committee terms of reference have been updated to remove the Chief Executive Officer as a member of the Committee. The Chief Executive Officer may attend Committee meetings on an adhoc basis or as required.

4.2 Six meetings took place in the period from October 2020 – March 2021 and all were quorate.

4.3 A formal review of the terms of reference was undertaken in July 2020 and the terms have been updated as necessary throughout the year. A review of the Committee's compliance with its own terms of reference has been undertaken in June 2021 by scrutinising the agendas and minutes of the six Committee meetings which took place between October 2020 and March 2021.

5 DUTIES AND FINDINGS

5.1 The review indicates that reports were received, scrutinised and discussed in accordance with the committee's constitution as set out in its terms of reference. The committee discussed the following regular reports at each meeting:

- Care Group Quality reports;
- Risk Register: new significant risks;
- Risk Register: risks rated 12 – 25;
- Serious Incident Report; and
- Covid-19 report.

5.2 At the 26 October 2020 Meeting, the Committee received the following reports:

- UHD Quality report to provide an update on the key performance indicators relating to quality, safety and patient experience;
- Statutory Inspections (exception report);
- Estates Backlog (Poole Hospital) - a report that set out the action taken and future action to ensure the backlog of maintenance work minimised the risk to patient safety;
- Mortality Metrics and outcome of the thematic reviews - an update on the action plan for observed high HSMR for Poole Hospital in-patient deaths;
- Draft Quality Impact Assessment (QIA) strategy;
- CQC Insight report to advise the Quality Committee of the latest CQC insight reports.

- Quality Committee Governance Cycle. The Committee approved the governance cycle.

The Committee also received updates from the following Trust committees and groups; Medicines Governance Committee, End of Life Committee, Quality Governance Group, Mortality Surveillance Group, Health & Safety Group, Infection Prevention and Control Group and Radiation Group.

5.3 At the 23 November 2020 meeting, the Committee received the following reports:

- Estates update;
- Integrated Performance Report - to provide an update on the key performance indicators relating to quality, safety and patient experience;
- Statutory Inspections - CQC “Patient First”;
- Mortality Report - Mortality Metrics and outcome of the thematic reviews;
- Complaints and Patient Experience Report Q2;
- Quality Governance Action Plan Update - to provide assurance and oversight on progress with the actions and recommendations highlighted in the EY Quality Governance review;

The Committee also received updates from the following Trust committees and groups; Quality Assurance & Risk Committee (QARC), Nursing and Midwifery Group, Health & Safety Group, Medicines Governance Group and Radiation Group

5.4 At the 21 December 2020 meeting, the Committee received the following reports:

- Fractured Neck of Femur Performance - a report on the progress made and current work being undertaken by the Fractured Neck of Femur & Trauma Improvement Group;
- Integrated Performance Report: Quality Report;
- Statutory Inspections: CQC - a report to update the Committee on receipt of the CQC’s letter of intent under section 31 Health and Social Care Act;
- Quality Impact Assessment Process Report;
- Safeguarding Report Q2;
- Medicines Governance, Management and Optimisation Report Q2;
- CQC Insight Report;
- CAS Policy. The Committee approved the policy;
- Learning from Deaths Policy and terms of reference. The Committee approved the policy;
- Learning Event Report Notification (LERN) policy - a report that outlined a single framework for serious Incident investigations across UHD. The Committee approved the Policy;

The Committee also received updates from the following Trust committees and groups; Nursing and Midwifery Group, Infection Prevention and Control Group and Safeguarding Group.

5.5 At the 25 January 2021 meeting, the Committee received the following reports:

- The Ockenden Report - to provide an update on UHD's position in relation to the NHSE Self-assessment tool following the Ockenden report issued on 14th of December 2020;
- Integrated Performance Report: Quality Report;
- Medical Examiner Policy setting out UHD's approach to meet the Department of Health requirements. The committee approved the policy;
- Board Assurance Framework: changes relating to quality (Oct – Dec 20);
- Red Flags and Safest Staffing Policy - to inform the Committee of the policy and approach being taken within UHD for the governance of, and operational processes to support safe nurse staffing levels.

5.6 At the 22 February 2021 meeting, the Committee received the following reports:

- Estates Quarterly report;
- Integrated Performance Report: Quality Report;
- Quality Governance Action Plan - report to provide assurance and oversight on progress with the actions and recommendations highlighted in the EY Quality Governance review;
- CQC DC Action Plan;
- Medicines Governance Group - Pharmacy SBAR around staffing and service provision;
- CQC Insight Report;
- Claims Report (July – December 2020) - to inform the Committee of the current position in respect of claims and inquests against the Trust;
- Claims Policy;
- Medicines Governance, Management & Optimisation Report (Oct – Mar);
- Mortality Report (Oct – Dec);
- Maternity Safety Champions Report (Oct – Dec).

The Committee also received updates from the following Trust groups; Quality Governance Group, Strategic Nursing, Midwifery, AHP/Healthcare Scientists Group and Health and Safety Group.

5.7 At the March 2021 meeting, the Committee received the following reports:

- Integrated Performance Report: Quality Report;
- CQC DC Action Plan;
- Mortality Report which included an update on the outcome of the Pneumonia Panel Review;
- Complaints and Patient Experience Report Q3;
- Infection Control Group Terms of Reference.

The Committee also received updates from the following Trust groups; Quality Governance Group, Strategic Nursing, Midwifery, AHP/Healthcare and Scientists Group.

5.8 Annual Reports and Declarations:

5.8.1 The Committee received and discussed the following annual reports as set out in its terms of reference:

- Annual Infection Control Report, and
- Annual Complaints and Patient Experience Report.

5.8.2 According to its terms of reference, the Committee should receive the following annual reports:

- Annual Quality Account Report;
- Annual Patient Survey Report;
- Annual Safeguarding Children Report;
- Annual Statement on Safeguarding Adults;
- Annual Learning Disabilities Access Statement;
- Annual End of Life Report and Care of the Dying Audit;
- Annual CQC Self-Assessment Report; and
- Annual Radiation Report.

However, the schedule and timing of the above reports falls out of the six month reporting period, the committee therefore did not receive the reports.

6 MEETINGS

6.1 Six formal meetings were held during the year:

- Monday, 26 October 2020
- Monday, 23 November 2020
- Monday, 21 December 2020
- Monday, 25 January 2021
- Monday, 22 February 2021
- Monday, 29 March 2021

6.2 Meeting attendance is detailed in **Appendix 2.**

7 CONCLUSION

7.1 The committee has complied with its terms of reference in 2020/21, during which time it received, scrutinised and monitored the following:

i) Updated the terms of reference;
ii) Reports relating to quality, patient experience and patient safety;
iii) The Board Assurance Framework as it relates to the principle strategic objective to the principle strategic objective of continually improving quality;

iv) Quarterly reports on Infection Prevention & Control, Safeguarding, Mortality, Medicines Safety, Patient Experience (including PALS and Complaints), Getting it Right First Time and Maternity Safety Champions;

v) Reports relating to clinical outcomes, risk management, health and safety, safeguarding, Infection Prevention and Control, Medicines Management, Learning from Deaths and End of Life Care.

vi) Received reports from the following committees and Trust groups;-

- Medicines Governance Group;
- Nursing and Midwifery Group;
- Quality Governance Group;
- Mortality Surveillance Group;
- Infection Prevention and Control Group;
- End of Life Committee;
- Quality Assurance & Risk Committee (QARC);
- Radiation Group;
- Health and Safety Group;
- Safeguarding Group; and
- Strategic Nursing, Midwifery, AHP/Healthcare Scientists Group

Caroline Tapster
Chair of the Quality Committee
June 2021

Appendix 1

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

QUALITY COMMITTEE

GOVERNANCE CYCLE

(October 2020)

REGULAR REPORTS

Quality Committee Minutes	Chairman
Action Log	Chairman
Key items for communication	Chairman
Serious Incidents report	CMO
Quality Report	CNO
Risk Register: Risks rated 12-25 (new and current)	CNO/ADQGR
Care Groups Quality Reports	CG DoN/MD's
CQC Insight Report	CNO/ADQGR
Statutory Inspections (by exception)	CNO

QUARTERLY REPORTS

Maternity Safety Champions Report (Q1-September; Q2-December; Q3-February; Q4-May)	CG DoM
Ockenden Report Update on Action Plan (March; June; Aug; Oct)	CG DoM
Review Board Assurance Framework changes relating to quality (Q1 - July; Q2 - Nov; Q3 – Jan; Q4 May)	CNO/ADQGR
Reporting Accountant: Quality Governance Action Plan (Nov; Feb; May; Aug)	CNO/ADQGR
Complaints and Patient Experience Report (Summary to BoD) (plus one annual report – July) (Q3 – March; Q4 – June; Q1 - September; Q2 - November)	CNO
Medicines Governance, Management & Optimisation report (Q3 – Feb: Q4 – May; Q1 – September; Q2 – December)	ADP
Infection Prevention & Control (Q3 – February; Q4 – May; Q1 – August; Q2 – October)	CNO
Mortality Report (Q3 – February; Q4 – May; Q1 – August; Q2 – November)	CMO
Quality Impact Assessment Process Report (April, Aug, Oct, Dec)	CNO
Getting it Right First Time (TBD)	CMO

½ YEARLY / ANNUAL REPORTS

	Lead	**½ Yearly**	**Annual Reports**
Quality Account Draft Report	CNO ADQGR		April

National Patient Surveys	CNO	-	When published
Annual Safeguarding Report (Children, Young Adults & Adults) and to include Annual Learning Disabilities access statement	CNO		September
Annual Infection Prevention and Control Report and Statement of Commitment	CNO		August
Annual End of Life Report and Care of the Dying Audit	CMO		August
Annual Radiation Safety Report	CMO/ IR(ME)R Lead		July
Claims and Litigation Detailed Report (summary to Board of Directors)	CMO	January (July – December)	July (January - June)
Annual Complaints and Patient Experience Report	CNO		July
Annual PLACE Report	CNO		August
Quality Priorities and Monitoring Plan	CNO ADQGR	May (July –March)	August (April – June)
Quality Committee Governance Cycle (for approval)	Company Secretary		March
Quality Committee Terms of Reference	Company Secretary		September
Quality Committee Annual Report	Company Secretary		May/July

EXCEPTION/SBAR REPORTS FROM GROUP CHAIRS

CQC Reports/Submissions	CNO/ADQGR
Medicines Governance Group	CMO/ADP
Nursing & Midwifery Group	CNO
Quality Governance Group	CNO
Health and Safety Group	CPO
Mortality Surveillance Group	CMO
Infection Prevention & Control Group (Dec; March; June; Sept)	CNO
Radiation Group	CMO/IR(ME)R Lead
Safeguarding Group Report (Dec; March; June; Sept)	CNO
Same Sex Accommodation Declaration	CNO

Appendix 2

QUALITY COMMITTEE ATTENDANCE REGISTER 2020/21

NAME OF COMMITTEE:	**QUALITY COMMITTEE**					
REPORTS TO :	**BOARD OF DIRECTORS**					
Membership (as per Terms of Reference).	**MEETING DATES**					
	26 October 2020	**23 November 2020**	**21 December 2020**	**25 January 2021**	**22 February 2021**	**29 March 2021**
CAROLINE TAPSTER Non-executive Director & Chair	✓	✓	✓	✓	✓	✓
PHILIP GREEN Non-executive director	x	✓	x	✓	✓	✓
CLIFF SHEARMAN Non-executive director	✓	✓	✓	✓	✓	x
CHRISTINE HALLETT Non-executive Director	x	✓	✓	✓	✓	✓
DEBBIE FLEMING Chief Executive Officer	✓	✓	✓	✓	✓	✓
PAULA SHOBBROOK Chief Nursing Officer and Deputy Chief Executive Officer	x	✓	✓	✓	✓	✓
ALYSON O'DONNELL Chief Medical Officer	✓	✓	✓	✓	✓	✓
KAREN ALLMAN Chief People Officer	✓	✓	x	✓	✓	x
MARK MOULD Chief Operating Officer	x	✓	✓	✓	✓	✓
In attendance:						
DAVID MOSS Trust Chair	✓	✓	x	✓	✓	x
Governor Observer	n/a	n/a	n/a	n/a	✓	✓
Intern Auditor	x	x	x	x	✓	✓
Medical Directors	x	✓	✓	✓	✓	✓
Deputy Chief Officers	✓	✓	✓	✓	✓	✓
Associate Directors	✓	✓	✓	✓	✓	✓

Directors of Nursing	✓	✓	✓	✓	✓	✓
Was the meeting quorate?	Y	Y	Y	Y	Y	Y

UNIVERSITY HOSPITAL DORSET NHS FOUNDATION TRUST

TRANSFORMATION COMMITTEE ANNUAL REPORT
(OCTOBER 2020 – MARCH 2021)

1 PURPOSE OF THE REPORT

1.1 The Transformation Committee (the "Committee") has prepared this report for the Board of Directors. It sets out how the Committee satisfied its terms of reference during 2020/21 and seeks to provide the Board with evidence relevant to its responsibilities which include:

(i) monitoring implementation and assurance of benefits realisation for the Transformation agenda for the Trust;

(ii) ensuring delivery of transformation objectives described in the major transformation business cases and merger cases as outlined in the Terms of Reference

(iii) monitoring implementation progress of all components of post-merger benefits realisation and escalating issues and variances from the strategy to relevant Board Committees and the Board of Directors where there is risk to delivery;

(iv) Ensuring coordination and coherence of the entire transformation agenda, including both major programmes of changes, as well as creating a culture of empowerment and continuous quality improvement.

2 OVERVIEW

2.1 The existence of the Committee is the central means by which the Board ensures that there are adequate and appropriate transformation structures, processes and controls in place throughout the Trust.

2.2 The Committee independently scrutinises and monitors the Board Assurance Framework as it relates to the transformation of services including the digital, merger, improvement and reconfiguration programmes.

2.3 The committee came into existence as a result of the merger on the 1st October 2020 and as such the first two meetings during 2020/21 have focussed on setting up the committee, agreeing the terms of reference and developing the governance framework for reports and standing agenda items.

2.4 A forward plan detailing which papers are to be expected at each Transformation Committee is reviewed annually but is updated as necessary throughout the year. The Committee's forward plan was reviewed and approved in October 2020 and has been updated as necessary throughout the year. The forward plan is attached at **Appendix 1.**

2.4 During the course of the 2020/21 year, Michele Whitehurst in capacity as Trust Governor, attended the February meeting.

3 MEMBERSHIP

3.1 The Committee membership in respect of the financial year 2020/21 comprised:

- Pankaj Dave, Non-Executive Director and Committee Chair
- Cliff Shearman, Non-Executive Director
- Caroline Tapster, Non-Executive Director
- Debbie Fleming, Chief Executive
- Deborah Matthews, Director of Improvement
- Karen Allman, Chief People Officer
- Richard Renaut, Chief of Strategy and Transformation
- Peter Gill, Chief of Informatics
- Stephen Killen, Transformation Director
- Alan Betts, Director of Improvement and Integration
- Mark Mould, Chief Operating Officer
- David Moss, Chairman
- Michele Whitehurst, Governor

4 COMPLIANCE WITH TERMS OF REFERENCE

4.1 In accordance with its terms of reference, the Committee is composed of three non-executive directors (one of whom chairs the committee), the Chief Executive, Chief of Strategy and Transformation, the Chief Operating Officer and Chief of Informatics and the Chief People Officer.

4.2 All meetings for 2020/21 were quorate.

4.3 Development of the Committee's terms of reference took place during September and October 2020 and the draft Terms of Reference were discussed at the first meeting in November 2020. The Terms of Reference were subsequently approved.

4.4 This review indicates that reports were received, scrutinised and discussed in accordance with the Committee's terms of reference. The Committee discussed and scrutinised the following reports during the year:

- Escalation Report from Digital Programme Group
- Escalation Report from Reconfiguration Oversight Group
- Escalation Report from Transformation and Improvement Group
- Escalation Report for Benefits Realisation Assurance Group
- Benefits Report
- Update from the Integration Group
- Risk monitoring process, update and review of mitigations
- Review of the 6 month merger report for NHSE/I
- Scrutiny of the priorities for Strategy and Transformation team for 2021/22
- Review of the Full Business case for Reconfiguration

5 MEETINGS

5.1 Two formal meetings were held during the year.

- Thursday, 19 November 2020
- Thursday, 18 February 2021

5.2 Meeting attendance is detailed in **Appendix 2**.

5.3 The Committee receives reports from groups reporting into the Transformation and Improvement Group, all of which meet months, as outlined in **Appendix 3.**

7 CONCLUSION

7.1 The Committee has complied with its terms of reference during 2020/21, during which it has:

i) Held quorate meetings;
ii) Reviewed risks relating to transformation;
iii) Reviewed and discussed a number of reports covering transformation and reconfiguration;
iv) Reviewed and scrutinised issues impacting on digital strategy, integration and benefits realisation
v) Reviewed and scrutinised reports as outlined in paragraph 4.4

Pankaj Dave
Non-executive Director and Chair of the Transformation Committee
June 2021

Appendix 1

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

TRANSFORMATION COMMITEE

FORWARD PLAN (OCTOBER 2020)

Quarter 4 2020-21 (Feb 2021 meeting)	• Early PIRs: stroke, and integration by CG/ Corporate • QI Academy proposal • BRAG plan for 21/22 incl CIP
Quarter 1 2021-22 (June 2021 meeting)	• Cardiac early PIR • Innovation and BU joint strategy draft • Reconfiguration • Digital strategy
Quarter 2 2021-22 (Sept 2021 meeting)	• First Care Group deep dive • Update on Innovation Strategy • Overview of allies in transformation • Check of programme governance
Quarter 3 2021-22 (Dec 2021 meeting)	• Second Care Group deep dive • Merger Benefits PIR • Digital PIR e.g DCR • Overview of reconfiguration progress and timeline
Quarter 4 2021-22 (Mar 2022 meeting)	• Third Care Group deep dive • Other PIRs • Draft plan for 2022-23

Appendix 2

TRANSFORMATION COMMITTEE MEETING ATTENDANCE

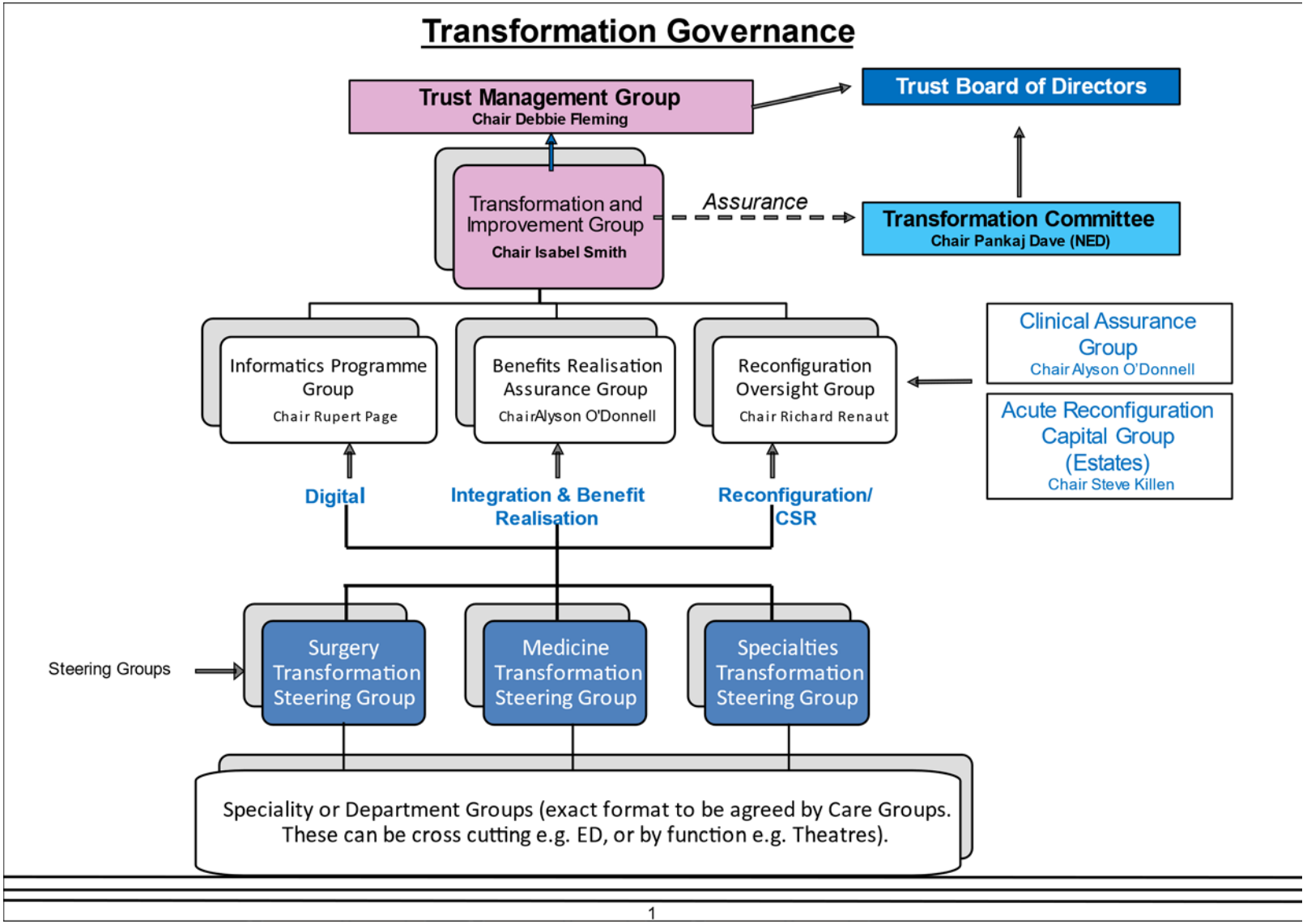
REGISTER 2020/21

NAME OF COMMITTEE:	TRANSFORMATION COMMITTEE	
REPORTS TO:	BOARD OF DIRECTORS	
Membership (as per Terms of Reference)	MEETING DATES	
	19 November 2020	**18 February 2021**
Pankaj Dave	✓	✓
Debbie Fleming	✓	✓
Richard Renaut	✓	✓
David Moss	✓	✓
Peter Gill	✓	x
Karen Allman	✓	✓
Deborah Matthews	✓	x
Steve Killen	✓	x
Alan Betts	✓	✓
Caroline Tapster	✓	✓
Cliff Shearman	✓	✓
Michele Whitehurst	(not invited*)	✓
Mark Mould	x	x
In attendance:		
Helen Rushforth	✓	✓

*Michele Whitehurst was not invited to the first Committee meeting as governors had not been appointed at this stage.

Appendix 3

SUB-COMMITTEE GOVERNANCE AND REPORTING ARCHITECTURE



UNIVERSITY HOSPITAL DORSET NHS FOUNDATION TRUST

SUSTAINABILITY COMMITTEE ANNUAL REPORT
(OCTOBER 2020 – MARCH 2021)

1 PURPOSE OF THE REPORT

1.1 The Sustainability Committee (the "Committee") has prepared this report for the Board of Directors. It sets out how the Committee satisfied its terms of reference during 2020/21 and seeks to provide the Board with evidence relevant to its responsibilities which include:

(i) monitoring implementation and assurance of benefits realisation for the Sustainability agenda for the Trust;
(ii) ensuring delivery of Sustainability objectives described in the Sustainability strategy known as the Green Plan as outlined in the Terms of Reference
(iii) monitoring implementation progress of our journey to net Carbon Zero in line with the national NHS target and a sustainable health service while escalating issues and variances from the strategy to relevant Board Committees and the Board of Directors where there is risk to delivery;
(iv) Ensuring coordination and coherence of the entire sustainability agenda across all areas of action, as well as creating a culture of empowerment and continuous quality improvement.

2 OVERVIEW

2.1 The existence of the Committee is the central means by which the Board ensures that there are adequate and appropriate sustainable teams, structures, processes and controls in place throughout the Trust.

2.2 The Committee independently scrutinises and monitors the Board Assurance Framework as it relates to the sustainable strategy and the outcomes of the ten areas of action outlined in the Green Plan, reviewing the Trust's annual business plan and other strategies to ensure sustainability and mitigations to climate change is assured and embedded.

2.3 The Committee came into existence as a result of the merger on the 1st October 2020 and as such the meetings during 2020/21 have focussed on setting up the committee, agreeing the terms of reference and developing the governance framework for reports and standing agenda items.

2.4 A forward plan detailing which papers are to be expected at each Transformation Committee is reviewed annually but is updated as necessary throughout the year. The Committee's forward plan was reviewed and approved in October 2020 and has been updated as necessary throughout the year. The forward plan is attached at **Appendix 1.**

2.4 During the course of the 2020/21 year, Andrew McLeod in capacity as Trust Governor, was invited to attend the meetings.

3 MEMBERSHIP

3.1 The Committee membership in respect of the financial year 2020/21 comprised of the following Board Members:

- John Lelliott, Non-Executive Director and Committee Chair
- Philip Green, Non-Executive Director
- Stephen Mount, Non-Executive Director
- Debbie Fleming, Chief Executive
- Richard Renaut, Chief of Strategy and Transformation
- Pete Papworth, Director of Finance

In addition the following members were in attendance:

- Edwin Davies, Director of Estates
- Stuart Lane, Sustainability Manager
- Andrew McLeod, Governor
- Elliot Prescott, Travel and Transportation Manager
- Isobel Smith, Consultant and Medical Director Strategy & Transformation
- Ian Poultney, Head of Sustainability & Strategic Development BCP
- Lois Betts, Head of Sustainability BU
- George Atkinson, Associate Director of Estates

4 COMPLIANCE WITH TERMS OF REFERENCE

4.1 In accordance with its terms of reference, Membership of the Group comprises three non-executive directors, the Chief of Strategy and Transformation, the Chief of Finance and the Chief Executive. The Group will be chaired by a non-executive director of the Trust (not the Chairman of the Trust), appointed by the Board of Directors.

4.2 All meetings for 2020/21 were quorate.

4.3 Development of the Committee's terms of reference took place during September 2020 and the draft Terms of Reference were discussed at the first meeting in November 2020. The Terms of Reference were subsequently approved.

4.4 This review indicates that reports were received, scrutinised and discussed in accordance with the Committee's terms of reference. The Committee discussed and scrutinised the following reports during the year:

- The NHS Net Carbon Zero plan
- The sustainable assessment tool use for UHD
- The creation of a Sustainability Strategy, aka Green Plan
- Agreeing action plans and SMART targets

- Escalation Report from Transformation and Improvement Group
- Scrutiny of the priorities for Sustainable action teams for 2021/22

5 MEETINGS

5.1 The Group will normally meet on a quarterly basis and at such other times as the Group shall require.

5.2 Meeting attendance is detailed in **Appendix 2**.

7 CONCLUSION

7.1 The Committee has complied with its terms of reference during 2020/21, during which it has:

i) Held quorate meetings;
ii) Reviewed the development of the UHD Green Plan and recommended approval by Board
iii) Reviewed and discussed a number of reports covering sustainability

John Lelliott
Non-executive Director and Chair of the Sustainability Committee
July 2021

Appendix 1

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

SUSTAINABILITY COMMITEE

FORWARD PLAN (OCTOBER 2020)

Quarter 4 2020-21 (March 2021 meeting)	• ToRs developed • Review of NHS NCCZ plan • Draft Green Plan review • Develop links with BU & BCP
Quarter 1 2021-22 (June 2021 meeting)	• Cardiac early PIR • Innovation and BU joint strategy draft • Reconfiguration • Digital strategy
Quarter 2 2021-22 (Sept 2021 meeting)	• Steering group reports • Carbon Tracker review • Approval of action schemes recommended by the steering group
Quarter 3 2021-22 (Dec 2021 meeting)	• Steering group reports • Carbon Tracker review • Approval of action schemes recommended by the steering group
Quarter 4 2021-22 (Mar 2022 meeting)	• Steering group reports • Carbon Tracker review • Review Green priorities plan for 2022-23

Appendix 2

TRANSFORMATION COMMITTEE MEETING ATTENDANCE

REGISTER OF BOARD MEMBERS 2020/21

NAME OF COMMITTEE:	TRANSFORMATION COMMITTEE	
REPORTS TO:	BOARD OF DIRECTORS	
Membership (as per Terms of Reference)	MEETING DATES	
	19 November 2020	**18 February 2021**
John Lelliott	✓	✓
Philip Green	✓	✓
Stephen Mount	✓	✓
Debbie Fleming	✓	✓
Pete Papworth	✓	✓
Richard Renaut	✓	✓

* Andrew McLeod was not invited to the first Committee meeting as governors had not been appointed at this stage.